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# **Towards Culturally Appropriate Speech-Language and Hearing Services:**

*Exploring the Cultural Narrative in Initial Consultations  
with Xhosa-speaking Patients*

A Dissertation submitted to  
the Division of Communication Sciences and Disorders,  
Faculty of Health Sciences, University of Cape Town  
In fulfilment of the requirements of a MSc in Speech-Language  
Pathology

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University of Cape Town

## ABSTRACT

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. This move towards more culturally and linguistically appropriate services is in line with the worldwide trend away from the biomedical to a more biopsychosocial and patient-centered approach to health care. Within the field of Speech-Language and Hearing Therapy (SLHT), the provision of more culturally appropriate services has been emphasized and research has focused on the new field of Cultural Speech-Language Pathology, interpreter-mediated consultations, and the use of more appropriate assessment and rehabilitation procedures. Penn (2000) proposed the use of the cultural narrative as a more appropriate means of gathering information from patients in initial consultations. Research into the use of narratives has been conducted in a number of health related disciplines, however, to date, this area has been under-researched within the field of SLHT and in the South African context. In this study, the researcher explored and documented the cultural narrative within multilingual, multicultural consultations in the field of SLHT in South Africa. The cultural narrative was compared to traditional methods of obtaining case history information in initial consultations across interpreter-mediated consultations with a white, English-speaking clinician and a black Xhosa-speaking clinician with Xhosa-speaking patients. In addition, post-consultation interviews using semi-structured questionnaires were carried out. Both the initial consultations and the post-consultation interviews were recorded and transcribed verbatim. The analysis of the initial consultation transcripts included an in-depth analysis of the interpreting practices. The post-consultation interview transcripts were thematically analyzed. The analysis included an analysis of interpreting and thematic analysis of the post-consultation interviews in which the participants also took part. The major finding of this study was that the cultural narrative method is more culturally appropriate, patient-centered and in line with a biopsychosocial approach to health care than the traditional case history method in both monolingual and multilingual, multicultural, interpreted consultations. This study has numerous theoretical, clinical and future research implications. It is hoped that these findings will be used to inform the training of clinicians and in practical application in clinical encounters. Although this study was conducted within the field of SLHT, the findings are believed to be applicable across all disciplines in health care.

**KEY WORDS:** Transformation, Cultural Speech-Language Pathology, Cultural Narrative, Illness Narrative, Traditional Case History Methods, Biopsychosocial Model, Patient-Centered Care, Biomedical Model, Initial Consultations, Interpreting, Cultural Broker

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## **ABBREVIATIONS**

<b>WC</b>	<b>White clinician</b>
<b>BC</b>	<b>Black clinician</b>
<b>TCH</b>	<b>Traditional Case History</b>
<b>CN</b>	<b>Cultural Narrative</b>
<b>Cg</b>	<b>Caregiver</b>
<b>Cl</b>	<b>Clinician</b>
<b>CH</b>	<b>Case History</b>
<b>FB</b>	<b>Feedback</b>
<b>PI</b>	<b>Positivity Index</b>

## CHAPTER ONE

### GENERAL INTRODUCTION

*"Even at its scientific best, medicine is always a social act"* (Davidoff, 1996: 43)

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. During this post-apartheid period, multiculturalism and multilingualism are emerging and being promoted. However, the reality of the South African situation is that the transformation process is long and tedious. In newly integrated services, overt disadvantage owing to race has been replaced by covert disadvantage owing to linguistic and cultural barriers.

There has not been equitable delivery of public services to all sectors of the South African population as a result of colonial rule and, later, *apartheid* (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. With the exception of nursing staff, the overwhelming majority of health professionals are unable to speak any of the indigenous languages<sup>1</sup>. The language, social and cultural divide between clinicians and patients in all spheres of health care is evidence of the wide gap still existing between health professionals 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). Speakers of indigenous languages are multiply disadvantaged in receiving health services by virtue of both their race and the language they speak (Drennan, 1999a, 1999b).

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

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<sup>1</sup> The term indigenous language shall be used throughout to refer to all of the official South African languages, with the exception of English and Afrikaans. The term shall be used interchangeably with the term Black African languages, but not with the term African languages as Afrikaans is considered to be an African language (Drennan, 1998).

health care system. The South African Constitution supports this move by enshrining the right of each individual to be addressed in the language of his or 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 inequalities in service provision.

The Minister of Education has on numerous occasions pledged to address the past inequalities of student profiles so that they reflect the demographics of the country. The National Plan for Higher Education has been introduced by the Department of Education in order to promote and develop the students who are being trained in those professions for which there had previously been no exposure (Department of Education, 2001). 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. A number of 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). 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).

In 1997 the Department of Health released a paper that outlined the transformation of the health care system in South Africa. Despite this critical initiative, the importance of communication in health care does not play a prominent role in this process. There is a need for more equitable health service delivery and the formulation and implementation of more culturally appropriate intervention methods.

This move towards transformation is in line with global health care trends. Worldwide, there is a move towards abandoning the traditional biomedical approach of health care in favour of a biopsychosocial approach. The biopsychosocial approach to health care was proposed by Engel in 1977 as an approach that would take into account the patient, the social context in which he lived and the complementary system devised by society to deal with illness. Engel proposed that his biopsychosocial model would provide a *“blueprint for research, a framework for*

*teaching, and a design for action in the real world of health care*” (Engel, 1977: 135). In addition to the shift in health care towards a biopsychosocial approach, there has been growing emphasis on providing patient-centered care. Patient-centered care has been defined as an approach that consciously adopts the patient’s perspective and involves the patient more actively in their own care (Gerteis, Edgman-Levitan, Daley & Delbanco, 1993).

The provision of health care that is patient-centered and in line with a biopsychosocial approach, is critical in the South African context in which, to date, the majority of the population, being disempowered by virtue of their language and culture, has received inadequate health services. Problems of distrust and misunderstanding exist in patients from low-income cross-cultural contexts (Bartz, 1999). To understand and to meet this challenge, Bartz (1999) proposed the need for further research of community-based clinician-patient interactions that bring together theoretical and empirical forms of enquiry.

There is a general awareness in health care of the need for more culturally appropriate services. However this knowledge is at present only implicit. What is lacking is an explicit plan for developing and implementing these services. Hence there is the need to develop more culturally appropriate procedures and services.

One of the health care fields which has placed much emphasis on the provision of more culturally appropriate services, is the field of Speech-Language and Hearing Therapy (SLHT). This field has been acknowledged as being ahead of many others in striving towards the provision of more culturally appropriate services (Battle, 1998; Wyatt, 1998; Penn, 2000). Cultural indices and the need for cultural sensitivity have been well-documented within the field of SLHT. Culture and language work hand in hand because, in order to communicate effectively in another language, an individual has to obtain a clear picture of the culture associated with that language (Loest, Britz & Pauw, 1997). Hence it is important to define SLHT in the paradigm of culture (Sishi, 2001). It has been proposed that the focus of research should not be on intercultural communication, that is communication (differences) between cultures, but on cultural communication, namely communication within a culture (Penn, 2000).

Hence, the rationale for this research is embedded in the need to take practical steps, which are clinically applicable, in the move towards more equitable and more culturally appropriate services, in SLHT in South Africa.

Within the field of SLHT a number of initiatives have been undertaken. These include the proposed new field of Cultural Speech-Language Pathology (Penn, 2000), using interpreter mediated consultations in cross-cultural and cross-linguistic encounters, and the use of more appropriate assessment and rehabilitation procedures.

All of these initiatives are important. However, it is critical to examine the procedures used in the initial point of contact in the clinician-patient relationship, namely the initial consultation. Initial consultations are a crucial part of the clinical interaction between the clinician and patient, as they form the basis for all future interactions. The initial consultation has been documented as having a dual purpose, namely to obtain case details from the patient, and for the clinician to make a diagnosis. Traditionally, this was carried out using a structured question and answer format, the traditional case history. What has been lacking has been a culturally appropriate means of obtaining a case history.

Recently, however, there has been research into the use of narratives as an alternative means of obtaining case history information from a patient (Greenhalgh, 1998, 1999; Greenhalgh & Hurwitz, 1998, 1999; Heath, 1998; Launer, 1999; Elwyn & Gwynn, 1998, 1999). It has been proposed that the lost tradition of narratives should be revived in the teaching and practice of medicine (Greenhalgh & Hurwitz, 1998). The use of narratives is based on the premise that patients' subjective experiences are overlooked in clinical interactions (Penn, 2000). The study of patients' *illness narratives* or *stories* has been proposed as a means of orientating the clinician to the patient-relevant outcomes of illness, which are dependent on the patients' socio-economic, psychological and cultural contexts. Greenhalgh and Hurwitz (1998) refer to the illness narrative as a story that can be shared in the clinical situation between the patient and the clinician and that is centred around the patient's experience of his illness. In order to elicit such a narrative, the clinician asks the patient to tell the story of his illness. This method differs from traditional case history methods in that the

focus is on the patient's story-telling, which is elicited from one, or possibly more, key questions, whereas traditional case history methods involve the clinician asking numerous questions. Penn (2000) proposed that the cultural narrative<sup>2</sup> method might be particularly appropriate to the multicultural, multilingual South African context. However, with the exception of Penn (2000) and Sishi (2001), no research on the use of narratives in initial consultations has previously been undertaken within the South African health care context or in the field of SLHT.

Hence, the purpose of this study was to explore and to evaluate the cultural narrative as a potentially culturally appropriate method of gathering information and obtaining case history details from patients in multicultural, multilingual initial consultations

The primary aim of this study was to explore and to document the use of the cultural narrative as a method of obtaining a case history in initial consultations in the South African context. Furthermore, this research aimed to compare the cultural narrative method to the traditional case history method in consultations with a black, Xhosa-speaking clinician with Xhosa-speaking patients and in interpreter mediated consultations between a white, English-speaking clinician and Xhosa-speaking patients. More specifically, this study aimed to document the perceptions of the clinicians, interpreter and Xhosa-speaking patients involved in the consultations and to analyse the actual consultations in which the two methods were used.

There are similarities between this study and preliminary research conducted by Sishi (2001), in that both investigated the traditional case history and the cultural narrative methods in initial consultations with Xhosa-speaking patients in the field of SLHT in South Africa. Like Sishi's (2001) research, this study was exploratory in nature. However, it differed from Sishi's in that it is a larger study, which made use of more in-depth analysis procedures. Research previously conducted by the researcher focused on interpreting in initial consultations in the field of SLHT (see Evans, 2000). This research equipped the researcher with knowledge and methods of analysis that allowed for an in-depth examination of the interpreted consultations. This research differs from past research in that it distinguished between the case history and the

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<sup>2</sup> In this study, the term *cultural narrative* (Penn 2000) shall be used interchangeably with *illness narrative* as described by Greenhalgh and Hurwitz (1998).

feedback components of initial consultations and involved all of the participants' perspectives in the study.

In this study the cognizance paid to the role of the interpreter reflects on the existing South African health care context in which it is the norm for white, English speaking SLHT's to provide intervention to patients of other cultural and language groups. It is well-established that interpreters are a necessity in cross-lingual consultations (Erasmus, 1999; Swartz, 1998; Evans, 2000; Fisch, 2001). Consultations with Xhosa-speaking patients were chosen because Xhosa is one of the official languages of both the Western and the Eastern Cape provinces in which this research was carried out. The majority of the patients seen by clinicians in these provinces were Xhosa-speaking.

This research draws on input from a number of different disciplines, including anthropology, sociology, communication, interpreting and medicine in general. As such, it is crossing the boundaries of a number of health and communication-related disciplines.

This study is believed to be clinically relevant to the multilingual, multicultural South African context and its existing health care system, which is focused on primary and community-based health care. In addition, it is believed to be theoretically relevant in its alignment with current trends in health care in moving towards a biopsychosocial and a patient-centred approach. This research has numerous clinical, theoretical and future research implications which may be of immediate clinical and social benefit. Although this study was conducted in the field of SLHT in South Africa, the numerous implications are believed to be relevant across all health care disciplines in multicultural contexts.

## **1.1 DESCRIPTION OF CHAPTERS**

Chapter Two in this study contains a literature review aimed at providing the reader with a theoretical orientation to biomedicine and the biopsychosocial approach to health care. This approach is discussed in relation to patient-centred approaches to health care, as well as its applicability in the South African context

Chapter Three focuses on the current situation in the field of SLHT in South Africa. The move towards cultural speech language pathology in this country is discussed with particular emphasis on interpreter mediated encounters and on exploring the origins and applicability of cultural narratives.

The methodological design, aims, rationale, data collection process, the analysis of the data and the measures of reliability employed, are outlined in Chapter Four.

Chapter Five presents the findings of the study and includes an in-depth discussion. These findings are presented under the themes of characteristics, transaction, patient-centred care and the role of the interpreter, which emerged from the discussions with the participants.

Finally, Chapter Six contains a general discussion, conclusion and implications of this study.

University of Cape Town

## CHAPTER TWO

### TOWARDS A BIOPSYCHOSOCIAL APPROACH TO HEALTH CARE

*" Doctors travel back and forth across the bridge, taking the patient's story of illness to be informed by medicine's abstract knowledge and then to be interrupted and returned to the patient as a presumptive diagnosis retold in the form of a case history"*

(Jones, 1997: 85)

There are two fundamentally opposing and mutually incompatible philosophical perspectives into which all theories can be divided, namely the *reductionist* (atomist, mechanistic) and the *holistic* (constructivist, organismic) perspectives (Hagedorn, 1992). These have been described as *metamodels* (Reed, 1984 in Hagedorn, 1992). Table 2.1 presents the basic tenets of each perspective as summarized by Hagedorn (1992).

**Table 2.1 : The Tenets of the Holistic / Constructivist and The Reductionist Perspectives (Hagedorn, 1992)**

<b>Holistic / Constructivist</b>	<b>Reductionist</b>
Views the person as a whole greater than the sum of its parts	Views individuals as divisible into components that may be studied separately
Systems are interactive and adaptive.	Systems are closed and fixed.
Control is based within the individual, who has free will and can make conscious, rational decisions.	Deterministic: control is external to the individual, or has an involuntary basis.
Present / Future-oriented	Past / Present-oriented
Thoughts, feelings and perceptions are important and affect behaviour.	Behaviour is important: Thoughts and emotions are by-products of physiology and/or behaviour.
Behaviour exceeds the utilitarian.	Behaviour is utilitarian.
Spirituality can be acknowledged.	Spirituality is not usually acknowledged.
Subjective methods of research are valid.	Objective methods of research are valid.

The reductionist viewpoint adopts a strictly objective and utilitarian view of concrete reality, which can be broken down into observable components in which the whole may be understood by studying the parts (Hagedorn, 1992). In contrast, the holistic viewpoint is subjective, reality is abstract and elements interact to form a whole that is greater than the sum of its parts, a *gestalt*. Each element of the gestalt cannot be understood in isolation (Hagedorn, 1992).

## **2.1 APPROACHES TO BIOMEDICINE**

Two dominant approaches to medicine have prevailed in the last few decades, namely the biomedical and the biopsychosocial approaches. 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, 1992: 89).

### **2.1.1 Biomedicine**

Helman (1996) outlines the basic premises of biomedicine. These are scientific rationality; the emphasis on objective, numerical measurement, physiochemical data and mind-body dualism; the view of diseases as entities; reductionism and the emphasis on the individual patient, rather than on the family or community. Within this framework clinicians assume that biological concerns are more basic, clinically significant and interesting than psychological or sociocultural issues (Kleinman, Eisenberg & Good, 1978). This perspective assumes that diseases are universal in form, progression and content (Fabrega & Silver, 1973 in Helman, 1996). Within the biomedical approach, there is less focus on the actual patient and more on the

diseased body part instead (Helman, 1996). The biomedical model concentrates heavily on bodily functions (Shaver, 1985).

In 1977 George L. Engel put forward a challenge to biomedicine for a new medical model in the journal, *Science*. Engel was responding to a perceived crisis that the biomedical model of disease, the dominant medical model of that time, was no longer adequate for the scientific tasks and responsibilities of the disciplines of both medicine and psychiatry (Engel, 1977). Although the biomedical model was viewed as constituting a sound framework within which to understand and treat disease, it was not relevant to the behavioural and psychological problems that traditionally fell within the domain of psychiatry (Engel, 1977). The biomedical model as described by Engel (1977) has molecular biology as its basic scientific discipline. One of the primary assumptions of biomedicine is that disease is fully accounted for by deviations from the norm of measurable biological (somatic) variables. Within this framework there is no room for the psychological, social and behavioural dimensions of illness.

In the late 1970s, the biomedical model was the dominant folk model of disease in the Western world. According to Engel (1977), this approach to disease had been successful beyond all expectations, but at a price. For in serving as the blueprint and justification for health care policy, biomedicine had also contributed to a host of problems. Distortions were introduced by the reductionist tendency to regard the disease as adequately characterised in terms of the smallest isolable component having causal implications. One contention with this is that, without perturbations at the biochemical level, the designation of *disease* does not apply. The attitudes and beliefs of clinicians are moulded by the biomedical model even before they embark on a professional education, which in turn reinforces it without necessarily clarifying how its use for social adaptation contrasts with its use for scientific research. As such, this model has been described as having the status of a *dogma*, a cultural imperative whose limitations are easily overlooked. The conceptualization of disease as the derangement of the underlying physical mechanism resulted in reductionism and exclusionism (Engel, 1977).

Engel (1977) cited the following reasons for adopting a new medical model:

- Health needs were not being met.
- Biomedical research was not having sufficient impact in human terms.
- Clinicians were lacking in interest and understanding, were preoccupied with procedures, and were insensitive to the personal problems of patients and their families.
- Medical institutions were seen as cold and impersonal.

Holman (1976 in Engel, 1977: 134) criticized reductionism saying:

*“While reductionism is a powerful tool for understanding, it also creates profound misunderstanding when unwisely applied. Reductionism is particularly harmful when it neglects the impact of nonbiological circumstances upon biologic process... Some medical outcomes are inadequate not because appropriate technical interventions are lacking but because our conceptual thinking is inadequate... The medical establishment is not primarily engaged in the disinterested pursuit of knowledge into medical practice; rather a significant part of it is engaged in special interest advocacy, pursuing and preserving social power.”*

There was a need for a new medical model that would acknowledge the human experience of illness and that the biochemical defect constitutes one factor among many, the complex interaction of which might culminate in active disease or manifest as illness. It is evident that biochemical defects cannot be accountable for all illness. Full understanding of the human experience of illness requires additional concepts and frames of reference.

According to Engel (1977) the biomedical model encourages bypassing the patient’s verbal account by placing greater reliance on technical procedures and measures. A new model would recognize the complexity of an examination, which, in the process of data collection, would require 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 clinician and the relationship between clinician and patient act as powerful influences on therapeutic outcome. These constitute psychological effects, which might directly modify the illness experience or indirectly effect underlying biochemical processes. The clinician's role of educator and psychotherapist requires psychological knowledge and skills, which are outside the biomedical framework (Engel, 1977).

The proposed biopsychosocial approach would take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is the role of the physician and the health care system. However, it was anticipated that the emergence of new findings and theories would rarely suffice in attempting to overthrow the well-entrenched dogma of biomedicine, as the power of vested interests, social, political and economic, are formidable deterrents to any effective assault on biomedical dogmatism (Engel, 1977). Engel (1977) anticipated that there would be difficulties in closing the gap between teachers ready to teach and learners eager to learn from this new approach to health care.

### **2.1.2 Biopsychosocial Medicine**

The Biopsychosocial model has been important for the practice of medicine for two decades. Clinicians working within 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 underlying philosophy of this approach is that health is maintained by improving and preserving mutually interdependent components of the physiological, psychological,

social, economic, cultural and environmental systems. In the biopsychosocial approach, the individual is a psychosomatic person interacting with the socio-economic context (Bolaria & Dickinson, 2001).

The biopsychosocial model was originally proposed as a scientific paradigm that aimed to be ethically neutral to the extent that 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). The model suggests that in caring for a patient, one needs to examine psychological, social, cultural and biological aspects (Brody, 1999). As a scientific paradigm, the biopsychosocial model speaks peripherally on the issue of clinician-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 history and the patient will, as a rule, provide a detailed, thoughtful and accurate history only when the clinician 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.

One criticism of the biopsychosocial approach to health care is a lack of appropriate research methodologies. The constructivist nature of this approach suggests that the most appropriate means of carrying out service within such an approach should embrace a constructivist rather than a reductionist approach. Combining techniques that are from within the same metamodel is likely to be more effective than trying to combine those from opposing perspectives (Hagedorn, 1992). It is consequently important to be aware of the underlying philosophy of a model, frame of reference or approach and to ensure that the techniques used are compatible with one another (Hagedorn, 1992). Recently, Greenhalgh and Hurwitz (1998) have advocated the use of narratives as a means of obtaining case histories from patients. This method could provide a solution to the lack of constructivist methods of information gathering within the biopsychosocial approach.

Bolaria and Dickinson (2001) state that for the biopsychosocial approach to succeed, it is vital for it to become a part of everyday discourse. 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 economic, social and political forces. 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 optimized by expanding research in this sphere (Bolaria & Dickinson, 2001).

Smith (1983) documents some of the chief complaints about the biopsychosocial approach that were raised in the early stages of the approach's existence. Firstly, the biopsychosocial approach is often considered to be intuitively obvious and therefore useless because it tells the clinician nothing new. Secondly, some clinicians have reportedly commented on their reluctance to address psychological matters. There has been concern that there is insufficient time within a consultation to follow such an approach. Clinicians' reluctance to adopt such an approach has also been reflected in their comments that they are already being respectful and kind to their patients so there is no need to change their existing practices, their misconception that open-ended interviewing is easy and that the clinician can adopt a more passive role, and that delving deeper into psychosocial issues upsets patients (Smith, 1983). In addition, some clinicians feel that the reductionist approach works, so there is no need to adopt another approach (Smith, 1983).

Smith (1983) considers the above objections to be misconceptions that can be attributed to clinicians' lack of understanding of the biopsychosocial approach. Although many educators understand the biopsychosocial approach conceptually, few have experience in its clinical application, and the psychosocial dimension in particular.

Now, almost twenty-five years since Engel proposed the biopsychosocial model, it is questionable whether this approach is completely understood in clinical practice. Debate still exists over whether it is truly a model or just an approach to medicine, its theoretical basis (McLaren, 1998; Mullen, 1998), its compatibility with patient-

centredness (Bartz, 1999; Brody, 1999) and the appropriate methodologies for working within such an approach (Hagedorn, 1992). Mullen (1998) believes that regardless of whether the biopsychosocial approach can be justifiably considered to be a model, the power in the phrase 'the biopsychosocial model' lies in its being seen by most health professionals as an obvious truth. Mullen (1998) states that once we have words to express emergent ideas these ideas take on a reality and attract themselves to a discourse.

## 2.2 DISEASE VERSUS ILLNESS

The biopsychosocial approach emerged from the context of the 1970s and the move towards Transcultural Psychiatry. In this same spirit of embracing holistic and cultural health care, Kleinman's research on the difference between illness and disease came to the fore. These concepts remain significant in health care today.

Rooted in the biomedical model of health care is the conceptualization of the patient's affliction as *disease*. Kleinman *et al.* (1978) raised the important distinction between *illness* and *disease*, in which *disease* describes the malfunctioning of the body and *illness* as the lived experience of suffering. Disease within the biomedical approach is regarded as being a deviation from normal functioning. A major source of misunderstanding between patients and clinicians relates to how each of them perceives health problems (Kleinman *et al.*, 1978). *Illness* for the patient has a broader meaning beyond the technical, in that it has an emotional and a social context that may, for the patient, be of greater significance. Illness is '*what the patient feels when he goes to the doctor*' and disease is '*what he has on the way home from the doctor's office*' (Cassell, 1978: 27). Through the investigation of psychological and social, as well as biological, factors in the biopsychosocial approach, it stands to reason that more factors relating to the patient's *illness* would be raised by the patient. A systematic way of asking about patients' illness experiences has been developed by Kleinman and his colleagues (Kleinman *et al.*, 1978; Katon & Kleinman, 1981, Kleinman, 1988 in Swartz, 1996). The focus of this research tradition is on *explanatory models*, which is the understanding that a person holds for illness. Kleinman defines an explanatory model as '*the notions about an episode of sickness*

*and its treatment that are employed by all those engaged in the clinical process'* (Kleinman, 1988 in Helman, 1996: 111).

Both patients and clinicians hold explanatory models. They provide explanations for the etiology or cause of the condition, the timing and onset of symptoms, the pathophysiological processes involved, the natural history and severity of the illness and the appropriate treatments for the condition (Helman, 1996). Patients' explanatory models are regarded as being idiosyncratic and dynamic and are influenced by both personality and cultural factors (Kleinman, 1988 in Helman, 1996). In contrast, the explanatory models held by clinicians tend to be based on a single causal train of scientific logic (Kleinman, 1988 in Helman, 1996). Helman (1996) states that explanatory models can only be understood in the specific context in which they are employed. This context includes the social and economic organization and the dominant ideology of the society in which the patient experiences his illness (Helman, 1996). In addition, the participants in the consultation and the status that the participants hold influence the patient's explanatory model. The power invested in the clinician by virtue of his background and training allows him to mould the patient's explanatory model to fit into the biomedical perspective, rather than allowing the patient's own perspective to emerge.

### **2.3 TOWARDS PATIENT-CENTRED CARE**

*"The responsibility for helping falls on the doctor-patient partnership but on neither party alone"* (Wolfe, Ingelfinger & Schmitz, 1994: 896)

Helman (1996) has outlined five strategies for improving clinician-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-clinician interaction, the clinician needs to adopt both a biopsychosocial and a 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 modeling, 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: 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 model 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) outline 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 their 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 recognize 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, 1997). The core aspects of patient-centredness include the availability of information at all times (Fulford, 1996), the attentiveness of the clinician (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).

The patient-centred approach lies within the spirit of humanism, which is a philosophy rather than a psychological theory. Rogers was one of the main proponents of such an approach and emphasized the significance in moving from teacher / therapist-centred directive approaches to client / patient-centred ones (Hagedorn, 1992). Therapists should act as counsellors and facilitators, providing resources and enabling people to change. Key features of this Rogerian style are that it is patient-centred, using a non-directive style, interpretation is avoided and the patient's ideas are reflected back, providing encouragement for the patient to search for personal meaning and self-actualization. Central to humanism is the rejection of power being exercised by one person over another. The therapist must ensure that control is given to the client, even at the expense of very slow decision-making (Hagedorn, 1992).

Patient-centred care requires that the caregiver 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 doctor. Another important aspect of patient-centred care is the appropriate training in communication skills (Fulford, Ersser & Hope, 1996). Communication skills appear to be a major factor in the provision of effective patient-centred care (Cassel, 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 clinician. 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 clinician and the patient (Little et al., 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 clinician-patient partnership lies in the recognition that the patient is an expert too (Coulter, 1999).

There is a growing emphasis on equalizing the partnership between clinicians and patients (Coulter, 1999). However, several barriers to equal partnership need to be overcome (Coulter, 1999). These barriers are crucial to the understanding of clinician-patient partnership in the 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 clinicians to be better trained in communication skills (Coulter, 1999). Perceived lack of time, clinicians' predisposition and skill and patients' inexperience are perceived as challenges to putting shared decision-making into practice (Towle & Godolphin, 1999).

Patients vary in their willingness to participate in the culture of biomedicine and in the degree to which they are willing to take part in their own care (Allshouse, 1993). There is a lack of consensus on what constitutes an *active* or *involved* patient (Allshouse, 1993). However, regardless of how a patient's involvement is defined, it is dynamic, changing with time, experience and the course of illness (Allshouse, 1993). Sickness often makes people more passive than they might otherwise be, relegating them to the role of a passive patient.

This adopted passive patient role has been described as the patient's *sick role*. It has been proposed that patients are inhibited by what Brody (1980 in Allshouse, 1993) has referred to as the *information gap* between clinicians and patients, largely owing to the use of pathophysiological terms or concepts used by clinicians. Patients reportedly find medical terminology intimidating and physiological functions mysterious (Allshouse, 1993). Patients may fear exposing their ignorance by asking questions, or by receiving answers that may baffle them further (Allshouse, 1993).

An overwhelming sense of helplessness and loss of control is one of the most commonly reported sensations experienced by patients within the health care setting (Allshouse, 1993). Yet the traditional rules and procedures of most hospitals demand that patients should be passive, submissive and more or less inanimate (Allshouse, 1993). Allshouse (1993) documents several researchers who have tried to find ways to help patients overcome the passive patient role and to become more knowledgeable and active participants in their own care. Eisenthal, Emery, Lazare and Udin (1979 in Allshouse, 1993) encourage the use of the negotiated approach, which encourages patients to be more assertive. The underlying assumptions of this approach are that patients have their own ideas about their illness and that they have expectations of their providers. The clinician's role is to encourage the patient to voice these views and expectations.

#### **2.4 THE CHALLENGE OF PROVIDING PATIENT-CENTRED CARE IN THE SOUTH AFRICAN CONTEXT**

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. Xhosa-speaking patients are disadvantaged to this end by virtue of their race and culture and the language that they speak. 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.

In order to deal with the challenges demanded by an increasingly dehumanizing system, health service providers must focus on patient-centred care informed by a realistic assessment of patient needs (Ravich & Schmolka, 1996). All patients, regardless of their ethnicity or degree of socialization, 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 (Allshouse, 1993).

Therefore, the challenge to the health professional is to provide patient-centred care within a biopsychosocial framework in a health care system that might not yet be ready to accommodate this shift to patient-centred care. Existing methods of assessment need to be re-examined and adjusted so that they are more suited to this end. Health professionals become as much victims of the system as their patients are if they do not take responsibility for ensuring patient-centred care (Kitson, 1996).

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## CHAPTER THREE

### TOWARDS CULTURAL SPEECH-LANGUAGE AND HEARING SERVICES

*"We inhabit the great stories of our culture. We live through stories. We are lived by the stories of our race and place. We are, each one of us, locations where the stories of our place and time become partly tenable."*

(Mair, 1991: 19)

Worldwide, speech-language and hearing therapists (SLHTs) participate in multilingual, multicultural interactions with patients. These interactions have special characteristics that should form part of clinicians' training and preparation (Penn, 2000). In South Africa, within the field of SLHT, the majority of practitioners speak English and Afrikaans with minimal knowledge of the other nine official languages (Penn, 2000). This provides a unique situation in which to examine multilingual, multicultural interactions with patients.

Statistics available from the Department of Education (2000) reveal that 76.64% of the South African population speak indigenous languages and only 24.05% speak English or Afrikaans. This is significant considering that fewer than four percent of registered SLHTs are able to speak an indigenous language. This raises numerous ethical questions about a SLHT providing treatment to patients of other languages.

A number of measures aimed at addressing the issues of linguistic and cultural sensitivity in multilingual, multicultural interactions have been undertaken within the field of SLHT. Cultural indices and the need for cultural sensitivity have been well-documented (Penn, 2000). These are reflected in ASHA's office of Multicultural Affairs and special interest groups in a number of First World countries that address the adaptation of training courses, test materials, policy and development of services (Penn, 2000). However, these can often be reduced to somewhat prescriptive lists (Penn, 2000). Within the South African context, it is ironic that the profession most closely associated with language has largely failed to address these issues in more detail. Furthermore, at present, it would

appear that the profession is merely paying lip service to the ideal of 'more culturally appropriate' therapy.

### **3.1 THE NEW FIELD OF CULTURAL SPEECH-LANGUAGE PATHOLOGY**

Penn (2000) distinguishes between cross-cultural speech language pathology and the field of cultural speech language pathology, the primary distinguishing feature being that the latter is not interested in the differences between cultures, but rather in “ *an approach to diagnosis and therapy which reflects sensitivity to cultural and linguistic influences and their interface with communication disorders*” (Penn, 2000 : 71). Cultural speech language pathology examines factors that facilitate and inhibit multicultural interactions (Penn, 2000). It has been recommended that it is more valuable to invoke an attitude that will generalize to various intercultural situations, than to be advised about specifics (Penn, 2000).

### **3.2 INTERPRETER MEDIATED CONSULTATIONS**

The use of interpreters in multilingual consultations has been a general health care initiative in the move towards providing more culturally appropriate services. Interpreting practices have received much attention internationally, in line with the recognition of the need for linguistically and culturally appropriate service provision in all aspects of the public sector. Against this background, the need for interpreting services to be made available to the majority of the South African population is clear. This is particularly noticeable in the area of health care services, where the provision of interpreting services is sorely lacking.

In South Africa, the issue of interpreting is greater and more complicated than in any other part of the world (Erasmus, 1999). Interpreting has been recognized as a need at all levels of health care. The absence of a common language amongst the majority of clinicians and patients is so much a part of the everyday experience of health service provision in South Africa as to make it almost invisible (Drennan, 1999a). The so-called

'language gap' and routine strategies to work around it have become institutionalised, even ritualised, aspects of the everyday practice of health care (Swartz, 1991).

At present most health care institutions rely primarily on *ad hoc*, haphazard, interpreting services in which anyone who is able to speak the patient's language is called on to interpret (Crawford, 1994; Ngqakayi, 1994; Drennan, 1998; Swartz, 1998; Swartz & Drennan, 2000). To meet the immediate needs of the South African population, the use of community interpreters<sup>1</sup> has been established, primarily because of the multilingual and the relatively low education level of the majority of the population (Lesch, 1999).

One factor contributing to the lag in linguistically equitable health service provision in the health sector is that the role of the interpreter in health-care is ill-defined (Bowen, 2000). The responsibility of an interpreter is to bridge the linguistic barrier between individuals speaking different languages. However, there is no consensus on the best way to achieve this (Bowen, 2000). Drennan (1998) acknowledged that interpreters are invariably subject to the stresses attendant on fulfilling a function for which there is a lack of definition. There is an ongoing debate regarding what exactly is meant by 'interpretation', how broadly the interpreter's role can be defined, and whether objective language 'translation'<sup>2</sup> can or should be combined with other roles, such as that of cultural broker, educator, mediator or advocate.

In the attempted provision of linguistically equitable health care services, interpreters assume multiple and often conflicting roles within an institution (Kaufert & Koolage, 1984). This is primarily due to the differing expectations of the institutions in which they work, as well as those of the patient and clinician within the interpreted consultation. This debate has emphasised crucial issues for service provision that cannot be easily resolved (Downing, 1995 in Bowen, 2000). It highlights the complexities of the interpreter's role

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<sup>1</sup> A community interpreter is responsible for "enabling professional and client, with very different backgrounds and perceptions, and in an unequal relationship of power and knowledge, to communicate to their mutual satisfaction" (Shackman, 1987:18 in Boloka, 1999).

<sup>2</sup> As defined by The World Book Dictionary (1994), *interpreting* refers to 'the act of explaining', while *translating* is more linguistic in nature and refers to 'the act of changing from one language to another'.

as well as the challenge and the need for 'measuring' the efficacy of interpreters in the provision of health care services (Fisch, 2001).

The role of the interpreter as a cultural broker is considered to be particularly critical in the provision of health care services in multicultural encounters. Cultural brokerage involves the establishment of meaningful links between socio-culturally differentiated groups whenever there is a need to establish ties between such groups (Herselman, 1994). In addition, it has been used to suggest advocacy for economically marginalized persons in relation to a larger community (Chambers, 1985 in Herselman, 1994). However, cultural brokerage presupposes considerable knowledge of the cultures involved (Van Willigen, 1986). Effective cultural brokerage is not a task that could be easily undertaken without the necessary training in multicultural issues (Fisch, 2001).

Advocacy is another role of interpreters that has received much recognition. Advocacy models of interpreting vary from the interpreter acting as a social worker or lay psychologist to the interpreter being part of a *professional team* (Erasmus, 1999). This model of interpreting is also sometimes known as the *community interpreting*<sup>1</sup> approach, because of the emphasis on community needs and the issues surrounding power relationships across communities. In the South African context, Erasmus (1999) and her colleagues have focused on the establishment and recognition of community interpreters.

A review of the interpreting literature reveals that this is indeed a burgeoning area of research. Notably, in the last decade, research into the field of interpreting has flourished, in line with the recognition of a need to shift towards more equitable service provision. Initially, the bulk of research undertaken on clinical interpreting focused on the accuracy of the interpreting process and on its impact upon diagnostic assessment and management (Muller, 1994). It is important to note that several researchers have primarily highlighted the negative impact associated with using interpreters, referring to "alterations in meaning" (Price, 1975: 263), "interpreter error" (Price, 1975; Vasquez & Javier, 1991), "mistranslations" (Price, 1975; Ebden, Carey & Bhatt, 1988), "distortions" (Marcos, 1979: 173) and "illegitimate deviances" (Launer, 1978: 934). However,

recently, there has been an acknowledgement of examining interpreters in a more positive light (Evans, 2000; Penn, 2000; Fisch, 2001). This is primarily in view 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).

Recently attention has been drawn to assessing the positive as opposed to the purely negative contribution of interpreters, since this is likely to be of more lasting benefit to the field of interpreting than an evaluation of weaknesses (Evans, 2000). The research focus has shifted away from a 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 interpreters, to how interpreters can meet the needs of the communities they serve. There has been a growing recognition of the complexity of the interpreting situation in health care (Swartz, 1991b, 1998). It is only recently that the issue of interpreting in SLHT has become a focus of research (Evans, 2000; Penn, 2000; Fisch, 2001; Sishi, 2001).

### **3.3 Culturally Appropriate Procedures**

Two of the many challenges facing SLHTs in South Africa, are the development of ways to make the clinical interaction more beneficial to the patient and the development of linguistically and culturally relevant assessment and management approaches. Furthermore, SLHTs are challenged to make communication a central focus of health service provision. Existing assessment methods used in SLHT in South Africa are imported from other countries, specifically the United Kingdom and the United States. These methods of assessment present a number of challenges for the SLHT in clinical practice in South Africa as they are not standardized for the South African population. These assessment methods were designed for white, middle class American and British populations, as is clearly evident in the test stimuli.

Every consultation starts with an interview that is far more than just a collection of data. Instead, it is an interaction, during which the patient should be able to express how he/she feels to the clinician, and the clinician needs to be open and receptive to this, and to listen to the patient. At the same time, the clinician needs to gather the information he/she requires. For decades initial consultations have been supposed to have dual purposes, namely to find out what is wrong with the patient and to alleviate cure or illness. It has been suggested that finding out the exact nature of the illness is the basis for successful intervention.

The initial medical consultation is a crucial aspect of everyday clinical practice. Traditionally, patients are expected to describe their illness while the doctor is expected to ask questions and make a diagnosis based on the information obtained from the patient and the tests they have performed (Mishler, 1984). Patients have been described as being subjected to the *medical gaze*, which immediately establishes the patient in a position of relatively less power than the probing clinician, who controls and directs the consultation by asking questions (Crawford, 1994). The clinician is regarded as the *expert* in the consultation and has the power to direct the consultation through the questions that he/she asks. As such, patients can be described as being relatively disempowered by medical discourse.

The traditional case history method is embedded within the biomedical model of medicine. In traditional case histories, the clinician controls the patient's illness narrative (Crawford, 1994). The voice of the patient and his/her opinions are not considered important. This encounter is considered to be the cornerstone of biomedical discourse. Patients are so rushed during consultations that they are not given the opportunity to say anything about their illnesses (Crawford, 1994).

*“At its most arid, modern medicine lacks a metric for existential qualities such as inner hurt, despair, grief ... that frequently accompany, and often constitute, the illnesses from which people suffer.”* (Balint, 1957 in Greenhalgh & Hurwitz, 1999 : 50).

In South Africa we need to begin to look at medical interviewing along radically new lines. Our approach needs to be centered on the notion of a shared responsibility in communication (Le Dorze, Julien, Genereux,, Larfeuil, Navenec, Laporte & Champagne, 2000). The concept of a collaborative partnership implies a more equal relationship between the patient and the clinician and a shift in the balance of power away from medical paternalism towards mutuality (Silverman, Kurtz & Draper, 1998).

A number of researchers have suggested that the biomedical approach to obtaining information from patients needs revision (Gillis, Elk, Ben-Arie & Tegin, 1982; Mishler, 1984; Loest, Britz & Paw, 1997). This does not apply just to speakers of indigenous languages, but to all patients. Recently, the use of narratives as an assessment method in medical consultations has been the focus of much research (Greenhalgh & Hurwitz, 1998; Heath, 1998; Launer, 1998; Elwyn & Gwyn, 1998). It has been proposed that the lost tradition of narrative should be revived in the teaching and practice of medicine (Greenhalgh & Hurwitz, 1998). In recent years a number of researchers and clinicians have seen the benefits of using the clinical illness narrative in everyday medical practice to replace traditional methods of obtaining information from the patient (Cassell, 1985a, 1985b; Crawford, 1994; Donald, 1998; Greenhalgh & Hurwitz, 1998; Heath, 1998). This move has signaled a shift away from the biomedical model of medical practice to a more biopsychosocial model of health care. The latter places more emphasis on the patient as a whole.

According to Squier (1998 in Bolaria & Dickinson, 2001), the study of narratives from a patient's perspective helps to orientate the clinician to the patient-relevant outcomes of illnesses which may sometimes depend on the socio-economic, psychological and cultural realities of the individual (Squier, 1998 in Bolaria & Dickinson). Greenhalgh & Hurwitz (1998) and Heath (1998) refer to the illness narrative as a story. These stories are shared within the clinical situation between the patient and the clinician as well as the people, feelings and emotions that are centered on the patient's presenting illness. This is important because illness is socially constructed and occurs apart from biological existence (Elwyn & Gwyn, 1998; Hinchman & Hinchman, 1997 in Sishi, 2001; Penn,

2000). The cultural narrative is based on the premise that the subjective experiences of the patient are overlooked in clinical interactions in the search for objective indices (Penn, 2000).

People experience illness within a narrative that shapes and gives meaning to what they are feeling from moment to moment (Donald, 1998). In the last few decades, the social sciences have been transformed by the understanding that people live within and embody socially constructed narratives from which they cannot be extricated (Donald, 1998). Illness narratives are different from those of the rest of our lives. However, narratives are not exclusive to illness, nor to patients (Donald, 1998). With very few exceptions, these insights into how humans work have yet to percolate directly into most health professionals' training or practice (Donald, 1998). It is only by listening to patients' illness narratives that we shall increase the accuracy and the usefulness of medicine's stories of disease (Heath, 1998).

The study of narrative in medicine has increased over the last decade and has added substantially to current medical understanding (Penn, 2000). According to Penn (2000: 72) *"the human predisposition is to create and develop narrative, and stories have the function of expressing life identity. More specifically, the story of an illness is a vital point of intersection among many disciplines, and provides fascinating and complementary perspectives on the condition as well as on diagnostic and therapeutic regimens."*

The patient's perspective (illness) is a separate narrative that summarizes professionally relevant information about the patient's personal experience of illness. It describes matters such as the patient's understanding of disease or disability, the impact of this on their life, the patient's goals and expectations and their treatment preferences (Donnelly, 1997). This perspective need not be a lengthy narrative. However, it should form part of the medical record (Donnelly, 1997). It has been advocated that by using the terms *illness* and *disease*, the perceptions of both the clinician and the patient can be recorded

(Stewart, Brown, Weston, McWhinney, McWilliam & Freeman, 1995 in Donnelly, 1997).

The origins of narrative can be traced to the field of anthropology and to modern and postmodern intellectual movements, including cybernetics and structuralism (Keeney, 1983, Daid, 1983 in Launer, 1999). Proposed approaches have included acknowledging the client as an expert and facilitating any possible account of reality, providing that it makes sense in the client's eyes (Launer, 1999). The narrative approach to health care is concerned with the question of how a patient and a clinician can together construct a story that makes sense (Launer, 1999). Clinicians can make useful contributions to patients' stories, although their contributions should not be seen as being superior (Launer, 1999).

It is the view of many philosophers and anthropologists that we live within narratives of which we are the principle authors (Donald, 1998). People are unconscious of the way in which they create their own narratives, seeing only the images produced that are mistakenly perceived as real (Donald, 1998). As humans, our story-telling capacity enables us to impose order and predictability on to our lives to make meaningful contact with other people across the void (Donald, 1998). This allows people to be creative, to invent new stories by which to live and to create new realities for themselves (Donald, 1998).

Particularly when there is a breach between the ideal and the real, narratives have an important role to play (Riessman & Kohler, 1993 in Skultans, 1998). Crises feed an individual's narrative drive and thus illness has a particularly close relationship with narrative. *"Illnesses acquire a moral meaning through plot, through embeddedness in a life story, and conversely, the individual illness experience serves as a wider metaphor for the suffering society"* (Skultans, 1998 : 228).

Narratives are dynamic human creations, which are changeable and do change (Donald, 1998); they have a finite and longitudinal time sequence, namely, a beginning, a series of

unfolding events and an ending (Greenhalgh & Hurwitz, 1998). Narratives presuppose a narrator and a listener, whose differing viewpoints affect how the story is told (Greenhalgh & Hurwitz, 1998). Narratives provide information that extends beyond just the unfolding events, as the same sequence of events told by another person might be told differently without being any less 'true' (Greenhalgh & Hurwitz, 1998). They have no self-evident definition of what is relevant or what is irrelevant for any particular narrative, as the choice of what to tell and what to omit lies entirely with the narrator and can be modified at the discretion of the listener through their questions (Greenhalgh & Hurwitz, 1998). In addition, narratives are absorbing as they engage the listener and invite listener interpretation. As such, they offer the listener the experience of living through, and not simply gaining knowledge about, the story (Greenhalgh & Hurwitz, 1998).

Conventional studies of clinical interactions have focused on structure rather than on content and are therefore considered by some researchers to be fairly superficial (Elwyn & Gwyn, 1999). Research into the consultation process in primary care has focused on the structure of meetings from greeting to closure (Byrne, 1976, Pendleton, Schofield, Tate & Havelock, 1984 in Elwyn & Gwyn, 1999). Doctor and patient-centredness have been described and measured (Levinstein, 1984, Stewart, Brown, Weston, McWhinney, McWilliam & Freeman, 1995 in Elwyn & Gwyn, 1999). The work of the aforementioned researchers has had a profound impact on clinical practice, since their observations have led to an ongoing exploration of the effect of communication style on patient satisfaction and clinical outcome (Elwyn & Gwyn, 1999).

### **3.4 CULTURAL NARRATIVES IN THE MULTICULTURAL SOUTH AFRICAN CONTEXT**

The narrative approach is relatively familiar across the social sciences and more interchange between various disciplines will be important in order to revise and extend the narrative therapy approach. Such discourse should assist in ensuring that therapeutic practice in South Africa challenges oppressive practices in all forms (Yule, 1993). Launer

(1999) outlines three uses for narratives in general practice, namely in the familiar role of taking a traditional medical history, in counselling (as something that needs to be listened to in order to allow patients to give coherence to their own history) and as a therapeutic stance that involves questioning the patient in a way that explores new meanings that may make a difference to the patient (Hunter, 1991, Shapiro, 1993 & Launer, 1995 in Launer, 1999). Yule (1993) has demonstrated the therapeutic applicability of the narrative approach in counselling in the South African context. However, detailed examination of the narrative as a means of eliciting case history details in initial consultations in health care has yet to be examined.

The oral tradition of myths and legends, which are continually created by the passing down of stories by word of mouth from one generation to the next, is still a feature in many non-Western societies and impacts profoundly on the experience of health and illness in such contexts (Greenhalgh & Hurwitz, 1998). It is proposed that it might be because Western culture has lost its grip on this oral tradition that the skills of listening to, appreciating, and interpreting patient's stories are only rarely upheld as core clinical skills in medical curricula (Greenhalgh & Hurwitz, 1998).

African culture has traditionally privileged the oral tradition through the shared telling of stories. A narrative approach recognizes the client's story as a story and privileges the telling of it (Yule, 1993). Implicit in the narrative approach is the respect for the other and his/her story, which greatly facilitates cross-cultural exchange (Yule, 1993).

According to Malahleha (1973), Africa has a long history of oral traditions. Stories were created as 'poetic recitative-musical' stories and as fables. There was a great deal of respect for the spoken word (Chaane, 1991). The ability to tell a story was recognized as one of the greatest achievements in fine arts. Stories were created to celebrate times of both happiness and suffering (Hinchman & Hinchman, 1993 in Sishi, 2001). Within African narrative recitals, the audience were as important as the narrator (Chaane, 1991). There were a number of cultural activities revolving around the narrative to suggest that the story-teller's functions and practice were bound up in his/her culture. As a result, the

narrator needed to develop a good memory. This ability to memorize information meant that the information had to be produced in a coherent manner to the audience. The ability to listen was considered an important part in interaction (Chaane, 1991).

Narrative therapy as conceptualized by White and Epston has been successful in many varied contexts including groups, individuals and families, and in a variety of settings including Australia, Canada and the United States. Its appropriateness within a cross-cultural setting has been demonstrated in New Zealand (Yule, 1993). Penn (2000) proposed that the study of narrative medicine might prove to be particularly beneficial in the multicultural context of South Africa as it has the potential to minimize the cultural barriers that exist in more structured consultation settings. In this post-apartheid period in South Africa, cultural diversity is being celebrated. The cultural narrative should be explored as a method for enhancing multiculturalism.

To date, application of the narrative approach has mostly been in first-world, white, middle-class, English-speaking contexts (Yule, 1993). Questions therefore arise as to the appropriateness and applicability of this approach with people from working-class, politically disempowered, and multi-language contexts (Yule, 1993). Narratives can potentially bridge cultures and inform clinical decision-making (Penn, 2000). From a training and a practical point of view, the narrative approach is potentially relevant and meaningful to all South Africans (Yule, 1993). Furthermore, narratives may provide a way of mediating between clinician and patient by closing the gap between them in clinical encounters (Greenhalgh & Hurwitz, 1998)

### **3.5 THEORETICAL MOTIVATIONS FOR NARRATIVE RESEARCH**

A review of the narrative literature strongly indicates the need for further research into the narrative, owing to its potential applicability in multicultural contexts, in contexts in which there is a history of disempowerment and across the health care spectrum. There is doubt as to the applicability of narratives in cross-linguistic encounters. Theoretical motivation for the study of narratives can be found in its strength as a research methodology and in its theoretical grounding.

There has been an appeal for research across the spectrum of human sciences and social services in order to move forward towards empowering and just practices (Yule, 1993). The case study format is accessible to clinicians working within related disciplines and the possibility of such interchange is one of the recommendations of such an approach (Yule, 1993).

There is some doubt as to the practicality of working with narratives in cross-lingual contexts. Fluency in the language has been considered a precondition in working with narratives (Skultans, 1998). The role of the interpreter in the narrative method requires examination. Penn (2000) proposed that the multiple roles of the interpreter could be extended to include that of facilitator through the narrative genre and that this would enhance effective clinical interactions. The narrative therapy approach is very applicable to working with individual clients, as demonstrated by Yule (1993). The extended range of problems that might occur in using the narrative approach in group therapy are yet to be identified (Yule, 1993). This is very crucial for this research, as one must remember that interpreted consultations are, out of necessity, group consultations and the dynamics of triadic rather than dyadic consultations do differ (Swartz, 1998).

The study of narrative offers the researcher the possibility of developing an understanding that cannot be achieved by any other means (Greenhalgh & Hurwitz, 1998). Narratives assist in setting a patient-centred agenda and could potentially challenge existing knowledge and generate new hypotheses (Greenhalgh & Hurwitz, 1998). Clinicians need to use more in-depth methods of analysis. Clinicians need to go beyond the superficial assessment of consultations to examine the perceived messages that patients take away in the longitudinal discourse of their lives (Charles, Gafni & Whelan, 1997 in Elwyn & Gwyn, 1999). By becoming interested in dialogue, clinicians might be able to listen more constructively to their patient's narratives and might be able to involve them more in the decision-making process (Kleinman, 1981, Silverman, 1987 in Elwyn & Gwyn, 1999).

The rationale for the cultural narrative is embedded in the relativist belief that greater understanding of the patient's illness (subjective perception of disorder) will allow the clinician to understand the patient's explanatory model and will assist the clinician in establishing some common ground between his/her own and the patient's explanatory model.

University of Cape Town

## **CHAPTER FOUR**

### **METHODOLOGY**

This chapter presents the aims, methodological design, subject selection criteria and description of subjects used in this study. In addition, methods of data collection and methods of analysis are described.

#### **4.1 AIMS**

The primary aim of this research was to explore and to document the cultural narrative method as proposed by Penn (2000) within multilingual, multicultural consultations in the field of SLHT in South Africa.

More specifically, this study aims:

- To compare and to document the Cultural Narrative method and the Traditional Case History method in initial SLHT consultations with Xhosa-speaking patients
- To compare and to document the Cultural Narrative method and the Traditional Case History method across interpreter-mediated consultations with a white, English-speaking clinician with Xhosa-speaking patients, and a black, Xhosa-speaking clinician with Xhosa-speaking patients
- To examine and to compare the role of the interpreter within the initial consultations across the Cultural Narrative and the Traditional Case History methods.

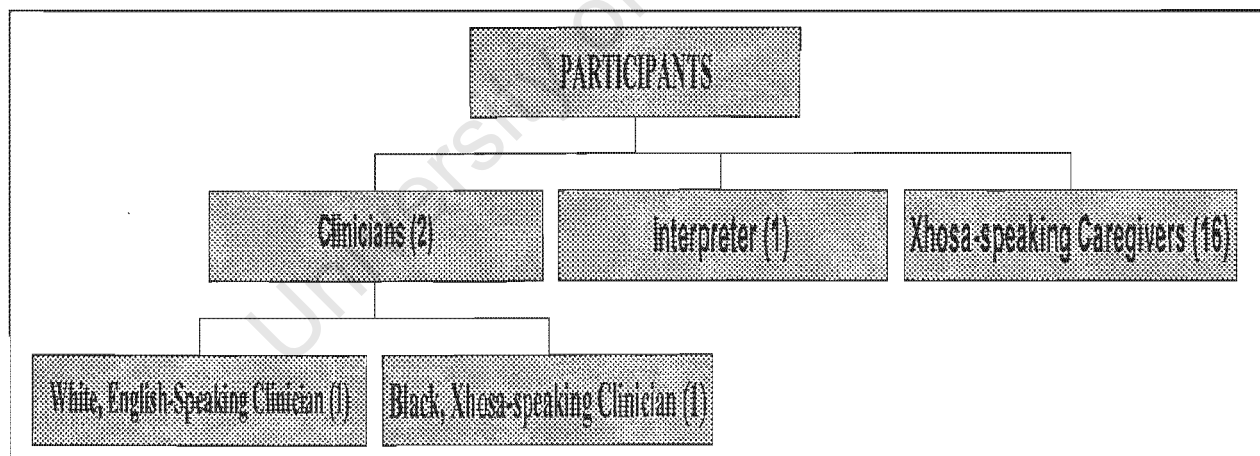
#### **4.2 RESEARCH DESIGN**

An observational, descriptive, qualitative research design was employed in this comparative study. Qualitative research is effective when used on an exploratory basis to establish hypotheses for future research and when used to get 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 & Yach,

1991). It is also useful for producing new ideas in areas that are new to research (Katzenellenbogen *et al.*, 1991). Qualitative research can be particularly effective when used simultaneously with other types of research to get an additional perspective on the problem (Katzenellenbogen *et al.*, 1991).

### 4.3 PARTICIPANTS

The sample in this study consisted of three distinct categories of participants. The first category comprised one white English-speaking clinician and one black, Xhosa-speaking clinician involved in the assessment and diagnosis of hearing-impaired children at community-based clinics. The second category comprised one trained, first Language (L1) Xhosa-speaking interpreter, who interpreted in the consultations for the Xhosa-speaking caregivers of the hearing-impaired children at these clinics. The third category consisted of the Xhosa-speaking caregivers<sup>1</sup> of hearing-impaired children, who participated in initial consultations at the community based clinics. The categories and numbers of participants are depicted in Figure 4.1 below.



**Figure 4.1 : Participants in the Study**

All of the participants in the study participated in initial consultations and in post-consultation interviews. A total of sixteen initial consultations and nineteen post-consultation interviews were included in the study.

<sup>1</sup> In this context, a *caregiver* is described as an individual who provides for the physical and emotional needs of the child (Oates, 1994 in Michelson, 1998)

In this study data was collected in different programmes, one in the Western Cape and one in the Eastern Cape. These two programmes were chosen because their basic programme objectives and programme structures were the same. The two programmes differed in that the Western Cape programme employed a white, English-speaking clinician and the Eastern Cape programme employed a black, Xhosa-speaking clinician. In the Western Cape programme, a trained interpreter was available at the site. No interpreting arrangement was necessary in the Eastern Cape programme.

#### **4.3.1 Selection Criteria**

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

##### **4.3.1.1 Clinicians**

The clinicians were required to be qualified Speech-Language and Hearing Therapists. One clinician was required to be an L1 English-speaker and one clinician was required to be an L1 Xhosa-speaker. The English-speaking clinician was required to have a minimum of two years' experience of working with an interpreter. This was considered necessary so that the effects of the interpreted consultation did not confound the findings of the comparison between the TCH and the CN methods.

##### **4.3.1.2 Interpreter**

The interpreter was required:

- To be an L1 Xhosa speaker
- To be an integral<sup>2</sup> part of the Western Cape Xhosa-speaking community
- To have been trained as an interpreter.

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<sup>2</sup> For the purpose of this research, *integral* membership of a community was defined as having self-identification with a community and being proficient in the language used by that group.

It was necessary for the interpreter to be trained, as it has been demonstrated that consultations with trained interpreters are better than consultations with untrained interpreters (Fisch, 2001).

#### 4.3.1.3 Caregivers

Each caregiver was required:

- To be the primary caregiver of a hearing-impaired child
- To be a L1 Xhosa-speaker with insufficient knowledge of English to allow them to communicate effectively in English in a clinical consultation.

#### 4.3.2 Participant Description

##### 4.3.2.1 Clinicians

The white, English-speaking clinician and the black, Xhosa-speaking clinician who participated in this research will hereafter be referred to as WC and BC respectively. Biographical details pertaining to the clinicians are summarized in Table 4.1 below.

**Table 4.1 : Clinicians' Biographical Information**

	White Clinician	Black Clinician
<b>Home Language</b>	English	Xhosa
<b>Other Languages</b>	Afrikaans	English, Zulu
<b>Proficiency in Xhosa</b>	Very Basic	Fluent (L1)
<b>Medium of Instruction at School</b>	English	Xhosa, English
<b>Training regarding Interpreting</b>	Module in Psychology III course	N/A
<b>Job Description</b>	SLHT in a community based Project	SLHT in a community based Project
<b>Experience in the Field</b>	Three years	Two years

#### 4.3.2.2 Interpreter

The trained interpreter who took part in this research will hereafter be referred to as TI. TI's biographical details are summarized in Table 4.2 below.

**Table 4.2 : Interpreter Biographical Information**

<b>Residential Area</b>	Mitchell's Plain, Cape Town
<b>Home Language</b>	Xhosa
<b>Other Languages</b>	English, Afrikaans, Sotho, Zulu
<b>Proficiency in English</b>	Good
<b>Medium of Instruction at School</b>	Xhosa
<b>Education Level</b>	Std 9
<b>Other Qualifications</b>	Computer course, Interpreter course
<b>Training</b>	Cape Town-based interpreter training programme
<b>Modules Covered in Training</b>	Interpreting, Cultural Brokerage, Language Development, Conflict Management, Constitutional Affairs, Gender Awareness
<b>Length of Training Course</b>	1 month theory (not completed), 1 month practical
<b>Year of Graduation</b>	1997
<b>Field-specific Training and Experience</b>	2 years experience
<b>Place of Employment</b>	Community-based rehabilitation programme
<b>Job Description</b>	Cultural Broker

##### i) The Interpreter Training Programme

The interpreter training programme completed by TI was run by a non-governmental organization based in Cape Town (Ntshona, 1999). The training programme formed part of a three-year pilot study. It was funded initially by the Flemish government in 1997 and it was hoped that the South African government would take over the funding after a period of 2 - 3 years. This has not happened and the South African government does not have an 'interpreter' category in its list of occupations. The programme aimed to train interpreters for work in hospital settings and to find posts

for them once their training was complete. A comprehensive list of the objectives of the programme and the course curriculum can be found in Ntshona (1999). The modules covered in the theory component of the training programme are summarized in Table 4.3 below.

**Table 4.3: Modules in the Interpreter Training Programme (Ntshona, 1999)**

Module	Duration
Interpreting	1 week
Counselling and Cultural Issues	1 week
Confidentiality	1 Day
Health Information including Health Promotion	1 Week
Ethical Issues	1/2 Day
Administration	1 Day
Constitutional Affairs	1/2 Day

#### ii) Job Description of the Community Interpreter

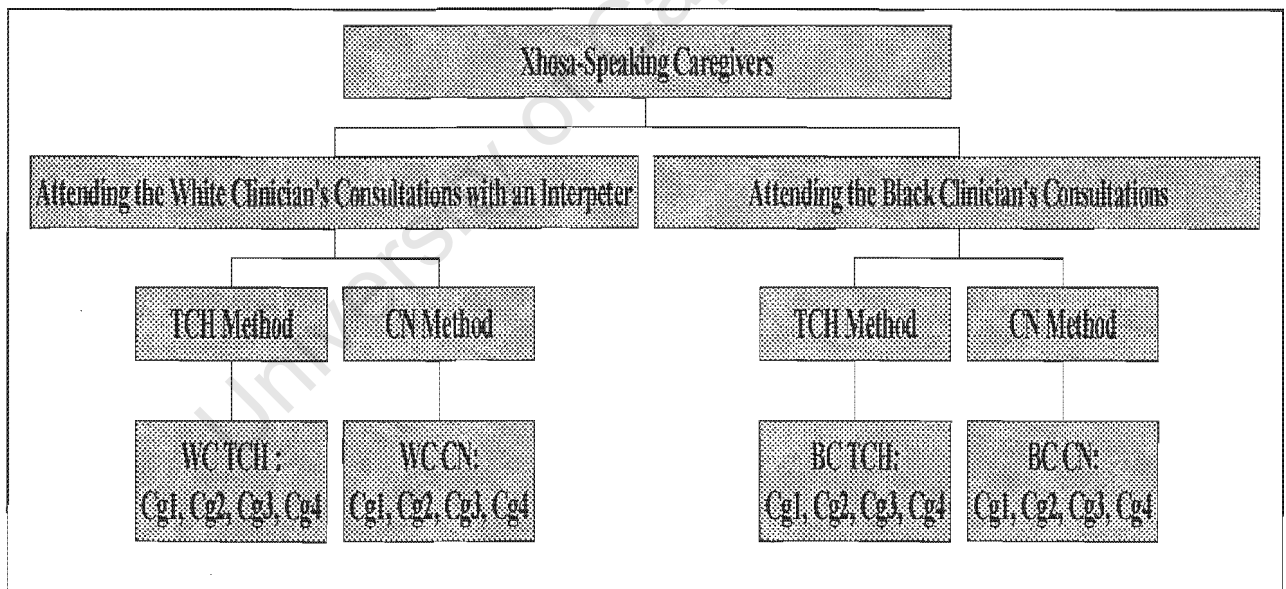
The interpreter (TI) working with WC was employed to act as a cultural broker and an interpreter. In terms of her job description (see Appendix A), the programme in which she was working stipulated that a cultural broker has a role that is two-fold, namely, one of translation, and one of cultural mediation. For the latter, it is expected that the cultural broker will assist the clinician in understanding and interpreting cultural beliefs, and the patient in understanding information mostly related to medical concepts.

Cultural brokerage was introduced into anthropological literature by Wolf in 1956 and Geertz in 1960 (Herselman, 1994). In the 1970s, Weidman focussed on it as being a key term in health-care contexts (Herselman, 1994). The job description of TI is consistent with that of Drennan's (1998), namely that a cultural broker will fulfil his/her function by explaining and clarifying the cultural context and the indigenous beliefs of particular patients. Swartz (1998) explains that a cultural broker can assist the clinician in assessing whether or not the patient's beliefs are in

line with the group from which he or she comes. In the community-based programme within which TI was working, it was crucial for her to act as both a cultural broker and a patient advocate, owing to the cultural and socio-economic divide that existed between the clinician and the patients.

#### 4.3.2.3 Caregivers

Sixteen caregivers participated in this study. All of the caregivers participated in initial consultations, half of which were conducted by WC and half of which were conducted by BC. Two types of methods of obtaining information were utilized, namely a structured, traditional case history (TCH) method and a cultural narrative (CN) method. The sixteen Xhosa-speaking caregivers who participated in this research are described in terms of the consultations in which they took part. This is illustrated in Figure 4.2 below.



**Figure 4.2: Xhosa-Speaking Caregivers**

All of the caregivers who participated in this study were mothers or grandmothers of Xhosa-speaking hearing-impaired children and had little or no knowledge of English or Afrikaans. All of the caregivers had a minimum education level of Standard Five (Grade Seven), and a maximum education level of Standard Eight (Grade Ten). All of the caregivers were unemployed or working as domestic workers. The caregivers

lived in the area surrounding the clinics that they had attended, namely Browns Farm and Khayelitsha in the Western Cape, and Tafelofefe and Fort Beaufort in the Eastern Cape. Five of the eight caregivers who attended consultations in the Western Cape had previously lived in the Eastern Cape and had family living there. The other three caregivers in WC's consultations still spent a part of each year in the Eastern Cape. For all of the caregivers, the initial consultation in which they were recorded was their first visit to the community-based project. The complexity of the cases was not pre-selected and varied from one caregiver to the next. The caregivers who were seen by WC generally had more complex cases. However, there was no difference in the complexity of the cases across the methods used.

#### **4.3.3 Informed consent**

Agreement of the clinicians, interpreters and caregivers to participate in the study, was confirmed through verbal and written consent in the first language of the participants. Anonymity was guaranteed prior to the collection of data.

#### **4.3.4 Pilot Study**

A pilot study was conducted with the white, English-speaking clinician, WC, the trained interpreter, TI, and two Xhosa-speaking caregivers. The aims of the pilot study were:

- To refine the procedures involved in the administering of the TCH and the CN methods
- To determine the appropriateness of the questions used in the post-consultation interviews.
- To identify any technical difficulties that might arise from the tape recording equipment and sound quality of the environment
- To determine the most appropriate tools for analysis.

Based on the pilot study, the following were determined:

- The Mistranslation Analysis Tool (Evans, 2000) was likely to be an effective means of identifying and examining mistranslations across the methods. However, modifications would be necessary owing to the differing focus of this research
- Thematic analysis of the post-consultation interviews would be necessary
- Some of the analysis would need to be data-driven in order for all relevant data to be included in the analysis.

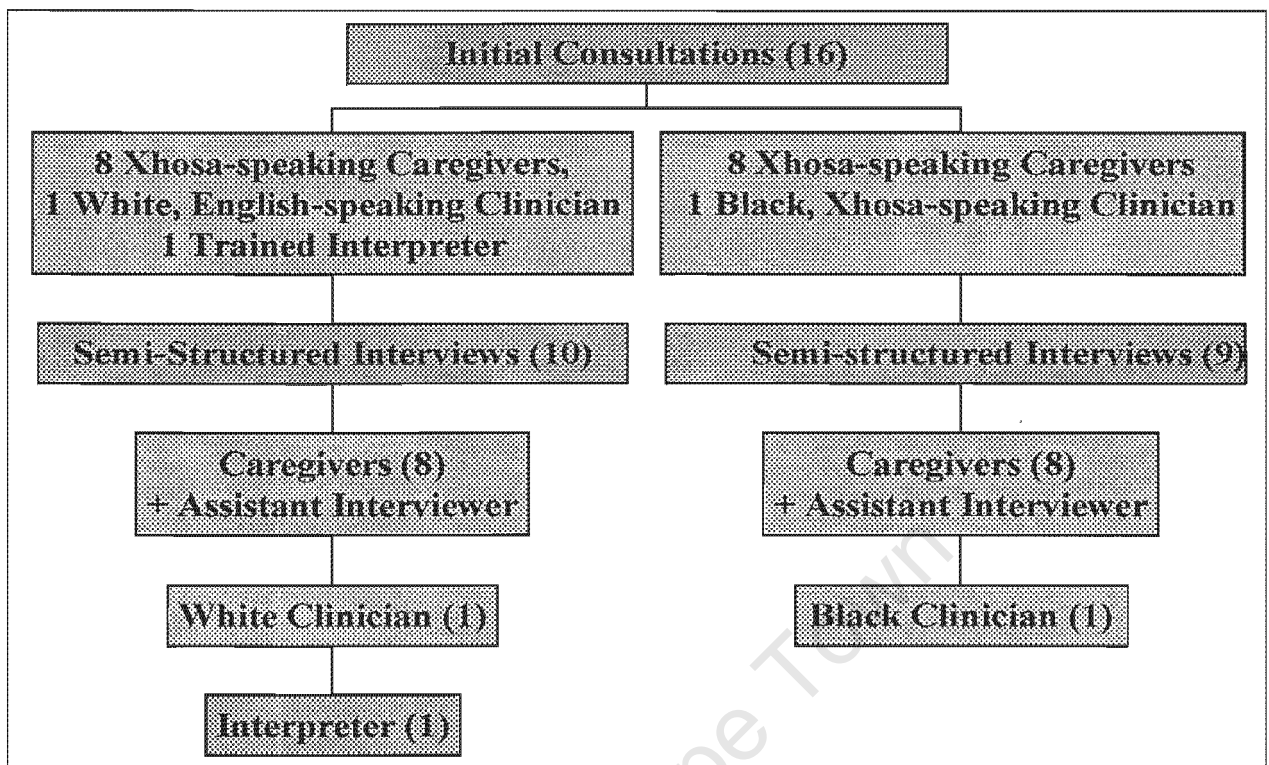
Data from the pilot study were not included in this research.

#### **4.4 DATA COLLECTION**

The data collection in this research project comprised of two main parts, namely:

- Recording initial consultations
- Post-consultation interviews with the participants from the recorded consultations.

The components of the data collection procedure are illustrated in Figure 4.3 below.



**Figure 4.3: Flow Chart depicting the Components of the Data Collection Procedure**

Each of the initial consultations consisted of two sections, namely a case history (CH) and a feedback (FB) section. Each of these sections has its own distinct characteristics. The division of initial consultations into components has been described by other researchers (Ramsden, 1999; Evans, 2000). Ramsden (1999) has identified obtaining information, feedback, coaching, counselling and referral as the main components of initial consultations. In this analysis, the CH section will incorporate the information gathering component of the consultations, as described by Ramsden (1999), and the FB section of the consultations will incorporate the feedback and the referral aspects, as described by (Ramsden 1999).

The usefulness of dividing the initial consultation into its components has been demonstrated in other research (Evans, 2000). When consultations are divided into case history, feedback and counselling sections, differences in interpreter accuracy and contribution can be found (Evans, 2000). By not dividing the consultations into

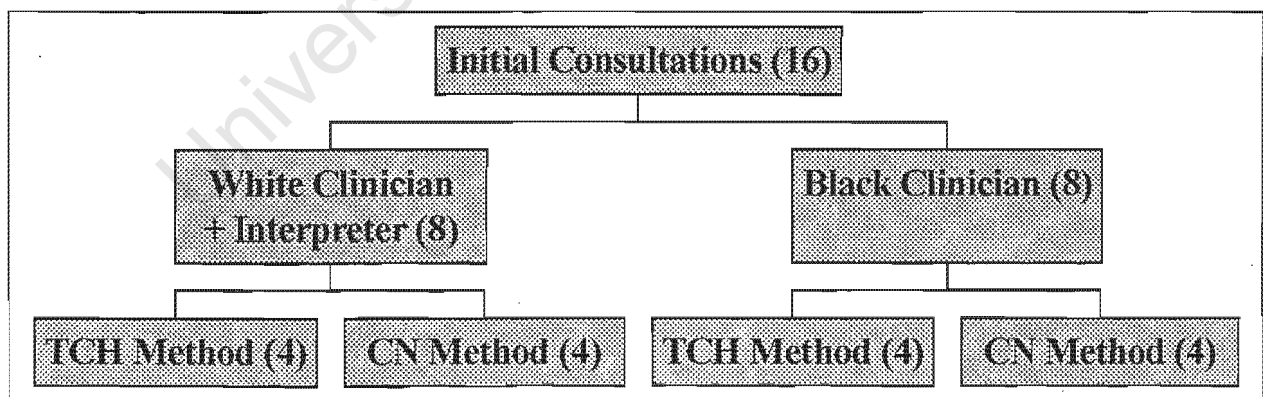
these components, the differing nature of the CH and the FB sections of the consultations could be obscured.

#### 4.4.1 Procedure

All of the caregiver participants took part in one of the sixteen recorded initial consultations. WC and TI conducted eight initial consultations, four using the TCH method, and four using the CN method. BC conducted eight initial consultations, four using the TCH method, and four using the CN method. Thereafter, all the participants were interviewed to obtain their impressions of the recorded consultation specifically, and their experiences in health care generally. In total, there were nineteen post-consultation interviews:

- Sixteen interviews with the caregivers
- One interview with WC
- One interview with TI
- One interview with BC.

The data collection procedure is illustrated graphically in Figure 4.4 below.



**Figure 4.4: Procedures of the Initial Consultations**

#### 4.4.1.1 Setting

Qualitative research needs to be carried out in as naturalistic an environment as possible, because this shows acknowledgement of the influence that the situation has on behaviour and that behaviour has on the situation (Cassell & Symon, 1997; Katzenellenbogen *et al.*, 1991). Recording of the initial consultations took place at the community-based sites during the regular clinic consulting times.

All clinician, interpreter and caregiver post-consultation interviews took place at the respective clinics where the initial consultations were conducted.

#### 4.4.1.2 Time

In total, 14 hours of video recording was used for the purpose of this study. The length of the initial consultations ranged from 8-58 minutes, whilst the length of the post-consultation interviews ranged from 10-15 minutes for the caregivers, and 20-45 minutes for the clinicians and the interpreter.

#### 4.4.1.3 Interview Recording Equipment

All sessions and interviews were recorded on to videotape. This method was preferred to audiotape, as it was felt that the additional visual cues provided by video recording would assist in the transcription process, particularly in the transcription of information provided from participants of varying cultures and languages.

#### 4.4.2 Materials and Methods

A number of different materials had to be developed in order to obtain the necessary data. These included the development of a structured questionnaire for use in the TCH method and the CN method in the initial consultations. In addition, questionnaires to be administered to the participants in the post-consultation interviews were developed.

The different materials developed for the data collection process are summarised in Table 4.4 below.

**Table 4.4 : Materials Used in the Data Collection Process**

	<b>Materials</b>
<b>Initial Consultations</b>	Traditional Case History Questionnaire
	Cultural Narrative Questionnaire
<b>Post-consultation Interviews</b>	Clinician Questionnaire
	Interpreter Questionnaire
	Caregiver Questionnaire

#### 4.4.2.1 Construction of the Traditional Case History Questionnaire

A case history questionnaire assists the clinician with compiling information about the child, the family and the problem, thereby helping the therapist to control the intervention (Hodgson, 1994 in Sishi, 2001). The TCH method is based on a number of underlying premises, namely that:

- It is important to cover all possible medical causes of pathology
- The patient's answers to the clinician's questions, when combined with objective testing, will be sufficient to make a diagnosis
- The issues that the clinician identifies from the patient's answers will be sufficient for the clinician to plan treatment.

Hodgson (1994 in Sishi, 2001) has identified the following functions of case history questionnaires:

- To collect information that will be helpful to the clinician during intervention
- To reveal misconceptions that the caregivers may have about the child's difficulties that should be resolved before successful intervention takes place
- To act as a way of involving the caregivers in the child's intervention from the beginning

- To give the clinician an opportunity to build a rapport with the child and the caregiver from the initial stages of the therapeutic relationship.

Traditional case histories vary in length from one institution to another. However, most questionnaires aim to be brief and succinct, an aim that is not always realised. Some case histories are designed to be filled in by parents prior to the diagnostic interview. However, in this study all of the case history information was obtained verbally by the clinician.

The use of existing methods for measurement in comparative research makes it possible to evaluate the value and impact of the tool (Moore, 1987 in Sishi, 2001). Therefore, it was crucial that the case history questionnaire used in this study was one that closely resembled those currently in use in health care institutions for the assessment of children presenting with speech, language and hearing difficulties.

The researcher chose to use a structured case history questionnaire compiled by Sishi (2001). This questionnaire was based on extensive examination of the questionnaires most commonly used at a number of secondary and tertiary health care institutions in Cape Town. It dealt with questions relating to biographical and referral details, prenatal and birth history, medical history, developmental milestones, school, speech, language and hearing history and general behaviour. The questionnaire developed by Sishi (2001) was considered to be highly representative of those currently being used in the field of SLHT and hence was used for the purpose of this study.

The TCH method contained numerous closed-ended questions and a few open-ended questions. The questionnaire employed in this study was compiled in English and therefore required translation into Xhosa for the use of the Xhosa-speaking clinician, BC. The TCH questionnaire is presented in Appendix B.

#### 4.4.2.2 Construction of the Cultural Narrative Questionnaire

A narrative is defined as a form of discourse that places events in sequence with a well-defined beginning, middle and end (Hinchman & Hinchman, 1997 in Sishi, 2001). This definition clearly separates a story from lists and case studies.

The CN method is based on a number of underlying premises, namely that:

- It is important to discuss whatever the patient chooses to talk about
- The information provided by the patient when combined with objective testing, will be sufficient to make a diagnosis and to plan treatment
- The information that the patient chooses to tell the clinician will highlight issues the patient wishes to have addressed.

For the purpose of this research, three open-ended questions were employed to elicit the caregiver's illness narrative. The three questions used were:

- "Tell me everything about your child's problem, right from the beginning."
- "Does your child have any other problems or difficulties? "
- "How do you and your family/others communicate with your child and how does your child communicate with you and your family? "

The Xhosa translation of the CN method is illustrated in Appendix C.

#### 4.4.2.3 Construction of the Post-Consultation Interview Questionnaires

Separate questionnaires were developed for the clinician, interpreter and caregivers. However, all these questionnaires were based on a number of central themes. These themes were guided by those used by Drennan (1998) and have subsequently been used by a number of researchers (Evans, 2000; Fisch, 2001; Sishi, 2001). The assistants were asked to reflect on their experiences in the recorded consultations and in the health sector generally. The clinicians and the interpreter were encouraged to compare the TCH and the CN methods. The caregivers were not

asked to do so as they only had the experience of the one method which had been used in their initial consultation.

**Table 4.5 : Themes on which the Questionnaires were Based**

Biographical Information:
General Health Care and Interpreting Experiences
Quality of Service offered to Speakers of Indigenous Languages
Cultural Factors which Impacted on the Initial Consultation
Availability and Satisfaction with Health Care and Interpreting services
Perceived Accuracy of Interpreting
The Role of the Interpreter
Ethical Concerns
Group Dynamics

**i) Principles underlying the Construction of the Questionnaires**

**a) Semi-structured versus Unstructured Interviewing and Self-administered Questionnaires**

All interviews were conducted in a semi-structured manner, that is, they followed the well-defined structure of the 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 systematicization in questioning is sometimes necessary when many participants are interviewed (Marshall & Rossman, 1995). Furthermore, an unstructured interview was beyond the scope of this study as the interviewer who directs an unstructured interview requires much skill and experience in interviewing in order to avoid poor reliability as a result of increased subjectivity (Joubert, Karim & Katzenellenbogen, 1997).

Skinner and van der Walt (1994 in Joubert *et al.*, 1997) indicate that an hour-long interview can take up to eight hours to transcribe. By employing a semi-structured interviewing method, the researcher was able to limit the length of the interviews, thereby limiting the length of the transcription. This was a significant factor, bearing in mind the time constraints and the scope of the study. In addition, interpreted interviews can take a long time and can be awkward to manage (Swartz, 1998). Consequently, careful planning is needed to ensure that the process is conducted as smoothly and efficiently as possible. A semi-structured interview allowed the questions to be translated prior to the interview. This gave the assistant interviewer the opportunity to ask for clarification about terminology that she did not understand.

A semi-structured interview was chosen above a self-administered questionnaire for the following reasons:

- Some respondents may not have been able to complete self-administered questionnaire forms owing to the problem of poor literacy skills
- A self-administered questionnaire would not allow the researcher to ask for further clarification on issues.

#### b) Types of Questions

The questionnaires consisted of both open- and closed-ended questions. The majority of the questions used in the post-consultation interview comprised of open-ended questions that 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). In addition, open-ended questions enabled the researcher to obtain more opinionated and emotional responses from the caregivers. Closed-ended questions requiring a “yes” or “no” answer or a response limited in alternatives were fewer in number and served the purpose of obtaining more factual information (e.g. biographical details).

### c) Phrasing of Questions

Questions were phrased in such a way that they would be concise, unambiguous and easy to translate into Xhosa. The language level of the questions had to be sufficiently easy for the participants to understand the questions.

### d) Language of Questionnaires

The clinicians and the interpreter chose to respond to the questionnaires in English. The caregivers were interviewed in Xhosa as they were Xhosa-speaking.

An example of the questionnaire used with the caregivers is illustrated in Appendix D.

### **4.4.3 Research Assistants**

In addition to those participants who took part in the study, a number of assistants participated in the data collecting process, in establishing the sensitivity and reliability of the tools to be used and in verifying the reliability of the data. These assistants will hereafter be referred to as A1, A2 and A3. All of these assistants were L1 Xhosa-speakers with excellent English proficiency, who were studying SLHT at the time that the research was carried out.

The assistants carried out the following duties:

- Translation and back-translation of the materials to be used in the data collection process (e.g., TCH questionnaire, CN questionnaire, post-consultation interview questionnaire, consent form)
- Obtaining informed consent from the caregivers at the initial consultation
- Interviewing the caregivers in the post-consultation interviews
- Transcription, translation and back-translation of the Xhosa data.

The assistants were trained to carry out the semi-structured interviewing in Xhosa, thereby eliminating the need for interpreting. The components of the informants' training are outlined in Table 4.6 below.

**Table 4.6: Components of the Assistants' Training**

The purposes and objectives of the research
The assistants' duties and responsibilities
Explanation of the interviewing procedure
Training the assistants to ask the questions and conduct the actual interview
Training the assistants to obtain informed consent from the participants
Troubleshooting of potential difficulties
Explanation of the purpose of verbatim transcription and translation of data
Practising verbatim transcription in the pilot study
Practising translation of the data in the pilot study

In accordance with suggestions made by Lutz, Chalmers, Lockerbie and Hepburn (1992), teaching materials were provided to the assistants for their perusal prior to the training session. The materials consisted of:

- A short, simple summary of the study, including the aims and objectives, as well as a description of the population and the community and any other people involved in the research.
- An English and a Xhosa copy of the questions to be asked
- An English and a Xhosa copy of the consent form to be administered
- Brief notes outlining how the assistants should conduct themselves
- Troubleshooting issues that might arise.

This input was provided prior to the pilot study. After the pilot study, the assistants observed the with the researcher and were encouraged to ask questions and to discuss and clarify issues about which they felt unsure.

## **4.5 TREATMENT OF DATA**

### **4.5.1 Transcription of Raw Data**

Each initial consultation and post-consultation interview was transcribed verbatim from the video recordings. Verbatim transcriptions were deemed necessary in order to allow a detailed analysis to be carried out (Patton, 1990). All Xhosa interviews were transcribed by Xhosa L1 speakers, and all the post-session interviews conducted in English were transcribed by the researcher. This was considered to be a major advantage because it allowed the researcher to become familiar with much of the data and, and at the same time allowed for the process of data analysis to begin (Minichiello, Aroni & Timewell, 1990). In total, 112 hours of transcription were carried out.

The assistants who participated in the collection of data transcribed and translated the Xhosa data. The selection criteria for the transcribers of the Xhosa dialogue required that they:

- Were L1 Xhosa speakers
- Had a university level education.

### **4.5.2 Translation of Raw Data**

All the Xhosa transcripts were translated into English. In total, 260 hours of translation from Xhosa to English were undertaken.

The assistants who participated in the data collection and the transcription of data assisted with the translation process.

## **4.6 ANALYSIS OF THE DATA**

The transcripts of the recorded consultations were analysed according to their duration, number of propositions, topic control and complexity, as described in

Chapter Four Section 6.1. Furthermore, the consultations, in which the CN method was used, were examined in order to determine the quality and well-formedness of the narratives elicited. In addition, the data from the consultations in which the interpreter and the white clinician had participated were analysed in terms of accuracy and mistranslations. The accuracy of the consultations was analysed using a propositional analysis and the mistranslations were analysed, using the Mistranslation Analysis Tool (Evans, 2000). The data from the post-consultation interviews were analysed, using a thematic analysis.

#### 4.6.1 Analysis of the Consultation Transcripts

Analysis of discourse addresses more than just the linguistic aspects of communication (Ulatowska, North & Maculoso-Haynes, 1981; Rosenbeck, La Pointe & Wertz, 1989). The naturalistic application of such an analysis is the primary motivation for its use (Armstrong, 1991). There are several different ways in which the discourse of individuals can be assessed (Rosenbeck *et al.*, 1989). In recent years, analysis of narrative discourse has been one of the most studied types of discourse in clinical assessment and research in a variety of different population groups (Ulatowska, Freedman-Stern, eiss Doyel & Macaluso-Haynes, 1983; Rosenbeck *et al.*, 1989; Doyle, McNeil, Spencer, Jackson Goda, Cottrell & Lusteg, 1998; Honda, Mitachi & Watamori, 1998).

The transcripts of the consultations were analysed qualitatively and a comparison was made between the results in the TCH and the CN methods. Furthermore, the consultations were broken down into CH and FB sections, as it was evident that each of these aspects of the consultations had differing characteristics. In the CH section of the consultations, the narratives of the caregiver and the interpreter were analysed according to duration, propositions, topic control, well-formedness of narratives and complexity of language. In the FB section of the consultations, the narratives of the clinicians and the interpreter were analysed according to duration, propositions, topic control and shifting and complexity of language.

#### 4.6.1.1 Duration

The duration of each consultation was examined in order to determine whether this varied according to the method used.

#### 4.6.1.2 Propositional Analysis

A propositional unit can be defined as an informational unit that contains a verb and an argument (Ulatowska, Hill, Thompson, Parsons & Wertz, 1998). All transcripts were divided into propositional units. The following instances were not counted:

- Repetitions of words and phrases
- Unintelligible words or phrases
- Empty fillers and hesitations
- False Starts.

Following this, the number of propositions were counted. In addition, the ratios of the propositions of the participants were calculated, in order to determine whether either method facilitated increased caregiver or clinician participation.

#### 4.6.1.3 Topic Control and Shifting

Topic control was analysed in order to determine whether the consultations were clinician-led or caregiver-led. Such an analysis would indicate:

- The number of topics in each consultation – each topic could contain a number of propositions
- The number of times topics were repeated or returned to in each consultation
- The ratio of topic shifts by each participant
- The topics that each participant introduced, in order to establish whether topic control was clinician-led or caregiver-led.

In order to analyse the number of topic shifts in the consultations, the researcher categorized the nature of the topics. The researcher then recorded the instances in which these topics were raised by each of the participants in the consultations.

#### **4.6.1.4 Complexity of Language**

For the purpose of this research, complexity of language has been used to refer to the use of medical jargon and the presence of tertiary vocabulary. Furthermore, complexity was determined by the strategies adopted by the clinician and the interpreter to counteract this complexity. Related to the complexity of language was the clinician's use of examples, repetitions and clarification of the caregivers' understanding.

#### **4.6.1.5 Quality and Well-formedness of the Narratives**

The characteristics of narratives, as outlined in Chapter Two of this study, are well documented. Ulatowska *et al.* (1998) describe how narratives can be examined in terms of global structure and completeness, temporal sequence, reference, coherence and clarity among other aspects. Global structure evaluates the presence of setting, complicating action, resolution and coda. These are defined by Labov (1977) and described below:

- Setting provides an orientation at the outset to the time, place, people involved and their activity
- Complicating action is the sequence of events
- Resolution is a statement that reflects the final events or ends the experience
- Coda is a signal by the narrator that the narrative is finished.

Temporal sequence evaluates the chronology of events. The caregiver's narratives and the interpreter's translation of the caregiver's narratives were examined to determine whether the aspects of global structure were present, and to determine the order in which they occurred. The structure and chronology of the dialogue in the TCH consultations were commented on in order to compare the structure and chronology of the TCH and the CN methods.

#### 4.6.2 Analysis of the Consultation Transcripts from the Interpreted Consultations

In addition to those aspects outlined above, the transcripts of the interpreted consultations were analysed in terms of accuracy and the nature of the mistranslations, using the Mistranslation Analysis Tool (Evans, 2000).

##### 4.6.2.1 The Mistranslation Analysis Tool (MAT)

Early research on interpreting focused primarily on the problems related to using interpreters and on the *errors* that interpreters made in attempting to provide an accurate translation. This focus on the ideal of a word for word exchange in interpreting was firmly embedded within the *black box* or empiricist perspective, in which a word from one language was believed to be directly exchangeable with a word from another language (Swartz, 1998). In the late 1990s there was a shift away from the empiricist view of interpreting to a hermeneutic approach, in which interpreting was viewed as a transfer of meaning and not of word for word equivalents. In line with a hermeneutic approach, Evans (2000) proposed the use of the MAT as a means of analysing not only the accuracy of the consultation, but also the relatively positive or negative contribution of the interpreter within interpreted consultations.

The researcher previously examined the communicative, interpersonal and therapeutic dynamics of the audiologist, interpreter, caregiver triad in interpreted audiological consultations (See Evans, 2000). In order to examine the dynamics of this triad both qualitatively and quantitatively, the researcher had to develop a number of tools for the purpose of analysis. The MAT was devised to analyse mistranslations according to type (addition, omission, initiated question, substitution and condensation), contribution (positive, negative or neutral) and direction (English to Xhosa, or Xhosa to English).

For the purpose of this research, however, the MAT needed to be revised and adapted in order to focus on the contribution of the interpreter across the two

methods. An explanation of the original MAT and its uses, as well as the modifications made to it for the purpose of this study, is outlined below.

The original MAT (Evans, 2000) provided a means of systematically evaluating the positive and negative contributions of the interpreter mistranslations within the discourse. In order to be able to evaluate the contribution of the interpreter, any exact translations, that is any instances in which the interpreter was acting purely as a linguist (Swartz, 1998), were eliminated, so that only mistranslations were analysed. Thus, a large proportion of the utterances that were accurately translated were not examined by the original MAT, since these were all considered to be positive.

The following terminology needs to be defined for the purpose of this analysis:

- Original utterance (O): This is the utterance that was spoken by either the caregiver or the clinician that required translating in order to be understood by the other.
- Translated utterance (T): This is the interpreter's translation of the original utterance.
- Proposition: A proposition was defined as a part of an utterance that contains one, and only one, main idea. For the purpose of this research, the proposition was the unit of analysis.
- Mistranslation: A mistranslation of a proposition can be said to have occurred when the original utterance and the translated utterance are not identical. In order to ascertain whether or not a mistranslation has been made, the information contained in O needs to be compared to that contained in T. If an accurate translation has been made, T will be exhaustive, in that it will contain all the information contained in O, and limited, in that it will contain only the information contained in O. If a translation is not accurate, a mistranslation can be said to have occurred.

#### 4.6.2.2 Components of the MAT

The main components of the MAT are as follows:

- **Contribution:** All mistranslations were analysed according to the type of contribution that they made. Mistranslations were designated as making either a positive, negative or neutral contribution. For the purposes of this research, the neutral utterances were eliminated.
- **Type of Error:** A review of the literature indicated five types of mistranslations, namely: omissions, additions, initiation of questions, condensation and substitution (Vasquez & Javier, 1991; Wood, 1993; Drennan, 1998; Swartz, 1998).
- **Reason for Mistranslation :** A review of the literature (Sabin, 1975; Marcos, 1979; Ebden *et al.*, 1988; Wood, 1993; Swartz, 1998) identified a number of factors that were considered to result in mistranslations. Evans (2000) grouped these reasons within the broad categories of positive, negative or neutral, which could be further divided into the following:
  1. **Positive**, owing to attempts *to increase understanding* or *to facilitate cultural brokerage*

Interpreters often have to simplify some of what the clinician says in order for concepts to be more accessible to the patient. Examples of how this was achieved included: the explanation of a concept (cause and effect necessary for something to be considered an explanation); expansion of the topic (extension of an already-mentioned point, must involve the addition of new information); repetition; summary of a lengthy utterance (Wood, 1993); checking on the caregiver's or clinician's feelings about an issue; and seeking clarification.

Examples of facilitating cultural brokerage include: the use of more culturally appropriate terminology; the provision of analogies; modification of original lengthy utterances; the use of a euphemism or hyperbole as a more appropriate

way of illustrating a point; the use of repetition for effect; and the use of praise to provide encouragement.

2. **Negative**, owing to *textual factors* (the nature of the text including length, difficulty of words/concepts) and *non-textual factors* (i.e., external factors such as the interpreter's attitude or abilities)

Textual information includes all factors that are considered to be inherent in the text. This includes: the use of difficult anatomical or medical terminology (Ebden *et al.*, 1988) or lack of word equivalents (Swartz, 1998); technological terminology (Ebden *et al.*, 1988); difficult concepts (Wood, 1993); use of words with connotative meaning (words that hold associations or intentions) as opposed to denotative meaning (which refers to the actual definition of the word); lengthy original utterances (Wood, 1993); summary; emotive words (Sabin, 1975); reassurance; expansion; illustration with an example; explanation; questions; and instructions.

Non-textual information included all factors that were considered to be external contributors to mistranslations. Non-textual information included: selective interpretation; 'showing off' or the interpreter attempting to demonstrate her own medical acumen (Wood, 1993); cultural brokerage; poor language or translational skills (Marcos, 1979); lower level of sophistication in that field (Marcos, 1979 in Wood); poor attitude (Marcos, 1979); interpreter frustration or irritation (Swartz, 1998) and outside distractions.

3. **Neutral**, owing to *the presence of non-content information* or to the fact that *no translation was required*

Non-content information was not included in the study, as it was felt that, whether added or omitted, it made no impact on the consultation. Non-content information included: information that was the clinician's or caregiver's confirmation/clarification of what had previously been said; conversation fillers or 'thinking aloud'; administrative instructions; prompts by the clinician or the caregiver to the interpreter; poor sound quality on the recording; translated

language used by the clinician or the caregiver (when the clinician spoke in Xhosa or the caregiver answered in English); corrections; communication within groups (the clinician communicating with students or the caregiver communicating with her children); checking on an interpretation and thanks or praise directed at the interpreter. It was felt that none of these, whether added or omitted, contributed either positively or negatively to the interaction.

The following were considered not to require a translation to be fully understood: yes/no exclamations; gesture; simple propositions, e.g., “andiyaz”, “esikolweni.”, “what is your name?”; simple propositions containing a personal pronoun or a number, e.g., “nguMelanie igama lam”, “Khayalitsha, Block B”; questions directed at the interpreter from the clinician or the caregiver and answers to such questions. The reader is reminded that both non-content information and information that did not require a translation were eliminated and not analysed in this study.

It should be noted that decisions that involved the researcher making a judgement on cause (reason for mistranslation), and even more so on effect (contribution), were necessarily very subjective decisions. It should also be noted that within this field of interpreting it is very difficult to make an objective decision. According to Swartz (1998), there should be acknowledgement that research on interpreting issues can really never be empirical or neutral, as relationships of power, historical influences, and a whole history of labelling within the profession needs to be taken into account. Considering these factors, ensuring reliability of results entailed the use of a number of procedures, which are discussed in Chapter Four, Section 7.

#### **4.6.2.3 Modifications of the MAT**

The original MAT was shown to be a particularly comprehensive and useful tool for analysing interpreter contribution in interpreted consultations (Evans, 2000). The MAT has been shown to be sensitive to changes across consultation type (Evans, 2000), interpreters (Fisch, 2001) and between trained and untrained interpreters (Fisch, 2001).

However, for the purpose of this study, a number of modifications had to be made to the original MAT, owing to the differing focus of this study for the following reasons:

- The original MAT was felt to be too detailed for the purposes of this study
- It was unknown whether the MAT could be used in a narrative such as those elicited by the CN method, owing to the differences in structure of the narratives elicited.

In order to simplify the MAT, the categories relating to type of mistranslation were reduced from five (addition, omission, initiated question, condensation and substitution) to two, namely addition and omission. Additions incorporated both additions and initiated questions, and omissions incorporated omissions and condensations. Substitutions contained elements of both addition and omission and so were recorded as one of each. Furthermore, neutral mistranslations were eliminated from the analysis. A number of additional reasons for mistranslations were added, owing to the narrative structure of the transcripts of the consultations in the CN method. These included:

- Lack of Coherence
- Lack of Cohesion.

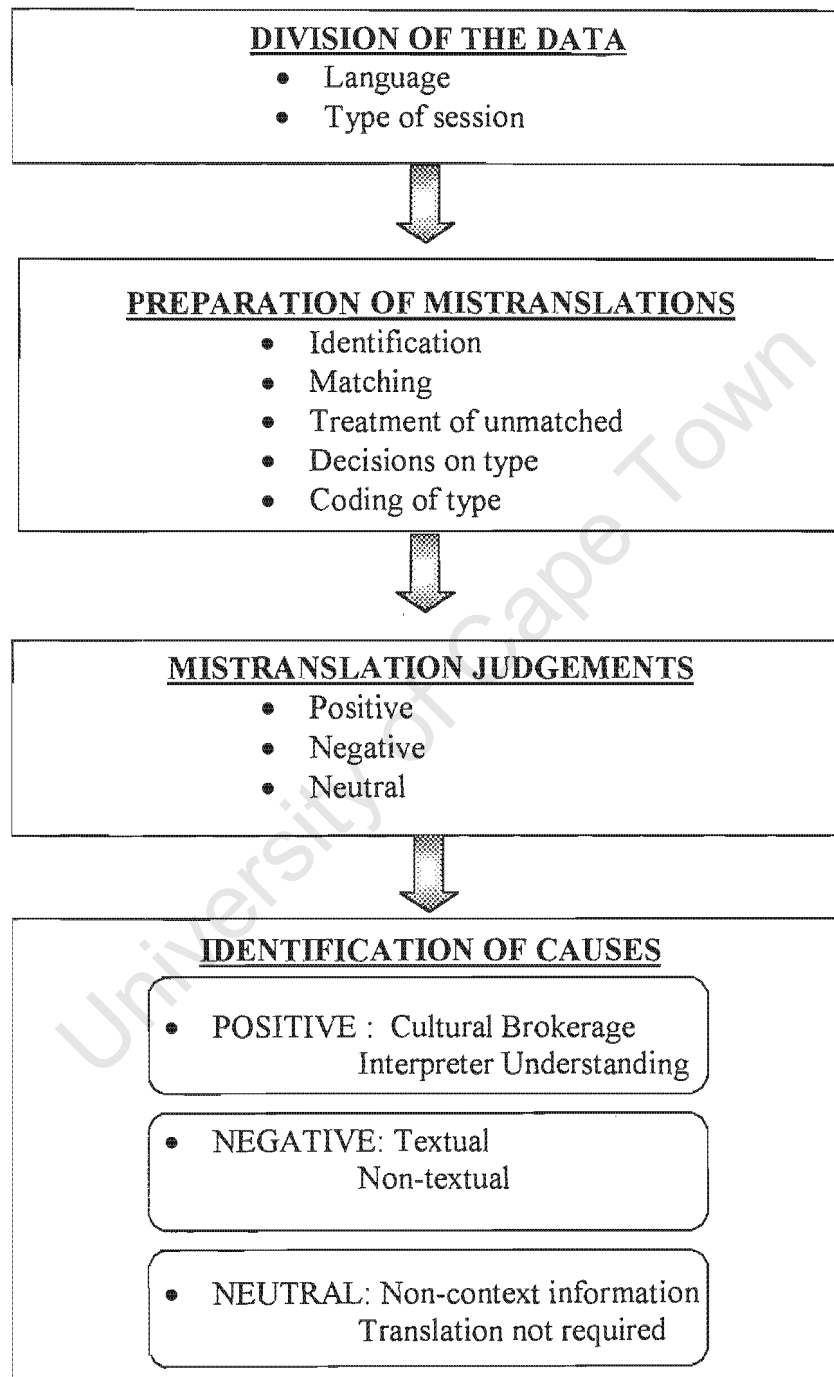
The MAT used in this study is illustrated in Figure 4.5.

			Addition	Omission
Positive	Cultural Brokerage	More culturally appropriate		
		Analogy/Example		
		Lengthy original utterance		
		Euphemism		
		Hyperbole/Emphasis		
		Repetition for emphasis		
		Praise/Encouragement		
	Increase Understanding	Explanation		
		Expansion		
		Repetition/Reinforcement		
		Summary		
		Checks Cg's/CI's understanding		
		Clarification		
		Accurately repeats what was said		
Negative	Textual	Anatomical/Medical terminology		
		Difficult terminology		
		Difficult concept		
		Connotative word		
		Lengthy original utterance		
		Summary		
		Emotive		
		Praise/Encouragement		
		Expansion of previous utterance		
		Example		
		Explanation		
		Questions		
		Instructions		
		Lack of Coherence		
		Lack of Cohesion		
	Non-Textual	Selective interpretation		
		Demonstration of medical acumen		
		Interpreter fatigue		
		Interpreter frustration		
		Cultural brokerage		
		Poor language skills		
		Lower level of sophistication		
Poor attitude				
Outside distraction				
Interpreter as interviewer				

**Figure 4.5: MAT used in this Study**

#### 4.6.2.4 Procedure for Analysing Data from the MAT

The procedure for analysing the accuracy across the TCH and the CN methods, involved four stages of analysis. Figure 4.6 below depicts the MAT analysis procedure.



**Figure 4.6: Flow Diagram Depicting MAT Analysis Procedure**

Figure 6.1 above depicts the stages involved in the MAT analysis that was devised by the researcher in previous research (See Evans, 2000). In the first stage, the data were divided into manageable portions. This involved dividing the data into English-Xhosa and Xhosa-English to allow for later comparison of whether the interpreter differed in her ability to translate in either direction. In addition, the data were divided into the method used (TCH or CN) and according to the section of the consultations (CH or FB).

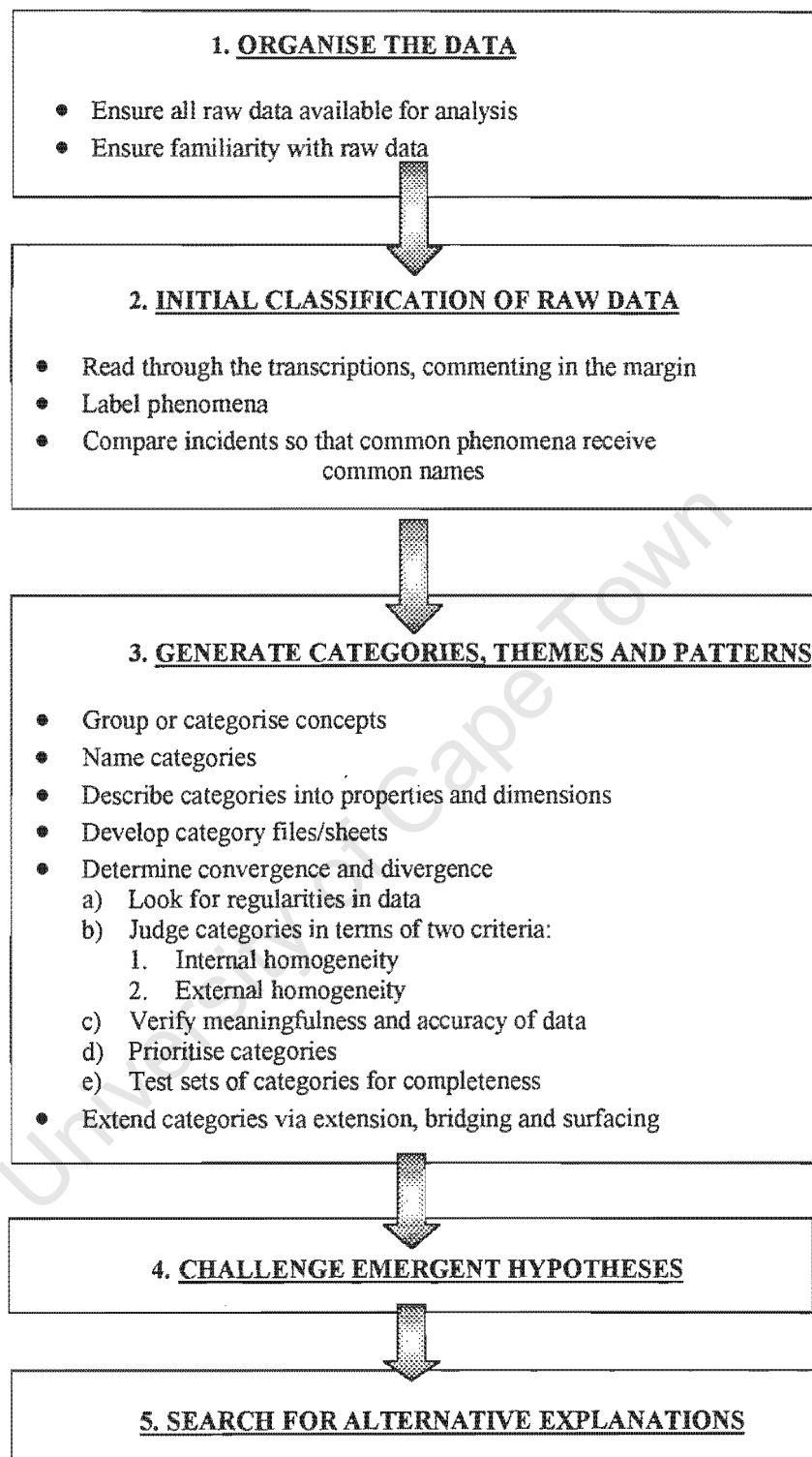
In the second stage, the data were prepared for the mistranslation analysis. This involved dividing the data into propositions and matching those propositions that were identical. Propositions were said to match if T contained all that was contained in O and nothing more than what was contained in O. Matched propositions were counted as accurate translations. Therefore, the remaining propositions consisted of mistranslations that were ready for analysis. The propositions were then coded according to type of error made. Additions and omissions were coded, using the letters A and O respectively.

In the third stage, each mistranslation was individually analysed according to whether it was considered to be making a positive, negative or neutral contribution. Positive, negative and neutral were indicated using + ; - ;  $\phi$  signs, respectively. Neutral mistranslations were not included in the analysis.

In the fourth stage, each mistranslation was analysed according to the presumed cause of the mistranslation. The reasons for the mistranslations were coded by number, according to the order in which they appeared on the sheet. The coding was written above each proposition and a tick placed on the appropriate MAT sheet.

#### **4.6.3 Thematic Analysis of the Data from the Post-consultation Interviews**

The data obtained from the post-consultation interviews were analysed, using a complex series of procedures based on a system of analysis devised by Michelson (1997) which was informed by a number of sources (Corbin & Strauss, 1990; Patton, 1990; Marshall & Rossman, 1995).



**Figure 4.7 Analysis of Post-consultation Interviews  
(Michelson, 1997)**

The stages depicted in Figure 4.7 are described in more detail below.

In the first stage, the researcher ensured that all raw data had been gathered and were available for analysis. The transcription of the post-session interviews, as well as numerous additional readings of the raw data, allowed the researcher to become familiar with the information, thereby facilitating further analysis (Patton, 1990; Marshall & Rossman, 1995).

The second stage marked the beginning of the coding process, in which a content analysis was conducted. The researcher read through the nineteen interview transcripts and made 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, was 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 conceptualized in this way to facilitate the large number of raw data in the transcriptions.

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 sub-categories.

Patton (1990) suggested that data should be organised into topics and files. Therefore, each category was allocated a separate category sheet. After a detailed coding procedure had been completed, the information pertaining to that topic was then cut out from a copy of the original raw data and placed on to 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 entailed “fleshing out” patterns and categories in order to determine what could be appropriately fitted together in particular categories. This was achieved by:

- Looking for regularities in the data
- Judging categories in terms of internal and external homogeneity<sup>3</sup>
- Working back and forth between data and classification systems to verify meaningfulness and accuracy of placement of data within certain categories
- Prioritising categories, by determining which categories were more important according to features of saliency, uniqueness and credibility.

Sets of categories were tested for completeness by:

- Extension – building on items of information already known
- Bridging – making connections between different items
- Surfacing – proposing new information and verifying its existence.

At this stage certain categories were joined together to form themes, and 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.

In the final stages, the data were searched in order to find information that might not be in agreement with the hypotheses (Corbin & Strauss, 1990). 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).

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<sup>3</sup> *Internal homogeneity* refers to the extent to which data in a category hold together. *External homogeneity* refers to the extent to which differences in a category are bold and clear (Guba, 1985 in Patton, 1990).

## **4.7 PROCEDURES ADOPTED TO ENSURE RELIABILITY OF RESULTS**

Research is said to be trustworthy if the research process is carried out fairly and the product is closely representative of the participants involved. Thus, a number of methods were employed in this study in order to enhance and determine the rigour of the data analysis procedure. This had to be undertaken at a number of different levels in the research to ensure that the data were accurate throughout (Evans, 2000).

### **4.7.1 Confirming the Accuracy of the Transcription and the Translation of the Data**

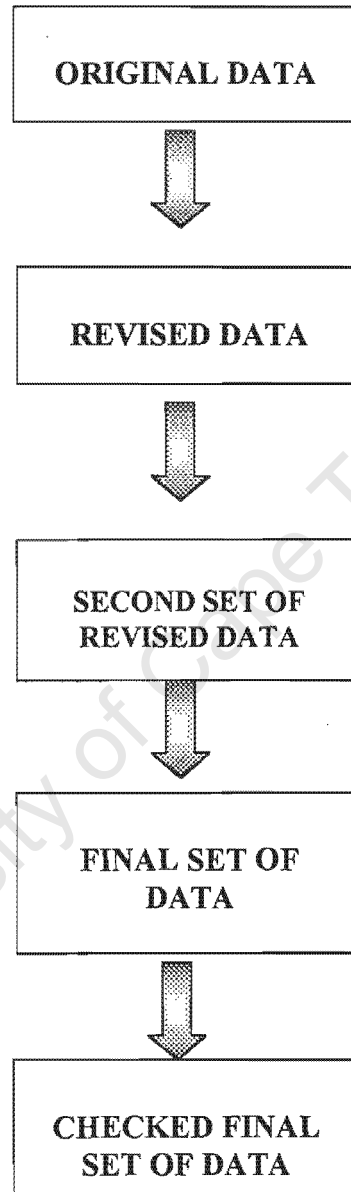
When interpreted consultations were analysed, the Xhosa and the English data were checked separately, as it was assumed that the Xhosa data had two possible levels of breakdown, in the transcription and in the translation phases, whereas the English data had only one possible level of breakdown, in the transcription phase (Evans, 2000).

#### **4.7.1.1 Xhosa Data**

Twenty percent of the transcribed and translated Xhosa data were rechecked by the original translator and transcriber (intra-rater reliability) and 100% of the transcribed and translated Xhosa data were checked by an additional two first language Xhosa speakers for inter-rater reliability. Each time the Xhosa data were checked and altered, a new set of data was formed. The original data underwent three different modifications (formulating the revised, the second revised and the final set of data) before the data were ready for analysis purposes.

The rationale for undergoing such detailed revisions of the Xhosa translations was as Muller (1994) stated: that there can be no authoritative translation from one language to another. Consequently, all of the various stages of translation were useful to the researcher when making statements about meaning. Field notes relating to additional explanations of meaning were added in brackets to the final set of data to assist the researcher in making accuracy judgements. The use of three raters, namely A1, A2, and A3, was felt to allow for greater reliability than the use

of back translation (Brislin, 1986), under circumstances where one – one word equivalents across languages is not always found. Consequently, the procedure previously devised by the researcher (See Evans, 2000) depicted in Figure 4.8 below was adopted for confirmation of the accuracy of the Xhosa data.



**Figure 4.8: The Stages Involved in Confirming Reliability**

#### 4.7.1.2 English data

To ensure intra-rater reliability, the researcher validated all the English data from the Xhosa sessions whilst working with A1 on validating the Xhosa data.

In addition to this, 20% of the English data, from the English-Xhosa initial consultations and the English-only post-consultation interviews, were reviewed by an L1 English speaker, to ensure inter-rater reliability. Twenty percent of the data were chosen from a cross-section of recorded sessions. The data were randomly selected, in that any part of these sessions was selected for this purpose.

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 4.9: Formula for Inter-Rater Reliability**

Inter-rater word-by-word agreements for transcriber 1 vs. transcriber 2 across the nineteen transcribed post-consultation interviews are presented in Table 4.6 below.

**Table 4.7: Inter-Rater Transcription Reliability**

	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5
Rater 1 & 2	93.20%	97.50%	91%	93.50%	93%
	Interview 6	Interview 7	Interview 8	Interview 9	Interview 10
Rater 1 & 2	95.40%	96%	98%	97.80%	97%
	Interview 11	Interview 12	Interview 13	Interview 14	Interview 15
Rater 1 & 2	91%	96%	97.50%	96%	98.20%
	Interview 16	Interview 17	Interview 18	Interview 19	
	98%	97.80%	99.20%	98%	

The mean percentage word-by-word agreement across the nineteen interviews for transcriber 1 and 2 was 96%. This result indicated high inter-rater transcription reliability. 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.

#### **4.7.2 Validating the Data at the Level of Thematic Analysis**

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

##### **4.7.2.1 Data on Characteristics of Respondents**

It is important to report on the characteristics of the respondents in order to give an indication of the reliability of the responses (Joubert *et al.*, 1997). Research demonstrates that, in our everyday communications and social interactions, we take an enormous amount of cultural context for granted, and we tend to bracket this as an obvious or common sense (Polgar & Thomas, 1991). When the cultural backgrounds of individuals diverge, the understanding of personal meaning becomes less obvious. The cultural and social background of the participants in this study needed to be described. Biographical details, details of training and experience as well as descriptions of the programmes to which the assistants were affiliated, were included.

##### **4.7.2.2 Audit trail**

The researcher is more a part of the phenomenon being investigated in qualitative research than in quantitative research (Polgar & Thomas, 1991). The advantages of using a human measuring instrument are that human beings are more adaptable and multi-purpose than even the most sophisticated machinery and can observe subtle behavioural changes and verbal and non-verbal cues in their subjects. One way of indicating the train of thought of the researcher is through an audit trail. An audit

trail involves the researcher reporting on his/her train of thought (De Poy & Gitlin, 1994).

This was achieved via the following:

- Post-consultation field notes
- Notes on procedures in the methodology
- Notes on the construction of materials in the methodology
- Notes on the utilization of the constructed materials in the methodology.

#### **4.7.2.3 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. This can involve using several kinds of method or data, including using both quantitative and qualitative approaches. Any given study can include several mixes of the approaches by including several measurement approaches, by varying design approaches, and by varying different analytical approaches to achieve triangulation. (Patton, 1990). The use of triangulation recognises that the researcher needs to be open to more than one way of looking at things.

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

Denzin (1978b in Patton, 1990) has specified four basic types of triangulation:

- Data triangulation - the use of a variety of different data sources in one study
- Investigator triangulation - the use of several different investigators/ evaluators

- Theory triangulation - the use of multiple perspectives to interpret a single set of data
- Methodological triangulation - the use of multiple methods to study a single problem or programme.

Triangulation was used to strengthen the validity of this research in the following ways:

**Data triangulation** was used in that the following different types of data were compared:

- Video recordings of the initial consultations
- Transcriptions from the initial consultations
- Video recordings of the post-consultation interviews
- Transcriptions of the post-consultation interviews
- Field notes of observations
- Consultation analysis
- Mistranslation analysis
- Thematic analysis.

**Investigator triangulation:** Although the researcher was essentially the chief investigator, the perceptions of the clinicians, the interpreter and the caregivers in the post-consultation interviews provided multiple points of view. All of the participants can therefore be considered to have played an investigative role.

**Methodological triangulation** was used in that observational data (from the video-recordings of the initial consultations and the post-consultation interviews) could be compared to the transcriptions of the initial consultations and the post-consultation interviews.

According to Patton (1990), observational data, especially participant observation, permits the evaluation researcher to understand a programme or treatment to an extent not entirely possible using only the insights of others obtained through

interviews. The purpose of observational data should be to take the reader into the setting that was observed. This means that observational data must have depth and detail. The skilled interviewer must also be a skilled observer, able to read nonverbal messages, sensitive to how the interview setting can affect what is said, and carefully attuned to the nuances of the interviewer-interviewee interaction and relationship (Patton, 1990).

Argyris (1982 in Polgar & Thomas, 1991) has emphasised the importance of differentiating *espoused theories* from *theories-in-use*, in which espoused theories are what people say they do, and theory-in-use is what actually happens. By observing what had actually happened in the initial consultations, as opposed only to listening to the participants' descriptions of what had occurred, the researcher was able to discover the theory-in-use. The espoused theory should, however, not be dismissed as being irrelevant as it has its own uses.

#### **4.7.2.4 Subjective Assessment of the Interviews Immediately after the Recording**

In accordance with suggestions made by Patton (1990) and Marshall and Rossman (1995), immediately after each interview session the researcher wrote down brief field notes on the positive and negative aspects of the session, as well as the researcher's feelings about the responsiveness of the participants. Patton (1990) states that the best time to write down ideas about a session is immediately afterwards. Patton also states that this requires great discipline on the part of the researcher.

After the post-consultation interviews with the caregivers, the researcher and the assistants A1, A2 and A3 held a brief discussion on how the researcher felt the session had gone. These sessions were recorded but not transcribed. A short interview assessment was compiled based on recommendations by Marshall and Rossman (1995) and Patton (1990). The components of this assessment included:

- 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.

An example of the researcher's own Assessment of Interview form can be found in Appendix E.

#### **4.7.2.5 Data Indicating Missing Data**

The incidence of missing data (Joubert & Katzenellenbogen in Joubert *et al.*, 1997) was reported in the subject description section of the methodology. Very little other data could not be transcribed. The data that could not be transcribed could be attributed to one of the following:

- Speaker variables: Some of the caregivers had very soft voices that contributed to poor sound quality
- Environmental/Situational variables: A trade-off had to be made between ensuring privacy, comfort and quiet and making the sessions as naturalistic as possible.

#### **4.7.3 Confirming the Accuracy of the Preparation of Data for the Mistranslation Analysis**

The researcher relied on intra-rater reliability and inter-rater reliability to ensure the accuracy of the preparation of the data for analysis.

##### **4.7.3.1 Intra-rater Reliability**

A total of 316 pages of translated transcripts from the initial consultations were prepared for the data analysis. The researcher re-checked a random 20% of this data

to ensure that the decisions that had been made pertaining to the following were consistent:

- Division into propositions
- Matching of propositions
- Contribution of propositions
- Neutrality of propositions.

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## CHAPTER FIVE

### RESULTS AND DISCUSSION

The findings from the analysis of the initial consultations and the post-consultation interviews are presented and discussed under each of the theme categories emerging from the thematic analysis of the interviews. These themes are listed in Table 5.1 below.

**Table 5.1 : List of Themes**

Characteristics of the Two Methods
Transaction
Patient-Centred Care
Role of the Interpreter

Within each theme, the findings are compared across the methods used and the participants involved as illustrated in the matrix in Figure 5.1 below.

White Clinician + Interpreter TCH Method	Black Clinician TCH Method
White Clinician + Interpreter Cultural Narrative Method	Black Clinician Cultural Narrative Method

**Figure 5.1: Matrix of Comparison**

As previously mentioned in Chapter Four, the overall findings from the analysis of the initial consultations will be discussed overall and thereafter in the case history (CH) and the feedback (FB) sections of the consultations.

## 5.1 CHARACTERISTICS OF THE TWO METHODS

In the post-consultation interviews with the participants, the clinicians expressed their preference for the CN method, as opposed to the TCH method, for the following reasons:

- The open-ended nature of the CN method
- The CN method highlighted the patient's primary concern
- The TCH method was insufficient in itself because, in order to gauge the patient's perceptions, additional open-ended questions needed to be added
- Having to follow the questions in the TCH was the most frustrating aspect of this method and proved distracting because this meant that there was less focus on the patient and the patient's attention was more easily lost.

**WC:** *"With the cultural uh the cultural narrative? I love it [CN]. I mean you just you're basically asking two or three very basic questions and it highlights for you where to go in terms of management."*

**BC:** *"Well, it's [TCH] not comfortable at all. Because I had to follow the questions. So in some stages I felt that I was losing the patient's attention."*

**BC:** *"Having to follow the questions is the most frustrating aspect of those [TCH] interviews."*

Although the clinicians commented favourably on the CN method, the interpreter had mixed feelings about this method. It emerged from the discussions with TI that her concerns were directly related to her concern about the accuracy of the consultation. This will be discussed in more detail in the next theme, Transaction, within Chapter Five.

The analysis of the consultations indicated that the nature and form of the two methods resulted in distinct differences in duration, type and amount of information, topic control, structure and well-formedness, chronology, degree of flow and style and time. This section will discuss the findings from the analysis within each of the above-mentioned characteristics.

In addition to these key differences between the two methods, a number of more subtle differences emerged, depending on whether the clinician was black or white and on whether an interpreter was present at the consultation. A summary of the key differences between the two methods can be found in Table 5.2 on the next page. Following the table is a more in-depth discussion of these differences, as well as the more subtle differences thought to be a result of the clinician's culture, language and the absence/presence of an interpreter.

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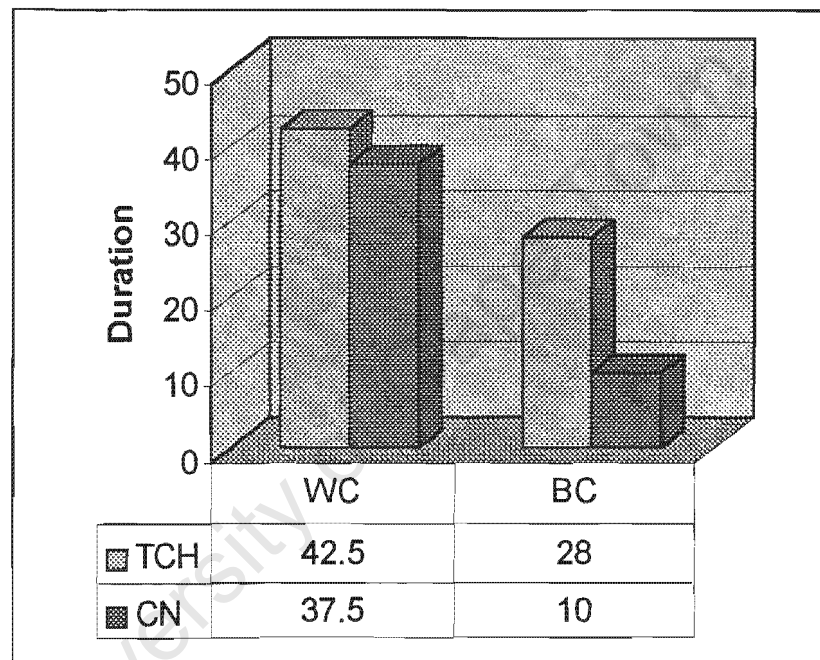
**Table 5.2: Key Differences Found across the Two Methods**

	<b>TRADITIONAL CASE HISTORY METHOD</b>	<b>CULTURAL NARRATIVE METHOD</b>
<b>DURATION</b>	Longer when no interpreting is conducted	Shorter when no interpreting is conducted
<b>TOPIC CONTROL</b>	Wide range of topics covered	Smaller, more select range of topics covered
	Topics being returned to in the discussion numerous times	Topics generally discussed once and not returned to again in the discussion
	Topics selected by the clinician	Topics selected by the caregiver
<b>TYPE OF INFORMATION</b>	More detailed	Less detailed
	More specific	More general in nature
	More disease/symptom - oriented	Illness – oriented
<b>DEGREE OF FLEXIBILITY</b>	Highly structured	Unstructured
	Rigid	Flexible
<b>FLOW</b>	Stilted	Free-flowing
	No Chronology	Chronological
	Numerous complicating actions and an occasional setting in no specific order	Distinct elements of setting, complicating action, resolution and (optional) coda in a chronological order
<b>FORMAT</b>	Lends itself to a written format	Lends itself to an oral format
<b>TIME</b>	Real-time based	Event-based

### 5.1.1 Duration

The duration of each of the consultations, as well as the average for the consultation overall (across type<sup>1</sup> of consultation), as well as in the CH and the FB sections of each consultation specifically, can be found in Appendix F. The average overall consultation durations are depicted in Figure 5.2 below.

#### 5.1.1.1 Duration of Consultations Overall



**Figure 5.2 : Average Overall Duration of the Consultations for WC and BC**

Figure 5.2 indicates that, as expected, the interpreted consultations took considerably longer than the consultations in which BC participated. In addition, when there was no interpreting, the TCH method took considerably longer than the CN method. When interpreting was conducted, overall durations indicated slightly longer TCH than CN consultations.

<sup>1</sup> Type used in the context of *consultation type* refers to whether the consultation used the TCH method or the CN method, as well as to whether the white or the black clinician conducted the consultation.

Overall, WC's TCH consultations ranged from 34-60 minutes and WC's CN consultations ranged from 22-40 minutes. BC's TCH consultations ranged from 14-22 minutes and her CN consultations ranged from 8-12 minutes. A large variation in durations existed for both BC and WC, regardless of the method used. This suggests that there were factors other than the method used that impacted on the duration of the consultations. Observational analysis of the videotapes and the transcripts of the consultations suggested that consultation duration appeared to be affected by:

- The presence of an interpreter
- The complexity of the case

The finding that the interpreted consultations took longer than the consultations in which BC participated supports Sishi's (2001) findings in which the consultations with the white therapist took longer than those with the black therapist. Research has established that interpreted consultations do take longer than consultations in which no interpreting is needed. Length of consultation is an important consideration in a busy clinic, as clinicians do not have the opportunity to spend much time with each patient. As a result of the large variation in duration within each method, prediction of the type of method was not possible from the durations.

Although the interpreter's presence certainly impacted on the length of these consultations, it was thought that this was not the only variable as the interpreter's presence was constant in both of the methods used in the consultations. An examination of the content of these consultations, revealed that there was a great variation in terms of complexity. As one would expect, the more complex cases, that is, the cases with complicating factors in addition to the hearing loss, had longer duration.

### 5.1.1.2 Duration in the CH and the FB Sections of the Consultations

The duration of the CH and the FB sections of the consultations are depicted in Tables 5.3 and 5.4 respectively.

**Table 5.3: Average Consultation Duration in the CH Section of the Consultations**

	TCH Method	CN Method
WC	32.5 minutes	26 minutes
BC	23 minutes	6 minutes

**Table 5.4: Average Consultation Duration in the FB Section of the Consultations**

	TCH Method	CN Method
WC	13 minutes	11.5 minutes
BC	7 minutes	5 minutes

As illustrated in Table 5.3 above, in the CH section of the consultation, the averaged lengths of the consultations reflected the large discrepancy in length between the TCH and the CN consultations. Table 5.4 indicates that in the FB section of the consultations, there was a much smaller difference between the lengths of the TCH and the CN consultations. Consequently, it is the CH section of the consultations in which the method had the greatest impact on duration.

In the post-consultation interviews with the participants, the clinicians commented on the reduced length of time taken in the consultations in which the narrative method was used.

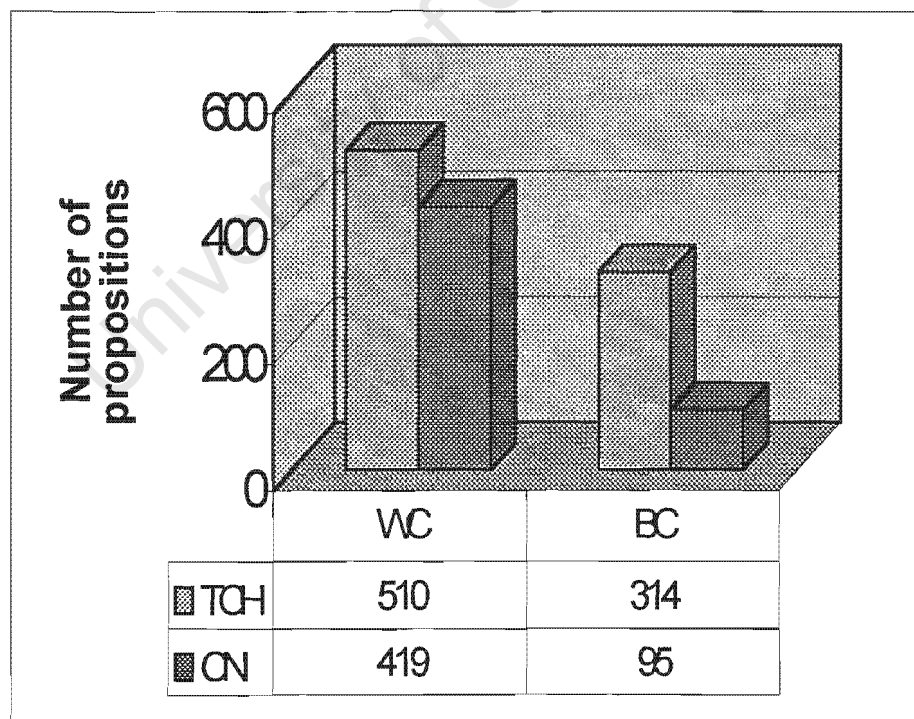
**WC:** *“The TCH method takes so long, ‘cos you have to go through the whole form, instead of just highlighting the important facts which would come through in the cultural narrative [CN], instead you have to go through this whole long spiel before you actually you know get the important stuff. So I’d say the TCH method takes quite a lot longer.”*

The finding that the CN method took less time than the TCH method in both WC’s and BC’s consultations has positive implications for clinical practice, especially

considering the South African health care context in which public health services are overextended, with clinicians seeing as many as 60 patients per day (Crawford, 1994; Crawford, 1999). Within the context of a busy hospital in which staff members have to perform numerous duties during the course of a single day, an effective yet time-saving means of taking a medical history is most welcome.

### 5.1.2 Amount of Information

As mentioned previously, a propositional analysis was conducted to determine the amount of information contributed by the participants in each of the consultations. For the purpose of this research, a propositional unit was defined as an idea unit (a verb with an argument). The rationale for conducting the analysis was to determine whether the amount of information obtained was the same across each of the methods. False starts, ritual utterances and empty fillers were not included. The number of propositions was averaged across each type of consultation and the overall results are presented in Figure 5.3 below.

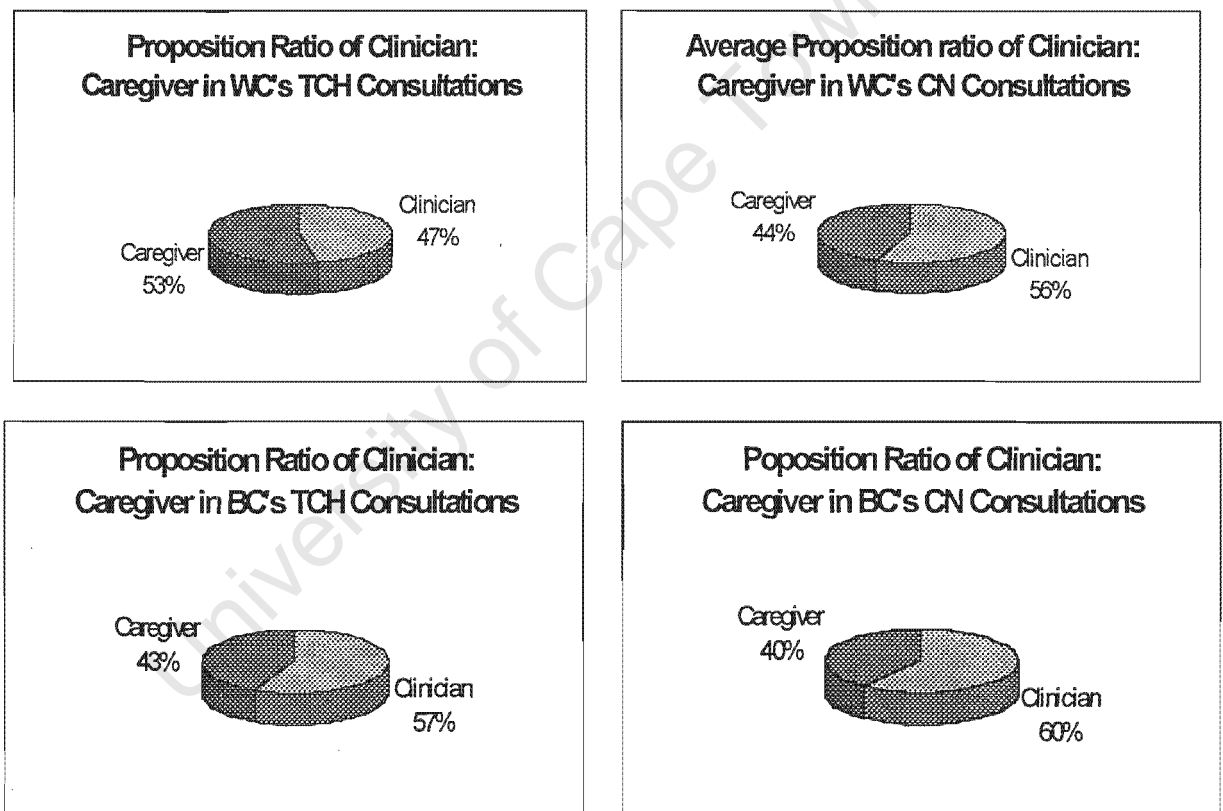


**Figure 5.3: Average Number of Propositions in the TCH and CN Methods**

An analysis of the number of propositions in each of the consultations indicated that BC's consultations had fewer propositions than WC's. This is unsurprising

considering that it mirrors the finding that BC's consultations were shown to be shorter in duration than WC's. For both WC and BC, a difference in the number of propositions was evident according to the method used. The CN consultations had fewer propositions than the TCH consultations. In the post-consultation interviews with the participants, the clinicians commented that they felt that the CN method elicited more information than the TCH method.

Sishi (2001) illustrated that by using a proposition count, the relative contribution of the different categories of participants could be illustrated. Figure 5.4 indicates the ratios of the number of propositions of the participants for each of the methods.



**Figure 5.4: Proposition Ratio of Clinicians: Caregiver for WC and BC in each of the Methods**

The findings from the analysis of the ratio of propositions for the participants revealed that there was little difference across methods. However, on further reflection, it was apparent that it was not necessarily the amount of information that was critical, but more important was the type of information and who had initiated the discussion of

topics. The number of propositions did not account for the degree to which topics were repeated or expanded on throughout the consultation. In addition, the proposition ratio gave no indication of which participant introduced the topics. Consequently an analysis of topic control and shifting was carried out.

### **5.1.3 Topic Control and Shifting**

In order to analyse the topic control and shifting in the consultations, the researcher categorized the nature of the topics. The researcher then recorded the instances in which these topics were shifted. A list of all the topics, as well as the number of times they were brought up in the consultations, and whether the clinician or the caregiver introduced the topic shift, can be found in Table 5.5 on the following page.

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**Table 5.5: Topic Shifts by the Clinicians (CI) and the Caregivers (Cg)**

	Case History				Feedback			
	TCH CI	TCH Cg	CN CI	CN Cg	TCH CI	TCH Cg	CN CI	CN Cg
Biographical Details	9		4					
Birth History	11	1		2				
Cause of Hearing Loss				1			2	
Communication, Speech and Language	20		10	1				
Development	13		1		1			
Diagnosis					1			
Discipline	1							
Ear Problems	9	1		6				
Ear Management				3	6		1	
Eating and Feeding	2							
Emotional State			1	2				
General Medical Problems	14	7	1	7				
Family History	3		1	3				
Feelings and Management					1			
Financial Problems			1	3		2		
Hearing History	9	1	1	2				
Hearing Results					1			
Hearing Mechanism					4			
Hearing Management				2	2		2	
Introductions	4		1					
Management of Speech and Language				1	1		2	
Management of Socio-Emotional State			2					
Monitoring School Performance					1			
Play	5							
Previous Medical Intervention/ Clinical Experience	16		4	5				
Procedure/ Instructions	3		4	1	4			
Problems with Health Service Delivery				2				
Psychosocial Problems				2				
Reason for Attending the Clinic		1						
Referral	6				8		11	
Relationship Problems		1						
Request for Examination		1						
School	6		6	4			1	
Socio-Emotional State	3	1	1					1
Summary	1				1			
Support Groups					1			
Test Results					3		10	
Unemployment								
<b>Total Number of Shifts</b>	<b>113</b>	<b>14</b>	<b>38</b>	<b>47</b>	<b>35</b>	<b>2</b>	<b>29</b>	<b>1</b>

The analysis of topic shifting and control indicated that there was a difference in the number of topics across the methods, as well as in the number of topic shifts. The findings indicated:

- That a greater number of topics were discussed in the TCH consultations
- That there were a greater number of topic shifts in the TCH consultations
- That a greater number of topics were introduced by the clinicians in the TCH consultations for both WC and BC
- That the number of topics introduced by the clinicians and the caregiver were equal in WC's CN consultations
- That a greater number of topic shifts were introduced by the caregiver in BC's CN consultations.

Table 5.6 below compares the number of topic shifts in the two methods.

**Table 5.6 : The Number of Topic Shifts for the Two Methods**

	<b>TCH Method</b>	<b>CN Method</b>
<b>Total Number of Topics</b>	28	21
<b>Average Number of Topic Shifts per Consultation</b>	15	10

Table 5.5 above illustrates that when the number of topics per consultation is examined, it is clear that a far greater number of topics were discussed in each TCH consultation than in those in which the CN method was used. This could be explained by the clinician-led focus in the TCH method, as opposed to the caregiver-led focus of the CN method. In the TCH consultations the clinicians explored numerous topics, whereas in the CN method the caregiver introduced only those topics that were relevant to her, thereby decreasing the number of topics discussed in the CN consultations.

The increased topic shifting in the TCH method can be explained by the fact that topics were repeated and returned to more often than when the CN method was used. It appeared that in the CN consultations the caregivers tended to introduce the topics and these were then discussed with the clinician once and not re-discussed at a later

point. In the TCH consultations the repetition of topics may be explained by the question-answer format of this method, which did not make room for each topic to be fully explored.

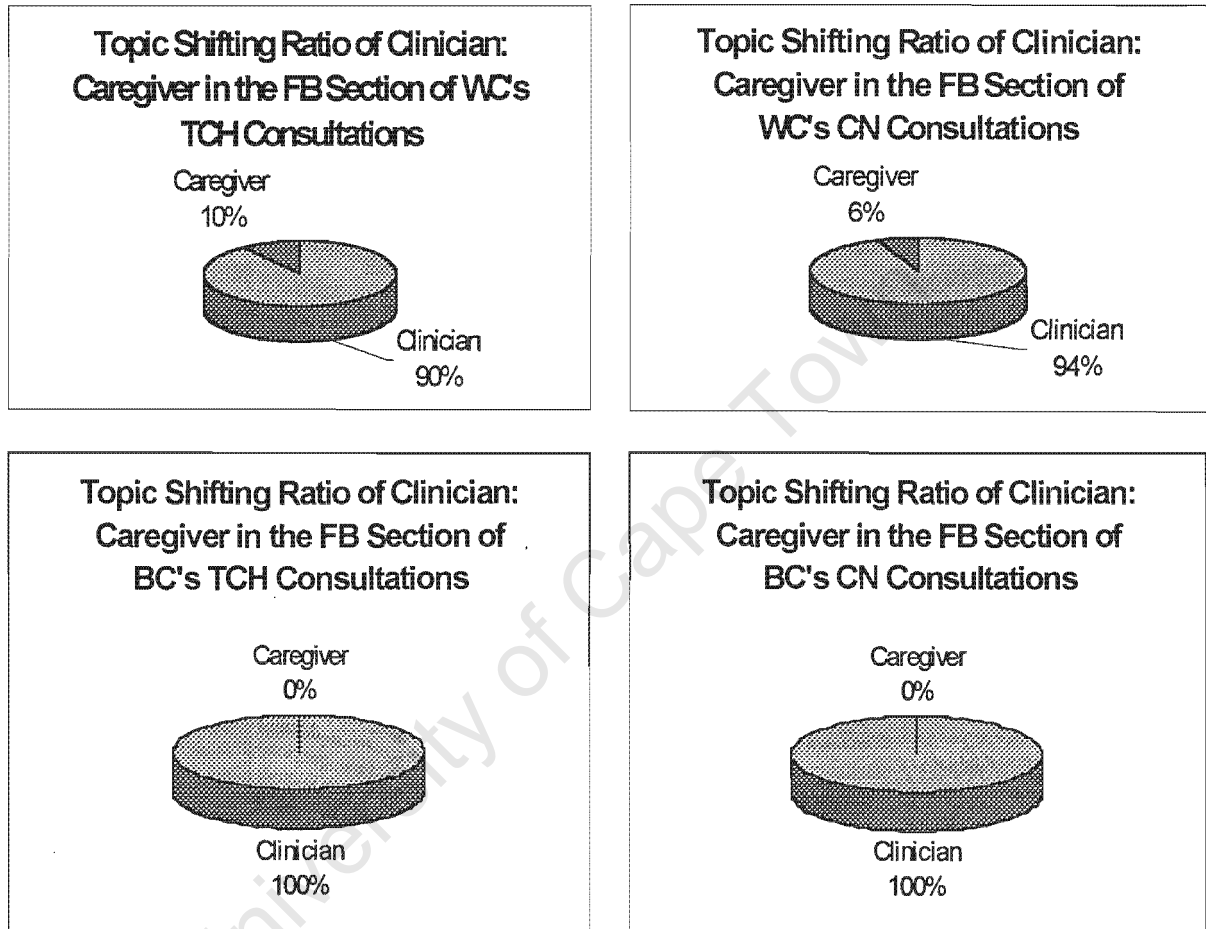
A large difference in the amount contributed by the participants (when calculated according to the topic shifting) was found for both WC and BC. The ratio of topic shifts between the participants in each of the respective methods is summarised in Figure 5.5 below for the CH section of the consultation, and in Figure 5.6 for the FB section of the consultation.



**Figure 5.5: Topic Shifting Ratios of Clinician: Caregiver in the CH Section of WC's and BC's TCH and CN Consultations**

The pie charts in Figure 5.5 above clearly reflect that in both WC's and BC's TCH consultations, the vast majority of topic shifts were made by the clinicians. For WC's consultations, the number of shifts made by the caregiver was similar to those made by the clinician when the CN method was used. For BC's consultations, the caregiver made more shifts than the clinician when the CN method was used. This reflects on

the patient-centredness of the CN method. The increased number of topic shifts by the caregivers in the CN method suggests that these consultations were more caregiver-directed, in contrast to the clinician-directed consultations in which the TCH method was employed.



**Figure 5.6: Topic Shifting Ratio of Clinician: Caregiver in the FB Section of WC's and BC's TCH and CN Consultations**

Figure 5.6 above illustrates that in contrast to the findings from the case history section of the consultations, the findings from the feedback section suggest very strongly that the method had no impact on participant contribution, as the entire feedback aspect of the consultations was dominated by clinician-directed topic shifting. These findings highlight two crucial points, namely the nature of the feedback in clinical consultations, and the importance of dividing the initial consultation into its components in order to show clear differences in the methods.

#### 5.1.4 Type of Information

In the consultations in which the TCH method was used, the clinicians selected the information that they believed was relevant and pertinent. In contrast, in the CN consultations, the caregivers' increased topic control meant that the caregivers selected the information that they believed was relevant. As such, the narrative method was more relevant to the needs of the caregiver, and could be considered to be more patient-centred. All of the information provided by the caregivers should be regarded as relevant. Narratives provide information that extends beyond just the unfolding events and the same sequence of events told by another person might be told differently without being any less 'true' (Greenhalgh & Hurwitz, 1998). Narratives have no self-evident definition of what is relevant or what is irrelevant for any particular narrative, as the choice of what to tell and what to omit lies entirely with the narrator and can be modified at the discretion of the listener through the listener's questions (Greenhalgh & Hurwitz, 1998).

Mishler (1984) commented that during biomedical interviews, clinicians control the content of the interview through both their initiation of certain topics and their tendency to ignore certain parts of the patient's report. On the other hand, caregivers construct the symptoms of illness according to what is relevant in their lives. Patients usually explain the history and symptoms of their illness and then include how it has affected their life – the *life contexts* of illness.

A review of the literature suggests that a number of different themes predominate illness narratives. Skultans (1998) has proposed that illness experiences serve as a wider metaphor for the suffering of society. Particularly when there is a breach between the ideal and the real, narratives have an important role to play (Riessman & Kohler, 1993 in Skultans, 1998). Crises feed an individual's narrative drive and thus illness has a particularly close relationship with narrative. "*Illnesses acquire a more real meaning through plot, through embeddedness in a life story, and conversely, the individual illness experience serves as a wider metaphor for the suffering society.*" (Skultans, 1998 : 228).

The existence of such plots emphasizes that most personal recollections are shaped by existing genres of story-telling in a society. Narratives are about personal experience. However, that experience is shaped by a shared cultural lens, which puts the illness to critical use (Skultans, 1998).

In the TCH consultations, symptoms of ear infections and birth details are provided, and we learn of the course of disease. In the CN method narratives, symptoms of ear infections and birth details are also provided, but this is embedded within a context and a web of social relations. Therefore, in addition to learning about the course of the disease, from the narrative genre we learn about problems with health service delivery in a developing country, disorganised schooling systems, and the reality of poverty in urban and rural South Africa. The caregivers' testaments to their numerous referrals, their lack of understanding of their child's diagnosis despite numerous consultations, and misunderstanding, confusion and chaos on previous clinic visits is testament to their perseverance to assist their children, as well as to their fatigue and dwindling reserves to cope within such a system. Social relationships are reflected in the narratives in the caregivers' attitudes to their children's school teachers, the extended family systems that place them as sole caregivers in families of seven or eight children and in the strength of these mothers who choose to make sacrifices for their own children for the collective good of all the other children for whom they are caring. All of this deeper meaning is lost in the consultations in which the TCH method is used.

The analysis of the consultations indicated that, regardless of the method used, the stories told by the caregivers reflected a search for help, that is a quest for medical intervention. The diseased body's need for a voice is the basis of Frank's principle plots of Western illness, namely restitution<sup>2</sup>, quest, chaos and testimonial narratives (Frank, 1995 in Skultans, 1998). The three plots of restitution, chaos and testimonial narratives were only fully reflected when the narrative method was used in the consultations. The caregivers' illness narratives bore testament to the disorder and chaos of the existing social services and sought restitution for the healing of their children and their families. These narratives were a testament to the strength of the

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<sup>2</sup> *Restitution* is defined as "the act of giving back something that has been lost or stole" (Collins Dictionary and Thesaurus, 1999 : 823) which in the context of illness narratives refers to lost health.

caregivers and the hardship that they had endured. Within this oral tradition, their plight was stated as life stories that were frightening in their reality. Without the colour and flamboyance of the narrative, it is difficult to imagine how the listener's feelings could even begin to approximate those heard in the narratives when the stilted, clinician-directed nature of the TCH method was used. The compassion and empathy evoked from such dialogues when the CN method was used appeared to be lost in the TCH method.

### 5.1.5 Well-formedness of the Narratives

Well-formedness will be discussed in relation to the global structure and chronology of each method. In the post-consultation interviews with the participants, the clinicians commented on the differences in flow between the two methods. They felt that the question and answer format in the TCH method was too structured, resulting in the clinician's eliciting too much unnecessary detail and a stilted dialogue. In contrast, the two or three basic questions asked in the CN method allowed for an easy-flowing, more naturalistic conversational exchange.

The clinicians also commented on the greater flexibility of the cultural narrative method. They felt that the questions asked in this method could easily be adapted to any context, making it ideal for a multilingual/multicultural country such as South Africa. In contrast, owing to the number of questions and the presence of medical jargon, the questions in the TCH method required translating that was more intense than in the cultural narrative method.

**WC:** *"But I find it [TCH] too structured and I find that the interview doesn't flow with that form. And I find that you get stuck in detail that you don't really need, so I don't really enjoy using that form."*

**WC:** *"I found it [TCH] very restrictive because your interview can't actually flow as well."*

The TCH method involved the clinician following a set of questions. The increased turn-taking for the participants, which is even greater when an interpreter is used,

becomes very stilted and tiring for the participants. In contrast the CN method is free-flowing, with longer periods of uninterrupted dialogue. Consequently, the flow of the interview is much more natural. WC2 even commented that she felt as if the narrative allowed for a 'conversation' to take place. WC referred to this as an 'informal chat'. The essence of these remarks was that the narrative approach was far more naturalistic and less tiresome for all participants.

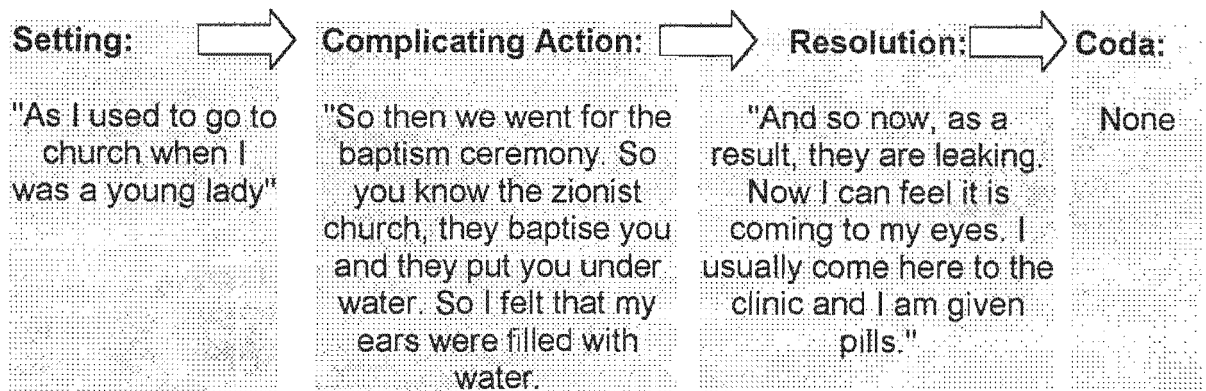
In the consultations in which the TCH method was used, interactions appeared to be more formal, with the clinician in a position of authority and power, controlling the consultation. These consultations were characterised by minimal patient participation, resulting in one-sided interaction. Despite the fact that the consultations were frequently lengthy, one senses, from observations of the consultation recordings, that interaction was rushed in order to get through everything. In contrast, the consultations in which the CN method was used were characterised by more informal interaction. There was more equal patient and clinician participation, particularly in the CH section of the consultations. There was no sense of being rushed or of running out of time.

In the post-consultation interviews with the participants, the clinicians commented on how the nature of the narrative method lent itself to an oral format, in contrast to the TCH method, which lent itself to a written format. This impacted on the dynamics of the consultation, including non-verbal behaviours such as eye contact. There appeared to be a preoccupation with both clinicians to write things down on the TCH form, despite the fact that neither was instructed to do so.

The link between narratives and an African oral tradition, is well documented (Hinchman & Hinchman, 1997 in Sishi, 2001; Yule, 1993). It would appear that when the clinicians referred to the narrative approach being about speaking in contrast to the TCH being about writing, the clinicians were referring to those elements of a narrative that made it a *story*, instead of just a list of information, as obtained in the TCH method. Narratives are a form of discourse that place events in sequence with an oral tradition with a well-defined beginning, middle and ending (Hinchman & Hinchman, 1997 in Sishi, 2001). As such, they can be distinguished from lists and case studies. A review of the literature has revealed that the structural aspects of

narratives, which essentially make them stories, are well-documented. Narrative structures have a conservative tendency (Foucault, 1974, Gadamer, 1975 & Fish, 1989 in Donald, 1998). A number of factors contribute to the form of the narrative, namely the global structure of the story, the time taken in telling the story, the amount of information obtained, the styles adopted in telling a story and the chronology of events (Ulatowska, Hill, Thomson, Parsons & Wertz, 1998; Von Bentheim, 2000). The global structure of the narrative evaluates four critical elements, namely the creation of setting, the provision of the complicating action, a resolution and an optional coda (Ulatowska *et al.*, 1998). These elements correspond with those proposed by Greenhalgh and Hurwitz (1998) namely, a beginning [setting], a sequence of unfolding events [complicating action], and an ending [resolution and (optional) coda].

Coherence refers to the continuity, well-formedness and plausibility of the story within each narrative. The narrative can be evaluated by observing the temporal sequence and chronology (Ulatowska *et al.*, 1998). In this study, the global coherence of the consultations was analysed by identifying the four elements of setting, complicating action, resolution and (optional) coda. The global coherence of the caregivers' narratives from consultations with WC and BC is illustrated in the Figures 5.7 and 5.8.



**Figure 5.7: Caregiver's Narrative in WC's CN3**



**Figure 5.8: Caregiver's Narrative in BC's CN3**

Figures 5.7 and 5.8 above illustrate that in all of the CN consultations for both WC and BC, the narrative elements of setting, complicating action and resolution, were clearly identifiable. With the exception of one consultation, the narratives generally did not contain codas, the optional element of narratives. In all of the narratives, the critical elements of the narratives were found to occur in a chronological order.

In contrast to the CN method, it was found that the nature of the TCH method did not allow for the distinct narrative elements to be elicited in any particular order. This finding was anticipated, as the chronology of events within the consultations in which the TCH method was used is predetermined by the questions asked by the clinician. For example, one of the very first questions generally asked by the clinicians when

using the TCH method, related to the reason for referral to the clinic. The answer to this question often comprised the resolution component in the consultations in which the narrative method was used. By asking this question at the beginning of the consultation, the chronology of events was immediately disrupted.

The lack of chronology in the consultations in which the TCH method was used supports the finding by Sishi (2001) that the caregivers in these consultations did not present their story in a coherent manner as they were unable to produce a natural chronology of events, as this was predetermined by the clinician. Sishi (2001) comments on her observation that despite being asked closed questions, the caregivers even in the consultations in which the TCH method was used, tended to attempt to expand their answers so that they approximated a narrative. For example, in WC's TCH 4, the consultation contained numerous anecdotes by the caregiver all of which approximated illness narratives. They usually included a complicating action and a resolution or a complicating action and a setting. These anecdotes were centred around themes of problems with the health service delivery in South Africa and a tendency to want to express their suffering. However, the TCH method did not facilitate this. A common theme throughout all of these anecdotes was the financial difficulty of an unemployed, single mother with a disabled child. Yule (1993), in her account of narrative therapy, explains that patients seek therapy at a juncture in their lives when the pieces of life's puzzle do not fit together. This hole or gap prompts the patient to seek therapy at a particular juncture. It is out of these junctures that illness narratives are derived (Yule, 1993). In the case of the caregiver in WC's TCH4 consultation, it appeared that she had reached such a juncture. For this particular patient, the traditional case history method was insufficient to satisfy her need to speak of her problems. As a result, the caregiver in TCH4 attempted to tell her story in fragmented parts, which made her story difficult to follow. The concept that as humans we have an innate ability to create narratives in order to make some meaning of our lives was reiterated in this case because, although the caregiver was not asked to tell the story of her illness, she attempted to do so.

The consultations in which the CN method was used were not limited to having a single illness narrative. One of the more complex cases (WC CN3) had five separate illness narratives, each with their own setting, complicating action and resolution. All

of these combined could be seen as a series of linked stories that formed a large part of a life narrative of the patient.

The caregiver's narrative in the consultations in which the CN method was used did not comprise the entire case history portion of the consultation. The patient's illness narrative sometimes only comprised as little as 21% of the CH section of the consultation, and only 37% of the caregiver's propositions in some cases. This suggests that a large proportion of the CH section of the consultations was not devoted to the narrative. The remaining portion of the CH section comprised the caregiver's answering questions posed by the clinician and the interpreter. The literature on the lengths of narratives suggests that this is unsurprising, as a patient's narrative in a medical consultation lasts, on average, only 28.6 seconds (Svab, 1991 in Heath, 1998). However, this could also be suggestive of a lack of familiarity on the clinicians' part with the acceptance of the sufficiency of the patient's narrative as the basis for a diagnosis. Both WC and BC asked additional questions of the caregivers in the consultations in which the narrative method was used. None of these questions actually revealed any issues that would have changed the diagnosis or management of the case in any significant way. In addition, the interpreter also asked a number of questions of the caregivers in order to clarify aspects that appeared to be unclear.

#### **5.1.6 Real-life versus Time-based Events**

Sishi (2001) documented the differences in the caregivers' concepts of time that were observable in the two methods. Findings in this research supported the claim that in consultations in which the CN method was used, the caregivers measured time according to real-life events, whereas when the TCH method was used, the clinicians attempted to align the caregiver's story with actual time. In this research, it was evident from the caregivers' selection of *Setting* [as outlined in the section on Global Elements] that time did not refer to linear time, but rather to important life events.

In the consultations in which the TCH method was used, the clinicians encouraged the caregivers to remember dates and ages of their children using actual time. BC commented on the inappropriateness, as well as the fruitlessness, of this exercise, as the caregivers very seldom knew the actual time, deeming the questions inappropriate.

It is well documented that within an African culture, there is a tendency to judge events on a linear basis (Gillis *et al.*, 1982). It has been proposed that this phenomenon is not culture-bound, but rather, appropriate in the context of all illness narratives (Mishler, 1984; Cassell, 1985). Periods of sickness are important milestones in people's lives and as such are ideally suited to the narrative genre as they become crucial elements in the enacted narratives of patients' lives (Greenhalgh & Hurwitz, 1998). Narratives provide meaning, context and perspective on the patient's illness as they define how, why and in what way, the patient is ill. The study of narratives offers the researcher the possibility of developing an understanding that cannot be arrived at by any other means (Greenhalgh & Hurwitz, 1998).

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## 5.2 TRANSACTION

Transaction was the second theme to emerge from the post-consultation interviews with the participants. The term *transaction* was first used in sociolinguistics and discourse literature (Watzlawick, Beavin & Jackson, 1967). The value of the use of language in the exchange of information is embedded within the discourse literature in which transaction is described as '*an expression of content*' or the '*conveyance of factual information*' (Brown & Yule, 1983). When viewed in the context of this study, it is anticipated that transaction in the consultations in which WC participated could differ from those in which BC participated, owing to the presence of the interpreter in all of WC's consultations. Transaction in interpreted initial consultations has recently been documented by Fisch (2001). Within interpreted consultations, transaction has been shown to vary according to consultation type (Evans 2000) and whether the interpreter is trained or untrained (Fisch, 2001). What remains to be determined is whether transaction varies as a function of the TCH and the CN methods.

Successful transaction, that is the successful exchange of information, appears to be dependent on a number of factors, namely the speaker, the content and structure of the message, and the listener. The analysis of the consultations indicated that transaction varied between consultations across the two methods on the basis of three factors, namely:

- The language of medical discourse
- Complexity of language
- Disease versus Illness.

Essential to understanding the above-mentioned factors is the discrepancy between the clinician and the caregiver on the basis of medical discourse. A substantial body of evidence about communication problems between clinicians and patients already exists (Spencer, 2001; Silverman *et al.*, 1998). It is well documented that the language used by clinicians reinforces a clinician-centred approach through the use of complex language

containing medical jargon. Donnelly's (1997) *Language of Medical Case Histories* reflects on the largely biomedical-oriented communication between clinicians and their patients. It also reflects on the lack of patient-centredness in consultations. Donnelly (1997) has identified a number of language maladies commonly made by clinicians in the process of taking a medical history. Donnelly (1997) explains that the aggregate effect of these maladies derogates, obscures or simply ignores the personal aspect of the patient and much of his or her experience of illness. Despite this effect and extensive criticism, these practices continue to be a characteristic of medical encounters (Donnelly, 1997).

The extent to which these maladies differ across the two methods had not previously been documented. In this research, the initial consultations were examined to determine the effect of the method on the clinician's language.

In the CH section of the TCH consultations, the clinician's language included the use of complex terminology and medical jargon. In contrast, in the consultations in which the CN method was used, the caregiver determined the level of language complexity. Through the caregivers' introduction of topics for discussion and topic shifting, their language choice reflected a level of complexity that set the tone for the dialogue in the consultation.

An example from the TCH method in this study was when the clinician asked the caregivers whether their children's ears were 'discharging'. Whereas, in the CN method, the caregivers reported that there was 'dirtiness' or 'water' coming out of their child's ears, and the clinician then followed this lead and continued to refer to the discharge as 'dirtiness' or 'water'.

The findings of the analysis of the FB section of the TCH consultations revealed a number of aspects of the clinician's narrative that were believed to have been impacted on by the method used. These were:

- The presence of medical jargon

- A focus on remediating the biological symptoms
- Converting the patient's story of illness to a story focused on biological dysfunction
- Minimizing the importance of what the patient had said, relative to what the clinician had said – i.e., subjective versus objective
- Failing to elicit and record important changes in the patient's perspective.

The clinician's tendency to use medical jargon was more apparent in the FB than in the CH section of the TCH consultations. In the feedback section of the CN consultations, the clinician's choice of words reflected the caregiver's own vocabulary selection. In contrast to the CH sections of the CN consultations, in which almost no medical jargon was apparent, a certain amount of medical jargon was still apparent in the FB sections. However, this was to a much lesser extent than in the consultations in which the TCH method was used.

In the post-consultation interviews with the participants, the clinicians commented that the TCH method was more detailed and identified information that was very medically specific. The medical nature of the information obtained from the TCH method, was strongly emphasized in the discussions with the participants. The clinicians' comments on this aspect of the TCH correspond with the findings from the analysis of the consultation transcripts. In contrast, the CN method elicited more general information. The clinicians both felt that if additional medical information were needed in specific cases, then the information furnished by the caregiver in the narrative would direct the clinician to following up these leads.

**WC:** *[How the type of information in the CN method differs from that in the TCH's]*  
*"No, I think it's a lot less medical. You're not getting as much medical detail and it highlights the important issues, the things that are important to the caregiver and that are important to the caregiver about the child."*

**BC:** *"Um, ok, in terms of the medical history it [TCH] was very positive, because you can get all the medical history of the child and all the related illnesses."*

In the TCH consultations, the clinician tended to focus her management on remediating the biological symptoms as reported by the patient. This could be explained by the fact that the type of information gleaned from the TCH method consultations, was predominated by caregivers' reports on the onset and progression of symptoms. Not unsurprisingly, therefore, the focus of the clinician's feedback was on remediating these symptoms. In contrast, in the CN consultations, there was a more equal focus on remediating psychosocial, as well as biological, problems reported by the caregiver.

According to Donnelly (1997), clinicians tend to refer to patients as biological specimens. This characterizes the patient in a way that paves the way for a case history that describes the patient's sickness primarily, or even exclusively, in terms of disordered biology. The practice of translating the patient's chief complaint into biomedical language banishes the voice of the patient, risks premature, incorrect diagnosis and the loss of important information, such as exactly why the patient sought medical care at this time, or his/her point of view and converts the patient's story of illness into a history solely focused on the onset and course of biological dysfunction. Donnelly (1997) states that this may be the most serious medical language malady, as what is lost in the translation into medical discourse has been well documented (Charon, 1986, 1992, Kleinman, 1995 & Toombs, 1987, 1996 in Donnelly, 1997). The exclusion of the patient's understanding of his/her illness and its effect on his/her life signals the patient's insignificance in medical care and relegates important realities, such as the patient's misunderstandings, fears and suffering, to an informal, off-the-record assessment and response (Donnelly, 1997).

In the FB section of the TCH encounters, there was an over-emphasis on details that the clinician had emphasized and no emphasis on the caregiver's primary concern. In contrast, feedback in the CN consultations focused on the symptoms selected by the caregiver.

The relativist approach was informed by anthropology (Swartz, 1998) and raised the important distinction that has been made between *disease* and *illness*. Kleinman (1988),

which termed the malfunctioning of the body as *disease* and the lived experience of suffering as *illness* (Swartz, 1998). From the results of the consultation analysis and the comments made by the clinicians in the post-consultation interviews with the participants, it is clear that the CN method has its roots in the relativist paradigm. One of its core principles is focusing on the patient's subjective experience. The CN method presents an account of illness, whereas the TCH method presents an account of disease. This is discussed in more detail in Chapter Five, Section 3.1.

Despite the above-mentioned differences in the clinician's narrative according to the method used, a number of Donnelly's (1997) maladies were evident across both methods. In both methods, in the FB section of the consultations, the clinician tended to:

- Make use of rhetoric devices to reinforce certain aspects of the diagnosis and management
- Pathologise the patient's thoughts or feelings.

One of the rhetoric devices used by the clinicians included the emphasis on the findings from diagnostic tests to confirm their diagnosis. The clinician stated that 'the tests confirmed' [BCTCH3] her findings, as if to give her diagnosis and management increased credibility. It is documented that clinicians tend to emphasize the objective in consultations, and to minimize the emphasis of subjective information. In addition, there is a tendency amongst clinicians to regard what the patient says as subjective and what the clinician says as objective (Donnelly, 1997).

It is well documented in the literature that clinicians use rhetoric devices to enhance their credibility or to cast doubt on the reliability of the patient's testimony, such as 'the tests confirmed the clinician's finding' for the former and 'the patient reports/claims/denies' for the latter (Donnelly, 1997). In this study, the clinicians' use of such devices to enhance their credibility would appear to be linked to their biomedical training in which objective testing would have been emphasized. Regardless of the method used, neither BC nor WC ever affirmed the caregiver's perceptions as to the cause of the symptoms or

expressed 'from what you have told me, I diagnose X'. In addition, in the TCH consultations the clinician failed to acknowledge the caregiver as expert on her illness narrative.

There are two proposed reasons for the perpetuation of this medical discourse (Donnelly, 1997). Firstly, sickness is still considered to be fundamentally, even exclusively, a matter of disordered biology. Secondly, if human illness is primarily biological, it follows that physicians should adopt, as much as possible, the viewpoint and methods of natural scientists. Such an approach tends to emphasize the value of objective, measurable manifestations of disease and its treatment and limits interest in the patient's subjective experience of symptoms, which are useful for tracking the course of the known disease (Donnelly, 1997).

Donnelly (1997) comments that the dubious language of medical discourse in conventional medical case histories can harm students and clinicians, as well as patients. Such practices are at odds with an accurate understanding of the probabilistic, observer-mediated nature of clinical knowledge, the clinician's need to work with patients as partners and not adversaries, and the professional obligation to alleviate adequately patients' suffering. Such practices impede the development of patient-centred health care (Donnelly, 1997). It is hardly surprising, therefore, that given what medical language claims for itself and the central role that it plays in the socialization of medical students, that it becomes the students' 'first language' for matters of health and disease (Donnelly, 1997). *"What may not be so apparent is that this language uses its users as much as users use it."* (Donnelly, 1997: 1047). Non-medical ways of thinking or talking about illness and disability can become something of a foreign language to clinicians, for which instruction should be provided. It is documented that medical education can *"sterilise your vocabulary"* (Coulehan & Block, 1992 in Donnelly, 1997: 1047).

### 5.2.1 Transaction in Multilingual, Interpreted Consultations

In addition to the transaction outlined in the previous section, a number of special characteristics of multilingual interpreter-mediated consultations were identified. In this section, transaction is discussed with particular emphasis on the accuracy and the contribution of the interpreter in terms of the participants' perceptions of them and according to the analysis of the interpreted consultations.

In the post-consultation interviews with the participants it was evident that there was a discrepancy between the caregivers' perceptions regarding the benefits of interpreting with those of the clinicians and the interpreter. All of the caregivers, regardless of whether the TCH or the CN method had been used, commented that the interpreter had interpreted accurately and that one of the reasons for this was that the interpreter had understood what she was interpreting. Some of the caregivers commented that they knew the interpreter had interpreted accurately because their own knowledge of English allowed them to understand English although they struggled to speak it. As such the interpreter was fulfilling her role of 'voice of the caregiver'. In contrast, the clinician and the interpreter expressed concern about the accuracy of the consultations when the CN method was used.

**CgTCH:**        *" Yes. There was not even one thing that she left out."*

**CgCN:**         *" Yes, she explained everything because she understood it."*

**CgCN:**         *"Yes, she was able to because I have something where I can hear a little English. I know some English but I don't know all English."*

**CgTCH:**        *"Yes she was able to interpret I'm sure because I can also understand a bit, the problem is I am not able to answer."*

**WC:** *“Disadvantages to the CN method? I think definitely using it with a translator [interpreter]. Because there is a lot of information which is going backwards and forwards and I think the accuracy might be less.”*

The interpreter and the clinician expressed concern that the CN consultations might be less accurate than the consultations in which the TCH method was used. A number of reasons were suggested for this, namely:

- Increased length of utterances in the consultations in which the narrative method was used
- The specificity of the TCH questions meant that the interpreter might have been more familiar with the type and format of information in these consultations.

WC felt that although her knowledge of Xhosa was limited, it was sufficient for her to know when information was left out. The clinician did not feel that it was problematic that the interpreter left out some information because she felt that although the interpreter summarized the lengthy original message, the main points were still conveyed.

**WC:** *“ Um, from my limited understanding of Xhosa, I could pick up that, it wasn't a direct translation, like things would be, I think sort of the way she listened to what I said and took the whole message and then explained it to the mom. Um, also I was, today giving big chunks of information and it's very, I mean it's impossible to translate big chunks like that verbatim, so I think that's probably why TI had to use her own skills to, to convey the information to the mom.”*

**WC:** *“I do think it's [TCH] um easier to translate. Um when I've given specific question and then she translates it and then the caregiver answers to that specific question. The CN method is more difficult for the translator [interpreter] because I'll ask an open-ended question and then a whole lot of information will flow back. And it's not as easy for the translator to give that information back to me then. For the CN method, the interpreter has got to have good paresis skills*

*because they have got to decide what to give back to you. It's a lot more responsibility then for the translator [interpreter]. And I do think it's more difficult to translate."*

**TI:** *"Those short questions are OK as long as they are short to explain everything. Somebody might answer in a long way as long as she gives me just short chunks to interpret. Allowing her to say whatever she wants and not then shorten what she said. Because there are many important things that come out.*

The interpreter explained that within the Xhosa culture, there is a tendency to express oneself loquaciously with elaborate and lengthy explanations. The interpreter felt that this contrasted quite starkly with the white, English-speaking clinician's culture, in which answers to questions tended to be shorter.

The interpreter felt that it was necessary to attempt to provide as accurate a translation as possible. Attempts by the interpreter to promote accuracy included stopping the caregiver and asking her to wait until she had translated what had been said in chunks. The significance of this was that the cathartic element of the exchange could be lost as the interpreter was interrupting the flow of the caregiver's dialogue.

**TI:** *"That is also very difficult. Because you will find some of them taking it a long way, like saying what happened to her before she give birth to this child and making long sentences, and I have to sometimes say just please give me a chance to explain what you are saying before I don't forget. But I think that is our culture; it is how we are doing it because you can get it even if we are asking each other how are you? It will not just be 'we are fine' it is as we are doing in English."*

**TI:** *"Ah ya. But then if she's going to long I will ask her to stop to interpret that."*

From the post-consultation interviews with the participants it was evident that all of the participants placed great emphasis on the accuracy of the interpreter's translation. The clinician and the interpreter expressed concern that the lengthy utterances in the caregiver's dialogue when the CN method was used would hamper accuracy. The CN method was perceived to hamper accuracy, place a greater burden on the interpreter's memory and require the interpreter to have greater field-specific knowledge. The clinician and the interpreter felt that the TCH method would be more accurate than the CN method, owing to the shorter length of utterances, thereby placing less emphasis on the interpreter's memory.

From the post-consultation interviews with the participants it was evident that, in addition to the length of utterances, there were a number of factors that were perceived as hampering accuracy. These were:

- The cultural relevancy of information
- The perceived ideal of a word-for-word exchange.

**WC:** *"It's quite difficult to say. Because you don't understand the language so you don't understand what the caregiver has said. And it might be that there were other important things that were left out. On the whole I thought that if there were important things, that these were highlighted. And if I did need to clarify something, then I could do that. So on the whole I think TI did fine. But it's very difficult to say."*

**WC:** *"I don't know [if misdiagnosis could result]. It's possible that with the CN method, that there are important things that are left out. And that's probably where the training comes in. To enable the translator [interpreter] to pick up on what's important what the critical main issues are. Because for a translator [interpreter], also being of a different culture to the clinician, they obviously relate better to the caregiver. So they might sort of see things that are more*

*relevant to them as part of their culture. They might leave out things that might be important for the clinician.”*

**WC:** *“Um, ok, and I almost felt in that situation, that the patient was getting uptight, because the interpreter was like, um, talked for a while and then the interpreter would turn to me and say just a few lines, and the patient almost felt something was missing out.”*

**WC:** *“I think it [TCH] is probably more accurate than the CN method if you’re looking for a word for word translation. Ya probably the accuracy is better.”*

The clinician explained that at times the interpreter was not translating verbatim what she had said, but that she did not find that this was problematic. This indicates a degree of trust in the interpreter’s abilities on the clinician’s part to allow the interpreter to play a more prominent role in the communicative exchange.

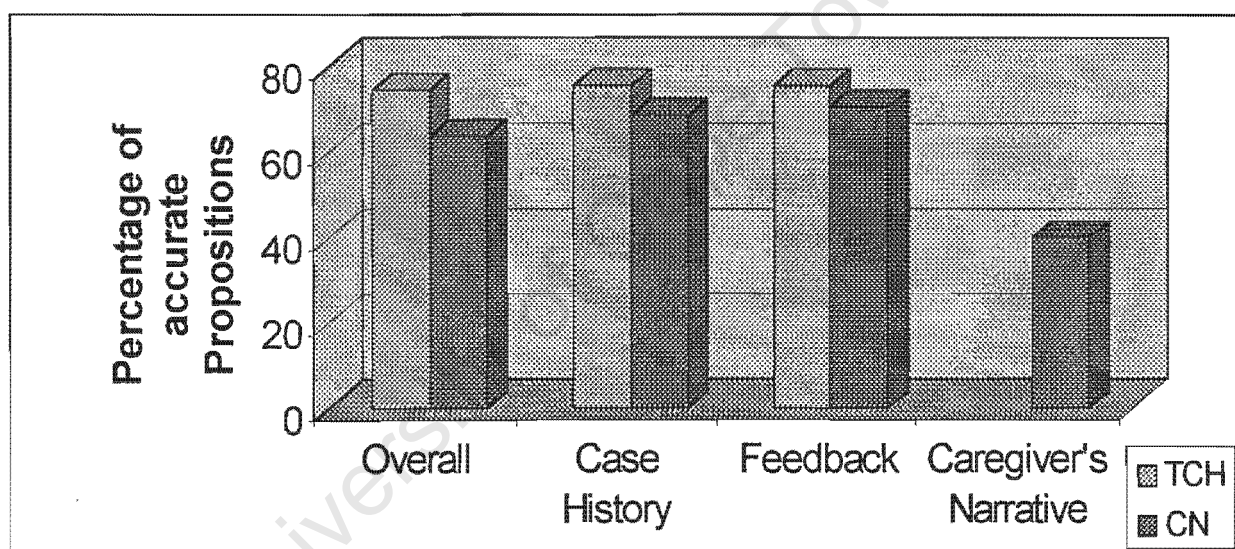
**WC:** *“Ya from the interpreting side, I think it went fine, um I didn’t pick up on any major problems...Um when I sort of said something, I didn’t think TI was translating verbatim, she was putting it into her own words. But I didn’t feel that that detracted from what she was saying.”*

**WC:** *“Well it’s really difficult to say, um, I think but the main message was always conveyed, um but it is possible that, that things were left out, but probably less meaningful things. I think the main message definitely got across....”*

The clinician was aware that as the length of the utterances increased, the likelihood of mistranslation occurring also increased. She was aware of the difficulty of the interpreter’s task and felt that it was to the interpreter’s credit that she was able to use her own skills to ensure that the information was conveyed to the caregiver.

In order to examine whether the participants' perceptions that the CN method was less accurate than the TCH method corresponded with what actually happened in the consultations, an analysis of accuracy and the contribution of mistranslations was undertaken, using a propositional analysis and the Mistranslation Analysis Tool (Evans, 2000). The findings will now be discussed below.

To allow for a more objective comparison, percentage values of accuracies and inaccuracies were averaged across the methods. The average results for the accuracy analysis overall and in the CH, FB and caregiver's narrative<sup>1</sup> of the consultations are presented in Figure 5.9 below.



**Figure 5.9 : Percentage of Accurate Propositions across Method**

Figure 5.9 above suggests that the accuracy of the CN consultations was slightly less than that in the TCH consultations. The accuracy ranged from 64% to 76% in all of these consultations. This finding of accuracy was very similar to that of Fisch (2001), in which her trained interpreters averaged an accuracy of 68%. Interestingly, the caregivers' narratives had an accuracy of only 40%. This suggests that the accuracy of the narrative

<sup>1</sup> The caregiver's *narrative* refers to the story aspect of the caregiver's dialogue. On average, the caregiver's narrative comprised 60% of the caregiver's dialogue.

aspect of the consultations is extremely poor and that the concerns of the interpreter and the clinician are well-founded. The nature of the narrative would appear to affect the accuracy of consultations negatively.

However, the measure of accuracy itself has been criticized previously by the researcher (see Evans, 2000) for its failure to acknowledge a hermeneutic approach to translation. Within the hermeneutic approach, the interpreter is considered to be more than just a machine or black box, which can objectively exchange one word for another. Consequently, the researcher (see Evans, 2000) introduced the idea of interpreter contribution, in which the relative positive or negative contribution of the interpreter's mistranslations should be analyzed. Positive mistranslations are said to be those which, though inaccurate, are beneficial to the consultation. For example, the interpreter's addition of examples to aid caregiver comprehension, although not accurate in the true sense of the word, are *helpful*, or *positive* in their contribution.

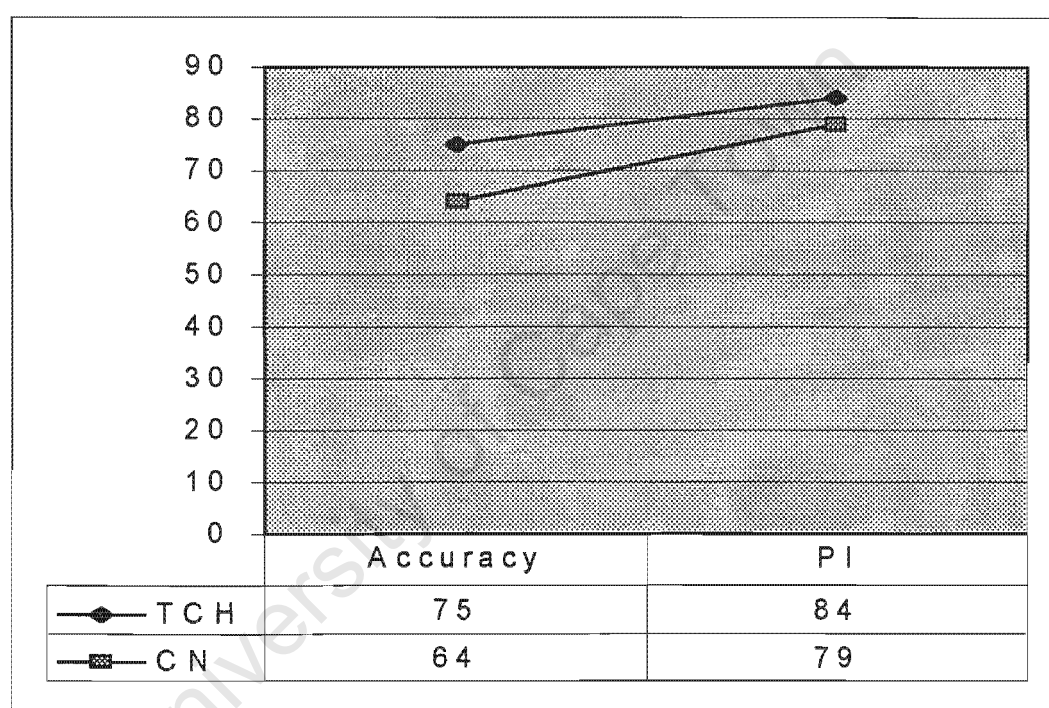
#### 5.2.1.1 Contribution

In this study, as previously defined by the researcher (Evans, 2000), mistranslations that were regarded as helpful were termed *positive* and mistranslations that were regarded as unhelpful were termed *negative*. The relative positiveness or negativeness of a mistranslation is to be referred to as its *contribution*. In order to demonstrate the contribution of the interpreter in the consultations, the researcher calculated a measure of positivity, or a positivity index, which was the percentage calculated by adding the number of accurate propositions to the number of positive mistranslations, and dividing it by the total number of mistranslations when the neutral mistranslations were excluded. Definitions and explanations of all of the components of the calculation can be found in Chapter Four. The positivity index calculation is illustrated in Figure 5.10 below.

$$\text{Positivity Index} = \frac{\text{Number of Accurate Propositions} + \text{Number of Positive Mistranslations}}{\text{Total Number of Propositions} - \text{Number of Neutral Propositions}}$$

**Figure 5.10: Positivity Index Calculation**

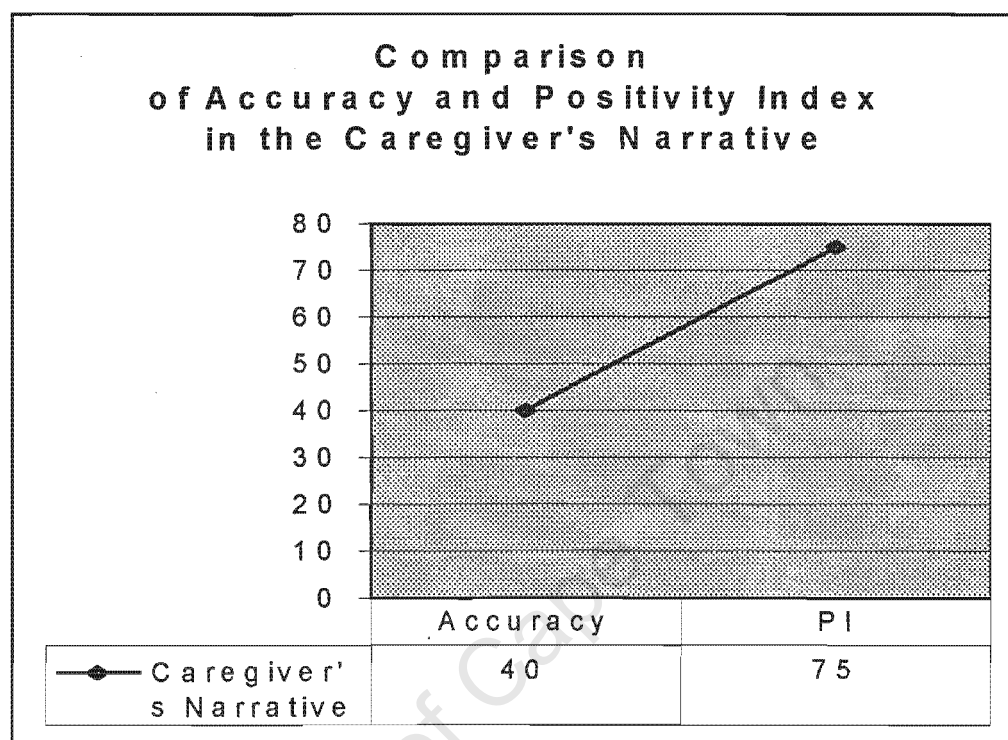
The accuracy and the positivity index (PI) of the consultations are compared overall in Figure 5.11 below.



**Figure 5.11: Comparison of Accuracy and Positivity Index Overall**

Figure 5.11 above illustrates that there is minimal difference in interpreter contribution between the TCH and the CN methods. This measure illustrates that, although the interpreter's accuracy is not as high in the CN method, and in the caregiver's narrative of the CN method in particular, when the contribution of the mistranslations was analysed, this difference was reduced from 11% overall when accuracy was measured, to just 5% overall when contribution was considered.

The greatest difference in accuracy and contribution was in the caregiver's narrative, which improved by 35%. This is illustrated in Figure 5.12 below.



**Figure 5.12: Comparison of Accuracy and Positivity Index in the Caregiver's Narrative**

Figure 5.12 above suggests that the clinician's and the interpreter's concerns about information being lost or misinterpreted are indeed unfounded. This is crucial in the comparison of these methods, as this concern was considered to be a major drawback to using the CN method in cross-lingual consultations.

Mistranslations were analyzed according to type, namely addition or omission. An addition was defined as anything that was added to the dialogue by the interpreter, including initiated questions. An omission was defined as anything that was left out of an original utterance, including condensation. Substitutions included elements of both addition and omission and were marked as such.

The type of mistranslation, namely addition and omission, was analyzed in terms of contribution. These results are illustrated in Tables 5.7 and 5.8 below.

**Table 5.7: Positive Contribution of Additions across Methods**

	<b>TCH Method</b>	<b>CN Method</b>
<b>Overall</b>	81%	88%
<b>CH</b>	80%	87%
<b>FB</b>	83%	90%

**Table 5.8: Positive Contribution of Omissions across Methods**

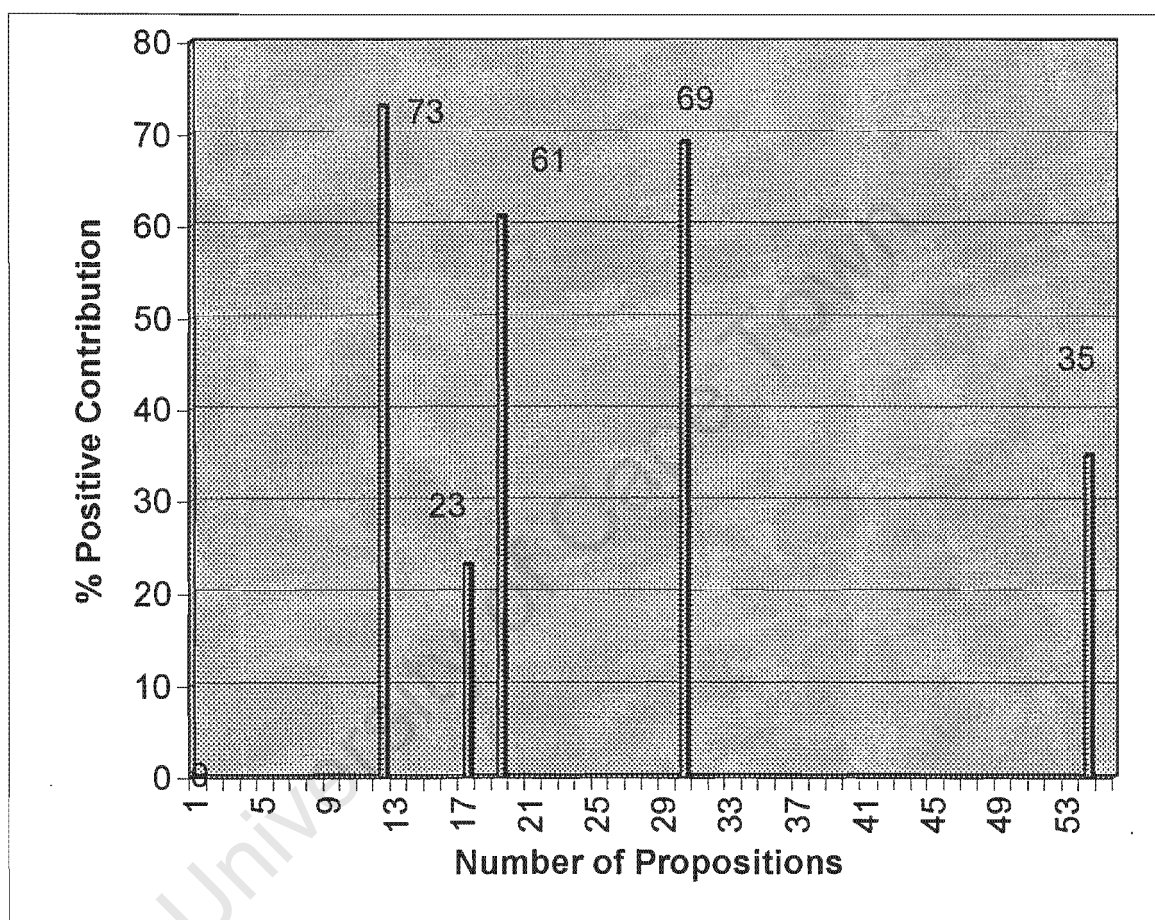
	<b>TCH Method</b>	<b>CN Method</b>
<b>Overall</b>	10%	14%
<b>CH</b>	14%	20%
<b>FB</b>	0%	7%

Tables 5.7 and 5.8 above clearly show that, regardless of the method used, additions were predominantly positive (80-90%) and omissions were predominantly negative (80%-100%). The finding that additions are predominantly positive and omissions predominantly negative supports those by Evans (2000) and Fisch (2001). Although the difference in contribution of additions across the two methods was only marginal, the contribution of additions in the CN method was even higher than that in the TCH method. This indicates that when information is added in the CN method it is even more likely to make a positive contribution to the consultation.

In order to investigate the clinician's and the interpreter's concerns about the impact of the length of the narrative on the interpreter's translation, the lengths of the narratives (measured in propositions) was examined in relation to the positivity of the narratives.

**Table 5.9 : Relationship between the Number of Propositions in WC CG3's Narrative and the Positivity Index**

WC CN Cg3's Narratives	1	2	3	4	5
Number of Propositions	12	17	19	30	54
Positive contribution	73%	23%	61%	69%	35%



**Figure 5.13: Relationship between the Number of Propositions in the Caregiver's Narratives and the Positivity Index**

The variability in Figure 5.13 illustrates that there is no relationship between length of narrative and positive contribution. An examination of the individual narratives indicated that the local coherence of the caregiver's narrative, rather than the length, appeared to impact to a greater extent on contribution. Coherence relates to the well-formedness of text in terms of plausibility, conventionality and conclusiveness (Ulatowska *et al.*, 1998).

Coherence can be used to characterize conceptual organizational aspects of discourse at the suprasentential level. The coherence of a text or discourse depends, at least in part, on the speaker's ability to maintain thematic unity (Ulatowska *et al.*, 1998). Global coherence refers to the manner in which discourse is organized with respect to an overall goal, plan, theme or topic. Local coherence refers to the conceptual links between individual sentences or propositions that maintain meaning in a text or discourse. While coherence is a general cognitive concept, cohesion refers to linguistic devices, such as anaphora and reference, that produce coherence (Ulatowska *et al.*, 1998).

The global coherence of the narratives elicited from the CN method was discussed in the previous Chapter Five Section 5.1.6. The global coherence of the narratives was one of the definitive features of the CN method. All of the narratives were found to have global coherence.

The local coherence of the caregiver's narratives varied. Some of the caregivers appeared to be better story-tellers than others, and some had more or less complex stories to tell. When local coherence broke down, the meaning became ambiguous, making the stories less plausible.

#### **5.2.1.2 Strategies to Increase Positive Interpreter Contribution**

From the post-consultation interviews with the participants and an analysis of the findings from the MAT, it was clear that a number of factors enhanced the positivity of the consultations, namely:

- Open communication between the trained interpreter and the clinician
- The use of clarification
- The form of the clinician's narrative
- The clinician's understanding that a verbatim translation should not be expected.

In the post-consultation interviews with the participants, WC felt that communication between her and TI was particularly effective for a number of reasons. She commented on the familiarity between her and the interpreter, the interpreter's familiarity with the content and the procedure of the clinic and their combined use of clarification strategies whenever any difficulties were incurred.

**WC:** *"We did between us have some communication difficulties but we clarified those, and we got over it. So um no, we didn't have any major problems."*

**WC:** *"I think so, um, there was also, there was an occasion where we had to confer again because I wasn't sure um, what, what the mom had said and I don't know if, if that's because the mom, mom wasn't clear or whether, the, the when TI relayed it to me, I didn't understand from how she put it, but once, so we had to discuss amongst ourselves to get clarification there."*

The clinician has in this instance also raised the important issue of the original form of the message. If the message is clearly conveyed by either the clinician or the caregiver to the interpreter, then this should be easier for the interpreter to translate. In contrast, if either the clinician or the caregiver appear confused about what they are saying to the interpreter, then it is more likely that a negative mistranslation will occur. The CN method lends itself to being clearly translated by the lack of complexity of its content. The content that is initiated by the caregiver has been shown to be lacking in complexity and medical jargon, thereby suggesting that it should be easier to translate.

Narratives presuppose a narrator and a listener (Greenhalgh & Hurwitz, 1998). Their different viewpoints affect how the story is told (Greenhalgh & Hurwitz, 1998). Skultans (1998) raises the issue of "Whose line is it anyway?" In cross-cultural encounters, narratives are often told by medical attendants or lay carers of the sick patient. Those who help the sick may tell the story of the illness, and in the telling, they both describe and create the social network that allow the illness to be attended (Skultans, 1998).

In interpreted consultations the narrative that the clinician is hearing is, necessarily, the interpreter's and not the caregiver's. The caregiver's and the interpreter's narratives were analyzed in order to determine the characteristics of the interpreter's narrative and to determine what differences, if any, existed between this and the caregiver's narrative.

A diagrammatic representation of the setting, complicating action, resolution and coda of both the caregiver's and the interpreter's narratives is outlined in Figures 5.14 and 5.15 respectively.

Setting:	Complicating Action:	Resolution:	Coda:
"X [her child] started, maybe when she was little..."	"... to have this problem with her ears. They were leaking and leaking and started becoming painful at times..." "... and what's happened now is that it has not been leaking but she does not hear very well at school."	"I usually come here to the clinic..." "... and the school teachers have sent me here to this ear department"	None

**Figure 5.14: Caregiver's Narrative (WC CN1)**

Setting:	Complicating Action:	Resolution:	Coda
"She said that X's problem started when she was still an infant..."	"It was both the ears that were leaking." "And after a while they could stop..." "Up until she was old and attended school it's when they noticed that she can't hear properly"	"And even the school teachers were complaining about that" "And she kept on returning to the hospital" "And they referred her to WC"	None

**Figure 5.15: The Interpreter's Version of the Caregiver's Narrative (WC CN1)**

A comparison of Figures 5.14 and 5.15 clearly show the presence of a setting, complicating action and resolution in both the caregiver's and the interpreter's narrative. The interpreter's narrative can, therefore, be shown to be as well-formed as the caregiver's. This has important implications, namely that:

- The narrative or 'story' element is not lost in translation
- This global structure could be contributing to the demonstrated positive contribution of the translation.

Despite the interpreter's and the clinician's concern about the effect of the interpreting on the consultation of the CN methods owing to the length of the utterances, no great difference in positive contribution was shown between the CN and the TCH methods. It is possible that this can be accounted for by the global structure of the caregiver's story. A narrative, with its predictable structure and storyline, might be easier to remember than the jumbled, fragmented dialogue found in the TCH method.

In addition to contributing to the positivity index of the consultations, the narrative provides a means through which the interpreter can express her interpretation of cultural or emotional elements of the caregiver's narrative. Illness narratives tend to be embedded in a specific locality, which reflects a web of social relationships, which are drawn out in the description of the effects of the illness (Skultans, 1998). It is documented that it is crucial to identify the source of illness narratives (Janzen, 1978 in Skultans, 1998). The issue of whose voice has the right to be heard has led to the recommendation that in cross-cultural contexts particularly, where there may be less consensus on this issue, different voices need to be heard (Skultans, 1998). The analysis of the transcripts of the consultations in this study indicated that information pertaining to the caregiver's cultural beliefs and socio-economic circumstances could be gleaned from the interpreter's explanations in the interpreter's narrative. Awareness of one's own story and one's own part in dialogue has a necessary corollary for the recognition of the voice of the other (Skultans, 1998).

As clinicians, our understanding of narratives should be dynamic, ever-changing entities in which the present and past and the individual narrator and his/her culture are in a perpetual state of interplay (Skultans, 1998). Skultans (1998) states that narrative understanding is the key to understanding oneself and others.

Language conveys truths about both primary level culture (the underlying beliefs and value systems that determine behaviour) and about the ethnographer and his or her informants (Fabian, 1983 in Skultans, 1998). Fluency in the language is, therefore, a precondition when working with narratives (Skultans, 1998).

### 5.2.1.3 Reasons for Mistranslations

#### i) Negative Mistranslations

An analysis of the reasons for negative mistranslations from the MAT indicated that in the TCH method textual factors were the greatest cause of negative mistranslations. In contrast, in the CN method both textual and non-textual factors contributed to negative mistranslations. An explanation of the terms *textual* and *non-textual* can be found in Chapter Four. When the CN method was used, the coherence of the caregiver's narrative and the cohesiveness of the interpreter's narrative, as well as expansions and selective interpretation, caused the majority of the negative mistranslations. In contrast, when the TCH method was used, clarification, explanations, expansion and repetition were the major causes of negative mistranslations. This is summarized in Table 5.10 below.



In the direction from Xhosa to English, the only cause of negative mistranslations was in the interpreter's attempts to redirect the caregiver back to a predetermined topic. This was considered to be negative because the caregiver was not given the opportunity to say what she would like to say; instead, she was interrupted by the interpreter and told which topic to discuss.

In the CN method, negative mistranslations only occurred in the direction from Xhosa to English. As already discussed earlier in this section, the textual factors contributing to negative mistranslations included the coherence and expansions of the caregiver's narrative and the cohesion of the interpreter's narrative. In addition, non-textual factors that caused negative mistranslations included fabrication and selective interpretation by the interpreter. It was unclear whether these were attitude-related, or related to the burden of memory caused by these methods. It appeared that if the caregiver's narrative was presented in an incohesive manner, then the interpreter fabricated or 'guessed' what she thought the caregiver meant. In such instances, the caregiver's intended meaning was lost or obscured.

## ii) Positive Mistranslations

Table 5.11 below summarizes the main causes of positive mistranslations.

**Table 5.11: The Main Causes of Positive Mistranslations**

Method	Direction	General Cause	Specific Cause
TCH Method	English to Xhosa	Cultural Brokerage  Attempts to Increase Understanding	<ul style="list-style-type: none"> <li>• Analogy</li> <li>• Appropriate Terminology</li> <li>• Clarification</li> <li>• Expansion</li> <li>• Explanation</li> <li>• Repetition</li> </ul>
TCH Method	Xhosa to English	None	None
CN Method	English to Xhosa	None	None
CN Method	Xhosa to English	Cultural Brokerage  Attempts to Increase Understanding	<ul style="list-style-type: none"> <li>• Context Specific Knowledge</li> <li>• Summary</li> <li>• Clarification</li> <li>• Explanations</li> </ul>

In the TCH method, the interpreter acted as a mediator to facilitate cultural brokerage through the use of examples and analogies and the use of more culturally appropriate terminology. This was only apparent in the direction from English to Xhosa. In addition, the interpreter engaged in frequent clarification, explanation, expansion and repetition,

which assisted the caregivers in understanding the more complex material in the TCH method. Ironically, these strategies, employed by the interpreter to facilitate caregiver understanding through more culturally appropriate explanations, were the same strategies that sometimes resulted in the negative mistranslations discussed in the previous section. In the direction from English to Xhosa in the CN method, there was no need for the interpreter to employ any strategies to facilitate understanding or cultural brokerage, as the short and simple questions in the CN method were already easy to understand.

In the CN method, positive mistranslations were caused by both attempts to increase the caregiver's understanding, and, to a far lesser extent, cultural brokerage. Positive mistranslations were most frequently caused by the interpreter's summarizing, clarifying or explaining what the caregiver had said. All of these devices were used to increase the clinician's understanding of the caregiver's primary concern. Occasionally, it was necessary for the interpreter to act as a cultural broker. The interpreter acted as a cultural broker through the addition of her context-specific knowledge. For example, the interpreter frequently added information to the caregiver's narrative about the family situation, the type of work the family members were doing and the schools in the area. The interpreter's contribution of context-specific knowledge highlighted the importance of the interpreter being an integral member of the community in which she was working.

### 5. 3 PATIENT-CENTRED CARE

Patient-centred care was the third theme to emerge from the post-consultation interviews with the participants. A review of the patient-centred literature indicated numerous elements that comprise patient-centred care (Gerteis *et al.*, 1993; Fulford, 1996; Cassell, 1985; Daley, 1993; Allshouse, 1993; Little, Everitt, Williamson, Warner, Moore, Gould, Ferrier & Payne, 2001). These elements can be divided into the five domains summarized by Little *et al.* (2001). The TCH and the CN methods will be discussed within three of Little *et al.*'s (2001) domains, namely exploring the experience of illness and disease, understanding the whole person, and enhancing the clinician-patient relationship. In addition, patient understanding in each of the methods will be discussed. Examination of the transcripts of the consultations revealed differences in patient-centredness, according to whether the TCH or the CN method was used.

#### 5.3.1 Exploring the Experience of Illness and Disease

In exploring the patient's experience of illness and disease, the clinician needs to investigate the patient's ideas about the problem, their feelings about and expectations of the consultation and the effects of the disease on function (Little *et al.*, 2001). In exploring the patients' experience of illness and disease in each of the methods used, the CN method was found to be preferable, owing to its focus on illness as opposed to disease in eliciting the patient's explanatory model and in its cultural sensitivity.

##### 5.3.1.1 Illness versus Disease

Suffering is a subjective experience that may or may not respond to intervention directed towards remediating the biomedical processes of disease, even when these regimens are technically effective (Cassell, 1982; Kleinman *et al.*, 1978; Baron, 1985 in Gerteis *et al.*, 1993). What patients experience and what patients think they experience should also matter to the health profession because that experience will determine how people use the health system and how they benefit from it (Gerteis *et al.*, 1993).

As previously discussed in the theme *Transaction*, a large part of the cultural discord that exists between patients and their clinicians lies in the inherent difference between the patients' subjective experience of illness and the clinician's objective approach to disease (Baron, 1981, 1985 in Allshouse, 1993; Cassell, 1982, 1984; Eisenberg, 1977, Hautman, 1979 in Allshouse, 1993; Helman, 1996; Kleinman *et al.*, 1978; Spector, 1979, in Allshouse, 1993). Illness, for the patient, includes the social and psychological, as well as the physical discomforts of ill health (Allshouse, 1993). It is the experience of illness that brings patients to the health care system (Allshouse, 1993).

The findings from the analysis of the consultations revealed that the TCH method focused on disease. This was concluded on the basis of the following:

- The type of information elicited, which focuses on the presenting symptoms and their progression
- The language of the consultation, which includes medical jargon and complex terminology
- The lack of openness to discussing the patients' concerns, owing to a predetermined set of questions that limited the scope of the caregivers' answers

In the TCH method, the information elicited from the caregiver related to the disease aspects of the patient's illness. Although the questions in the TCH method included psychosocial aspects of the patient's life (such as schooling), there was no focus on these issues. Instead, the focus of the consultation was on the medical symptoms of the disease and their progression.

In an extremely rushed consultation in which the TCH method is used it is not altogether inconceivable that the method could serve as a checklist used by the clinician to eliminate various pathologies. The TCH method loses the personal, individualized impact of illness on each patient. The term '*veterinary medicine*' coined by Kleinman, Eisenberg and Good (1978 : 252) entails the biomedical model of medicine carried to its extreme, in

which the illness experience becomes irrelevant except as the underlying presence of disease (Allshouse, 1993). The biomedical model of illness emphasizes pathophysiology, whereas to patients, illness presents what has been described as a “*problem of living*” (Eilers, 1993: 97). Within the biomedical model, the patient’s socio-cultural identity, which is the sum of the person’s beliefs, practices, habits, norms, customs and rituals, is considered a factor that merely clouds the physical symptoms (Allshouse, 1993). However, for the majority of patients, it is refuge from the effects of illness, as opposed to the disease itself, which they seek.

In contrast, the CN method elicited information that provided the listener with insight into the psychosocial impact of illness on the patient’s lifestyle. If health care institutions are to meet patients’ needs, then they must understand the need to confront patients’ experience of illness within this larger cultural context (Allshouse, 1993). To this end, the CN method provided an ideal way of dealing with illness. The onus to introduce topics of discussion lies with the caregiver, so it was not surprising that the effects of the illness on the patients’ lives were the focus of these consultations. The far-reaching effects of illness were evident in the consultations in which the CN method was used, for example, in the caregivers’ descriptions of having to give up work to look after their sick child or not sending other children to school owing to financial difficulties resulting from paying for the medical care of their sick children. For most of the caregivers it was not the otitis media itself, but the effects of having to care for the sick child in the home that had brought them to the clinic.

### 5.3.1.2 Explanatory Models of Illness

*“From the patient’s perspective, his or her actions and reactions make sense”*

(Wolf, Ingelfinger & Schmitz, 1994: 896).

Patients and clinicians bring their own explanatory models to an episode of illness. Their explanatory models are shaped by culture, education and experience (Kleinman *et al.*, 1978). Pre-existing beliefs form the basis of the patient’s understanding of the etiology of

the illness, its symptoms, the pathophysiological processes involved, the likely course and the seriousness of the illness, as well as the appropriate treatments (Allshouse, 1993).

It is argued that a number of different questions are asked by people when they become ill, for instance, 'Why me? Why now? What is wrong? How long will it last and how serious is it? What problems does it create for me? How do I get rid of this problem? That is, what will make me better?' (Kleinman, 1988 in Swartz, 1998: 5). The term *explanatory model* is used for the way in which we all understand our own illnesses (Swartz, 1998). It is the clinician's job to understand the patient's explanatory model and to negotiate between the models held by the patient and the clinician (Swartz, 1998). This will in turn establish common ground on which a basis for treatment can be found that will be acceptable to both of them (Swartz, 1998). This is based on the premise that a common understanding is likely to increase patient compliance with treatment (Swartz, 1998).

An analysis of the caregivers' dialogues in the consultations revealed that, with the exception of one consultation, WC TCH4, it was only in the CN consultations that one was able to gauge the patient's explanatory model. Answers to the questions 'Why me?' and 'Why now?' were found in the caregivers' tales of Zionist baptisms, which have caused a hearing loss [WC CN3], and the belief that the pain caused by a middle ear infection is the results of bewitchment [BC CN3]. Regardless of the method used, the caregivers reported the symptoms that they had experienced. However, the answer to 'What is wrong?' when answered in the context of the questions from the TCH method, focused solely on symptoms, whereas the answers within the narrative context reflected on beliefs, the family situation and social problems as the locality for 'what is wrong?'

The consultations in which the CN method was used included the caregivers' theories of causation. These theories assisted the clinician in understanding the caregivers' explanatory models. Most patients can be encouraged to venture a theory of causation attributing to the development of symptoms, and these attributions often prove to be correct (Malterud, 1992 in Heath, 1998). If the patient's fears remain unacknowledged,

they may continue to fester, closing down communication between clinician and patient (Heath, 1998).

When clinicians and patients come from different social and cultural backgrounds, there is a likelihood of a greater discrepancy between patients' and clinicians' understanding of illness (Helman, 1996). However, it is documented that even clinicians from similar social and educational backgrounds to their patients often have different explanatory models (Allshouse, 1993). Unless clinicians understand how patients understand their illness and discuss these beliefs with them, the effectiveness of treatment will be compromised (Allshouse, 1993). Successful clinical relationships are considered to be those in which the patient and caregiver arrive at a consensus concerning etiology, diagnostic labels, physiological processes, prognosis and optimal treatment (Helman, 1996). It is necessary to understand the patient's underlying explanatory model in order to reach such a consensus (Kleinman *et al.*, 1993)

### 5.3.1.3 Culturally Rooted Behaviours and Practices

Culture is defined by Helman (1996) as "a set of guidelines which an individual inherits as a member of a particular society, and which tell 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: 2). Culture shapes patients' beliefs about health and illness, how they act in clinical situations, and how they expect others to act (Allshouse, 1993). Health care practitioners 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 (Allshouse 1993).

The two methods must be viewed in the context of the culturally sensitive programmes in which the clinicians were working. Regardless of the method used in the consultations, the cultural sensitivity of the programmes in which both WC and BC were working were evident in their choice of team members. The black clinician, by virtue of her race,

language and background was culturally similar to the Xhosa-speaking caregivers with whom she was working. In contrast, WC was obviously culturally, linguistically and racially different to the caregivers with whom she was working. However, cultural sensitivity was shown in the employment of a trained interpreter to work in the programme. This situation is in itself 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). This cultural sensitivity was acknowledged and appreciated by the caregivers who participated in this research. For many of them, this had been the first time they had experienced a clinician of their same culture, or had had the option of being interpreted by a trained interpreter. It appeared that these steps in the move towards providing patient-centred care made a profound impact on the caregivers. The need for interpreters within the health care context, has been well documented (Evans, 2000; Fisch, 2001). It is necessary to work with trained interpreters in order to provide patient-centred care to patients in cross-lingual encounters.

In the post-consultation interviews with the participants WC commented on the necessity of the interpreter for reasons related to culture as much as to language.

**WC:** *“I think if you were proficient in a language then it would be a good thing, but you still wouldn’t relate to them culturally. It would bridge the linguistic barrier but not the cultural barrier.”*

Apart from having relevance to the patient’s needs, the CN method was also felt to be culturally sensitive to Xhosa-speaking patients. BC commented that this was one reason why she had always used this method. BC felt that the caregivers responded more openly to the CN method because they felt more comfortable with it. Xhosa has a longstanding oral tradition. The narrative focus on an oral approach is in line with such a tradition.

The interpreter, TI, very aptly described the tendency within the Xhosa cultural to answer elaborately and to talk in stories.

**TI:** *“But I think it is our culture, it is how we are doing it because you can get it even if we are asking each other ‘how are you?’ It will not just be ‘We are fine’ as you are doing in English ...it will be ‘I’ve been so stressed out in these last few weeks because of what happened at my place, my mum has lost her house and I have no place to go now and my sister’s child is sick’ etcetera etcetera. It is all in the process of that ‘how are you’ thing. It is not like ‘I am fine, good’ you know, I mean ‘I’m fine, thanks’. We are not having anything like that. It will be a long story.”*

In the post-consultation interviews with the participants, the clinicians commented that the questions asked in the CN method were more culturally appropriate because they were appropriate to the caregivers’ level of understanding. Some of the questions in the TCH method would have been considered inappropriate had she been a man or a younger woman asking them of a Xhosa-speaking caregiver. However, because BC was a mature woman with children of her own, the questions in the TCH method, although not ideal, would not cause offence.

**BC:** *[regarding whether all the questions were culturally appropriate]*

*“I think in terms of my age, and also in terms of the sex. I’m female, they’re female as well and I have children of my own, so everything was appropriate. It was going to be inappropriate if it was a young girl of 18 years to ask those questions... Ok, like asking about pregnancy, in front of the child as well, so the mum would feel offended, for you as a young child, or girl or woman to ask her such questions. So, in my case, I will make examples about my own kids and they will really feel free to talk about it... For the sex as well. For a male therapist the same discretions apply, the mums feel offended to be asked those questions.”*

**WC:** *“I feel that as woman and as caregivers and as potential caregivers we probably do share similar sensitivities. And I do think that even if you did have the experience of having your own children you would feel even more sensitive to the issues that come up.”*

By using the CN method, the clinicians were implicitly demonstrating respect for the caregivers' beliefs because the CN method was more culturally sensitive. In the CN method, the clinicians acknowledged the importance of the caregiver's subjective experiences of their illness and were providing them with the opportunity to share the stories of their illnesses. In contrast, the TCH gave no room for discussion of the patients' values and beliefs. Cultural assessment can be described as a negotiation between clinician and patient, in which each contributes important and relevant material and is treated as an equal (Tripp-Reimer, Brink & Saunders, 1984 in Allshouse, 1993). The lack of discussion in the TCH method, meant that culture was not negotiated within these consultations.

All patients, regardless of their ethnicity or degree of socialization, 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 (Allshouse, 1993). Erzinger (1991) states that patients and clinicians interpret cues based on a "scaffolding of culturally determined beliefs and values that are reflected in their interactional behaviour" (Erzinger, 1991: 91). The CN method emerged as a more useful means of constructing the scaffolding that reflected each patient's cultural beliefs. In addition, there was better communication between the clinician and the caregiver when the CN method was used. Communication and culture reciprocally influence each other. The culture in which individuals are socialized influences the way they communicate, and the way that individuals communicate can change the culture they share over time (Gudykunst, 1997).

### **5.3.2 Understanding the Whole Person**

In order to understand the patient as a whole person, personal and developmental issues, as well as the context of the patient's family life, need to be discussed (Little *et al.*, 2001). Kosnik (1974 in Ravich & Schmolka, 1996) stated that the health system must

become responsive to the total needs of the patient at the levels of person, family and society.

As previously discussed, the reductionist nature of the TCH method reduced patient's illness to a list of symptoms from which the clinician imposed the label of disease. In contrast, the CN method was implicitly subjective, individualized and constructivist in nature. The few questions asked by the clinician within this method, allowed the caregivers to construct a scaffolding which reflected the patient as a person, family and community member. The more holistic nature of the CN method was demonstrated in a number of aspects in the consultations, which are reflected on throughout all of the themes, namely :

- The patient as a *person* was reflected in the information obtained about the patient's experience of illness, his/her cultural beliefs, his/her primary concerns and therapeutic goals. The depth of information obtained far exceeded that obtained using the TCH method.
- The patient as a *family member* was reflected in the web of social relationships that were embedded within the problem-saturated story of the patient.
- The patient as a *community member* was reflected in the participatory aspect of the CN method, which is outlined below.

The constructive nature of the CN method encouraged community participation in the therapeutic process. The CN method acknowledges the caregiver as the author of her own individual story. However, it also makes room for input from multiple sources. For example, in the consultations in the rural clinics, the school nurses frequently brought children to the clinic during school hours. These nurses would walk long distances with the children and it was not uncommon for them to have known these children since they had entered school. Within the TCH method, these nurses, whose contribution is critical to the success of the community-based programme, would not have been able to answer the majority of the questions relating to medical conditions and birth history or even family history. However, the more flexible nature of the CN method allowed for their

story of the child's performance at school and in social activities, and this had real value in the therapeutic context. In such situations the school nurse or community health worker becomes the author of her own narrative about the child, and this is as relevant as any other narrative about the child.

In the post-consultation interviews with the participants, BC commented on the community aspect of working in a rural environment and the benefit of the continuity of care when the school nurses and community health workers became involved.

**BC:** *"We've got five community health workers and they come down with all their kids in tow, and they come with the kids each one separately. And they're so interested in the child. And the child has got a lot of respect for them as well, and also, this is slightly off the topic, but it helps because that particular child goes to the ENT and that the whole process is kept going."*

**BC:** *"Ya, the other people who have been very helpful are the school nurses. That's because they've been struggling for years with these kids in schools with discharging ears and they don't know what to do and now that our service is there they are so appreciative of it, and so are their children. They feel it's their responsibility. And I found that the difference between the rural and urban areas, I far prefer working in the rural areas with the nurses there... in general, because they care a lot more about the community, whereas the urban nurses, they don't have that same link with the patients, because they're not from their community, so they don't have that same ... they're much more involved with the patient."*

From the post-consultation interviews with the participants, the CN emerged as a more appropriate means of establishing the patient's primary concern. Although the TCH method asked the patients why they were attending the clinic, their responses to this question tended to focus on the physical symptoms of the child's disease. A myriad of symptoms was reported by the caregivers in the TCH consultations, with no indication of

their primary concern or the most pertinent factors impacting on their lives. In contrast, the CN method highlighted the patients' primary concerns, making it possible for the clinician to schedule their management around these concerns.

In the consultations in which the narrative method was used the caregivers commented on a sense of freedom at being able to express all of their problems. This cathartic, therapeutic aspect of the consultations in which the CN method was used, was reiterated by the interpreter. TI expressed the caregivers' need to express everything that they had to say.

**Cg CN:** *"What can I say. I told her everything ... No I was free."*

**TI:** *"If it was changed [to a TCH method] that she was not being helped because she will want to cough out everything what is inside concerning the child... sometimes you will see on her facial expression that she was not yet ready to stop."*

The interpreter expressed concern that in the interpreted TCH consultations, the caregivers might not return to the clinic if they were not given the opportunity to express their needs. She felt that there needed to be additional time built into the consultation in which the caregivers could be consoled and allowed to talk freely. Additional freedom for the interpreter has been advocated by Penn (2000). Within this study the interpreter suggested that time be built on to the TCH consultations in which a narrative approach could be adopted. Within the CN consultations this would be unnecessary as the caregiver already had the freedom of expression afforded by this method.

**TI:** *"Ya, because the fear is when, when she leaves here she will be telling herself 'I am not going back to that place again.'"*

**TI:** *"[What I can recommend] is that, when doing those [TCH] interviews, not you, for the audiologist only, is there is not specific time that you could add, just to console the mum and to let her talk."*

The caregivers in the consultations with WC commented on their past experiences in which no interpreter had been present. They felt that without an interpreter they could not discuss deeper issues with the clinician. Considering the South African interpreting situation in health care at the moment, the importance of having a trained interpreter present in a consultation should not be underestimated. However, there is a shortage of trained interpreters in this country and in health care particularly, and no funding for the provision of these interpreters.

Patients have reported a sense of anonymity and loss of identity within the health delivery system, coupled with a strong need to be recognized and treated with respect and dignity as individuals (Gerteis *et al.*, 1993). In order to respect patients' individuality and restore their autonomy, Gerteis *et al* (1993) recommend paying attention to quality of life, patient involvement in decision-making, and patient dignity, needs and autonomy.

In the post-consultation interviews with the participants the interpreter expressed that the caregivers were comforted by being assisted in their own language. She explained that even when they were supported by other caregivers in parent-training groups, for example, a major comforting factor was that they were being assisted in their own language.

**TI:** *"For instance there was a mum last week who was really not happy at all. We went for the parent training in MK [Institution] and I showed her some other mums like her, there uh, was mums who supported her with her, with her own language, that is the main thing to use her own language. So for me it's good."*

Another aspect related to feedback from the clinician was the determining and planning of appropriate management.

**WC:** *“With the cultural uh the CN? I love it. I mean you just you’re basically asking two or three very basic questions and it highlights for you where to go I mean in terms of management.”*

**WC:** *“I think sometimes with the TCH you ask all these questions and then it’s not really clear to you what your what the real the pressing issues are so that does make your management fairly more difficult. But ... But on the whole, I think management decisions are quite easily made with either. It’s quite dependent on the case as whole like how factors within the caregiver especially the caregiver you know how forthcoming they’ve been how they’ve related to the clinician and to the cultural broker.”*

**CgTCH:** *“Yes she gave me the opportunity to speak and I told her about everything.”*

**CgTCH:** *“Yes I was able to tell the doctor all about my problems and the ones during the pregnancy as well. I told her what happened.”*

The caregivers for whom the CN method was used felt that they had been given the opportunity to speak clearly and freely and to get things off their chest. Even in the interpreted CN consultations, the caregivers reported that they had ample opportunity to speak and to voice their concerns. In a number of the TCH consultations, the caregivers reported that they had the opportunity to speak, but then said that, despite having this opportunity, there were still questions that they would like to have had answered. These questions were linked to the caregivers’ concerns for other family members or socio-economic concerns.

**CgTCH:** *“This thing I was going to ask but I was not going to ask about this one [the child with her]. I was going to ask about Y [her child]”*

In contrast, the caregivers from the consultations in which a narrative approach was used discussed issues relating to other family members or any social or family issues that concerned them.

**CgCN :**        *“I told her everything. I even told her about the others (children) that are not here, because she is not the only one who has this ear problem, there is another one.”*

One of the aims of the CN method was to address those issues that were troubling the caregivers, i.e., their primary concerns. It would appear that in the TCH interviews, the information that was elicited did not assist the clinician in determining the caregivers' primary concerns, and indeed these concerns might not even have been raised if they did not fall within the prescribed line of questioning. After all, as illustrated by the examples above, it was not all that unusual for the clinician to ask about other children in the family or if the caregiver had any concerns regarding them. Clearly, the fact that the caregiver expressed to the assistant interviewer in the post-consultation interviews that this was a concern that she had, illustrated that her concerns were not being met. The feeling of being understood by another person is intrinsically therapeutic as it bridges the isolation of illness and helps to restore the sense of connectedness that patients need in order to feel whole (Suchman & Matthews, 1988).

### **5.3.3 Enhancing the Clinician-Caregiver Relationship**

The results from the post-consultation interviews with the participants indicated that the CN method was preferable to the TCH method in terms of enhancing the clinician-patient relationship. This was because the CN method made it easier to establish rapport with the patient and addressed the caregiver's emotional needs.

### 5.3.3.1 Establishing Clinician-Caregiver Rapport

In the post-consultation interviews with the participants, the clinicians stated that the CN method made it easier for them to establish rapport with the caregivers because of its informal nature. WC likened the narrative method to a conversation or a 'chat' between the participants, in contrast to the TCH method, which was more formalized.

**WC :** *[The interpreter's role in TCH's is] "More of a translator. More of a direct translator. You know. I'm trying to think of a nice metaphor. For some reason the CN is more of a circle. And you're having a chat. And I wouldn't describe that situation I wouldn't use the word 'triad' in that sort of situation [CN] but in the [traditional] case history I would describe more of a triad. Because in a triad there are three definite roles in the triad and it's more formal and there are more definite points in the translation well in the information exchanging process."*

**WC :** *"[The reason why she prefers the CN method] "Because, I feel like the, the patients are more relaxed, and I'm more relaxed, cause I feel like I don't have to remember every single question. And I do feel you get a lot more out of them if there is just an open question."*

**BC :** *"I've found it very frustrating when I was a student, having to ask each question. And it's not always necessary, and it breaks up the interview, um, and I think it causes the patients to feel stressed."*

**WC :** *"And they want to know that you're dealing specifically with their problem. That's what I've found, that they want to feel like, like they've come to the right person, and if you start asking them questions about their pregnancy and birth which they might think isn't necessary when their child has a discharging ear. They might lose a bit of trust in you."*

**WC :** *[re CN's] : "More caregiver or client-centred. Not superior to the caregiver. More informal. It's easier to establish rapport. Although I'm a structured person I like the unstructuredness of it. It's very free and flowing as opposed to having questions."*

### 5.3.3.2 Addressing the Caregiver's Emotional Needs

BC commented that some of the questions in the TCH were inappropriate, not in a cultural sense in that they might be offensive, but rather in terms of relevance to the patient's needs. She explained that a number of the caregivers did not know the answers to some of the questions asked, the prime example being that of developmental milestones. This could be linked to the issue of real life versus time-based events, which was raised by Sishi (2001) and discussed in this Chapter in Section 5.1.

**BC :** *"Well it's [TCH] not comfortable at all, because I had to follow the questions. So at some stage I felt that I was loosing the patients attention."*

**BC :** *"Even the patients had to think about the questions, especially the older mummies, because they have to think about the milestones. I found some of the information wasn't true, it was just guessing."*

There is no profession territorially when it comes to compassion and respect for persons (Kitson, 1996). Health professionals become as much victims of the system as our patients are if we do not take responsibility for ensuring patient-centred care (Kitson, 1996). There is a growing body of criticism of the narrow biomedical model that has focused attention on the neglect of the central functions of empathy and communication with the patient in the construction of a relationship that can facilitate healing (Kleinman, 1988 in Swartz, 1998). Amidst growing concern about the dehumanization of medical care, there is broad agreement within the medical profession that clinicians should demonstrate empathy and compassion in their interactions with patients (Suchman *et al.*,

1997). DiMatteo & Hays (1980) suggest that an association exists between clinicians' caring and the appropriateness of, effectiveness of, and satisfaction with care.

Morse, Anderson & Botoroff (1992 in Suchman, Markakis, Beckman & Franckel, 1997) have identified four components of empathy, namely, emotive, moral, understanding of the patient's feelings and feedback to the patient. The first two components, emotive and moral, refer to the clinician's intrinsic capacity and motivation to attend to the emotional experiences of others. Although they are necessary preconditions to empathic communication in a clinical encounter, the essence of empathic communication lies in the accurate understanding of the patient's feelings by the clinician and the effective communication of that understanding back to the patient, so that the patient feels understood (Morse, Anderson & Botoroff, 1992 in Suchman *et al.*, 1997). Suchman & Matthews (1988) highlight the importance of the patient's feelings understood by another person, and suggest that this is intrinsically therapeutic. It is thus clear that empathy and understanding are inextricably linked. This implies that if the caregivers in this research admitted to feeling understood by the interpreters and the clinicians, then it was likely that they felt the empathy being conveyed from both parties to them.

Studies examining diagnostic medical interviews show that, frequently, when patients bring up emotional topics, the physician abruptly shifts the discussion away from the emotion by changing the topic, generally to resume the diagnostic interview with questions of a biomedical nature (Suchman *et al.*, 1997).

**Cg TCH :** *[Do you think that the problem that you came here for has been resolved?] "No. Because they said that I must go to meet the doctor now for this child. Because the ears were doing this, they didn't see anything wrong with them. Now there is something else which I have a problem with, she like once had epileptic fits and she was admitted here. She usually complains about headaches as a result the vessel usually does this here (indicates beating against her head) here inside her."*

**CgTCH:** *"No I have accepted that. I give her love. Because by becoming worried, nothing is going to be solved. That will not help her because I would be crying Yes I need to be strong. For her so that she can get the love."*

The fears and anxieties provoked by illness have been documented as being as debilitating to patients as the physical effects (Gerteis *et al.*, 1993). Gerteis *et al.* (1993) recommend that clinicians pay attention to their patients' anxieties about clinical status, treatment, prognosis, impact of illness on self and family and the financial impact of the illness.

#### **5.3.4 Patient Understanding**

*"All my life I have listened to practitioners saying one thing  
and patients hearing another"*

(Edward E. Rosenbaum in Daley, 1993 : 72)

Communication is defined by Daley (1993) as the transmission of information, thoughts and feelings, so that they are satisfactorily received or understood. Patient understanding appeared to be hampered by the same barriers hampering mutual partnership between the clinician and the caregivers, namely linguistic barriers, the barrier of medical discourse and a disparity in sophistication and education levels. With the above-mentioned barriers, patient understanding was decreased.

Literature on patient education states that patients express fears that information is being withheld from them or that clinicians are 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, selfcare and health promotion (Gerteis *et al.*, 1993).

*“How much information is actually communicated to patients varies with the patient’s age, sociodemographic characteristics, income, health status, and cultural background.”*

(Daley, 1993 : 83)

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 clinician are also less likely to receive information from their clinicians (Daley, 1993). As expressed by Daley (1993), patients speak a different language from providers. Health promotion including health enhancement, risk reduction and early detection of disease, is considered to be one of the main domains of patient centredness (Little *et al.*, 2001). A crucial aspect of health promotion is patient understanding. Without patient understanding, health promotion would be ineffective.

Patients of different cultural backgrounds have been shown to have different educational needs (Ellers, 1993). This is particularly important in the South African health care context as it suggests that in order to increase patient understanding for Xhosa-speaking patients, additional measures need to be taken to ensure this understanding. In the post-consultation interviews with the participants, one of the caregivers and the interpreter commented on the impact of a limited education and the lack of health knowledge amongst Xhosa-speaking people.

**CgTCH :** *“Since we are different people, we are not the same. There are educated people and there are non-educated people. Someone may understand it but may be unable to reply back and someone may be able to.”*

**TI:** *“Yes. Because there is a lack of knowledge in our people. “*

The majority of the caregivers expressed that they had understood most of what was said by the clinician. The information that they found most difficult to understand was that

pertaining to the child's diagnosis, the cause of the child's problem and follow-up appointments. This was evident in the caregivers' queries as to which ear had the pathology, or a lack of understanding for why they had to return to the clinic on another day or why tests could not be administered on that specific day. Only one caregiver initially admitted that there were things that had been said that she did not understand. The other caregivers claimed that they had understood everything that the clinician and the interpreter had said, but then later asked the interviewer in the post-consultation interviews questions that displayed their misunderstanding.

**Cg TCH :** *"I don't know what it [the cause of the child's problems] is."*

**Cg TCH3 :** *"I didn't understand them about the right ear. Do you understand? I thought it was only the left side to find out it is the right side."*

Caregiver understanding was influenced by the method used and the language of the clinician. An analysis of the impact of the TCH and the CN methods on patient understanding suggested that the CN narrative method aided patient understanding in two ways. Firstly, it decreased the complexity of the message, and, secondly, it enabled the caregiver. These are discussed below.

#### **3.3.4.1 Decreasing the complexity of the message**

One of the barriers to patient understanding was the complexity of the original message from the clinician when the TCH method was used. In BC's TCH consultations, the increased complexity of the terminology, particularly in the complexity of the questions, hampered patient understanding. BC commented that she had to assist the caregivers in these consultations by providing examples to ensure that the caregivers understood the questions.

**BC :** *[with the TCH method] "I had to direct them [caregivers] and give them my own examples."*

In WC's consultations, patient understanding was similarly hampered by the complexity of the message. The interpreting effect was minimized by the interpreter's role in simplifying the complexity of the message for the caregivers, and in giving examples. A cultural difference in the manner in which BC and WC explained information emerged in these consultations. BC used much simpler language, made use of repetition, provided examples and frequently used clarification.

It emerged from the discussions with the clinicians that the style of their feedback was affected by the approach that they used. The CN method assisted the clinicians in providing feedback that was of a level appropriate to the caregivers, in both its simpler language and its focus on the patients' primary concerns. It appeared that feedback in these consultations was more focused and involved one or possibly two key issues, whereas feedback in the TCH method covered a number of different concerns. In the post-consultation interviews with the participants, WC commented that her feedback when the CN method was used was more discursive and open to discussion than in the TCH method.

**WC :** *[on the effect of the interview format]*  
*"Um I think it probably does um effect your response and your feedback. In the TCH I do think you would give more structured feedback whereas in the CN you would be more open and be discussing the issues which came up. But I think I would still be very clear as to what my management might be. XYZ."*

Those caregivers who were seen by WC using the CN method appeared to have a better overall understanding of how their children were going to be treated and what their role in the treatment process was than those caregivers who were seen by WC when the TCH method was used. There was a better overall understanding of the treatment procedure for the caregivers with whom the CN method had been used. This was possibly due to the

manner in which the clinicians' provided feedback. In the post-consultation interviews, WC commented that she felt her feedback was affected by the type of format used.

#### 5.3.4.2 Enabling the Caregiver

Information that is provided in the language of the clinician might not be regarded as being truly accessible if it is not pitched at an appropriate level of complexity or at a time in which the caregiver is equipped to deal with the information. In addition, information will not be accessible unless the caregiver is sufficiently empowered to ask for it. Enabling the caregiver is closely linked to the interpreter's role in the consultations. This will be discussed later in Section 5.4 of this chapter.

In WC's consultations, there was a very definite role for the interpreter to act as a patient advocate to the caregiver, thereby empowering the caregiver to ask for information.

Despite the obvious lack of the ideal situation (having a clinician of the same culture and language as the patient), having a clinician of a different language and culture can be advantageous when working through an interpreter, because the interpreter can fulfil the additional function of a patient advocate. In the US, even in monolingual consultations, ombudsmen/advocates are available to patients to ensure that information is accessible at all times. The presence of a patient representative department makes a definitive statement to patients and their families that management is patient-oriented. A successful patient representative programme reduces the sense of alienation often perceived in the health care setting (Ravich & Schmolka, 1993).

In the post-consultation interviews with the participants, the caregivers were unsurprisingly unanimous in their support of the interpreter. The post-consultation interviews were full of anecdotes from the caregivers on miscommunications at previous medical consultations when no interpreter was present. Regardless of the method used, without a trained interpreter the clinicians would not be sufficiently enabled to communicate with the clinician.

**CgTCH :** *"Yes. They must definitely have them [interpreters] as they are of a great help."*

**TI :** *"So as you can remember last week, some other mum said, 'let us go from here to Red Cross [hospital]' when she, she, she's there, she doesn't know where to go, they will just give her a file 'Listen lady, go to ...' she can't communicate with any other person, she meets in the uh, uh, uh in the passage to ask them 'where must I go' because she can't speak in the other language."*

**CgCN :** *"On that side (outpatients dept) I've come to the doctor on that side. When my mother wanted to speak. She says that they don't give you a chance to speak the way you want to speak and they do not understand you."*

The caregivers who were seen by BC were able to explain more about the findings of the procedures that were used, as well as possible causes of the children's problems. These caregivers also appeared to be more aware of where they were being referred and what the reasons for the referrals were. There appeared to be little difference between BC's TCH and CN method in terms of the caregiver's understanding of the management of the children. This is thought to be due to the support of the nurses in all of BC's cases. The infrastructure of community health workers, and school nurses particularly, supported the caregivers in understanding the overall procedure. This is important as it reflects on the nature of the different clinic situations and the support of small communities in rural clinics.

In contrast, the caregivers seen by WC were usually seen in busy clinics without the support of the local nurses or community health workers. In these consultations the presence of the interpreter and the impact of the tool were crucial to facilitating patient understanding. The understanding of the caregivers could have been due to the different styles of the clinicians concerned. BC assisted them by repeating everything she had said, using more examples and simpler language, and constantly asking whether the caregivers

had understood. In a sense BC was acknowledging the lack of familiarity that the rural Xhosa-speaking caregivers have within a biomedical model of health.

#### 5.4 ROLE OF THE INTERPRETER

Triadic interactions have different characteristics and interaction to dyadic consultations. Swartz (1998) highlights this difference by drawing on research from couple therapy, in which the triangle that forms results in an alliance between two of the members, alienating a third member of the triad (Hayley, 1976 in Swartz, 1998). The entry of a third person, the interpreter, into the medical consultation introduces additional difficulties and complexities into the consultation (Crawford, 1994). Given that the clinician cannot communicate with the caregiver and vice versa, it is anticipated that the interpreter will form an alliance with either the caregiver or the clinician (Swartz, 1998).

Understanding the dynamics of communication is compelling in the face of cultural diversity (Erzinger, 1991). Few studies have documented how culture and primary spoken language effect the provision of health services (Erzinger, 1991). More recently, there have been a number of studies that have focused on aspects such as group dynamics (Muller, 1991; Crawford, 1994). The interpreted interview in South Africa has unique group dynamics by virtue of the country's *apartheid* history and its array of cultural diversity (Evans, 2000). Crucial to the understanding of the triadic clinician-interpreter-caregiver interaction in this study is the role played by the interpreter.

Previously, few studies have documented the manner in which culture and language have impacted on the interpersonal interaction of participants in interpreted consultations (Fisch, 2001). However, studies have recently examined the complex relationships and group dynamics that exist between the clinician, caregiver and the interpreter within interpreted consultation, particularly considering the unique political history and present economic situation in South Africa (Crawford, 1994; Muller, 1994; Evans, 2000; Penn, 2000; Fisch, 2001).

A health care system is comprised of two inter-related aspects, namely a cultural aspect and a social aspect (Landy, 1977 in Helman, 1996). This social aspect is further divided into specified roles and rules governing relationships (Landy, 1977 in Helman, 1996). Several researchers have focused on the multiple and often conflicting roles that are expected of interpreters within an institutional context (Kaufert & Koolage, 1984; Crawford, 1994; Kaufert & Putsch, 1997; Drennan, 1998; Swartz, 1998; Evans, 2000; Fisch, 2001). That interpreters are invariably subjected to the stresses attendant on fulfilling a function for which there is a lack of definition is well documented (Drennan, 1998).

The roles of the interpreter within the consultations were examined across the two methods in relation to interpreter roles documented in the literature. This includes the invisible role of the interpreter as *linguist* (Swartz, 1998); *cultural broker* (Kaufert & Koolage, 1984); *patient advocate* (Swartz, 1998); *interviewer* (Swartz, 1998; Penn, 2000); *multidisciplinary team member* (Drennan, 1999) and as part of an *institution* (Drennan, 1999). The role of the interpreter within the primary health care system is also discussed. These roles are summarized in Table 5.12 and then discussed in detail thereafter.

**Table 5.1.2 : Summary of Interpreter Roles in the Two Methods**

	<b>TCH Method</b>	<b>CN Method</b>
<b>Linguist</b>	Predominant role of the interpreter within this method	Not an aspect of this method – a direct translation would be impossible considering the length and nature of the caregivers narratives
<b>Cultural Broker</b>	Predominant in the direction from the clinician to the caregiver in the explanation of terminology and complex concepts and not in the direction from the caregiver to the clinician	Predominant in the direction from the caregiver to the clinician in explaining cultural and socio-economic aspects of the caregiver's narrative
<b>Patient Advocate</b>	Significant owing to the relatively disempowered caregiver position	Present but not to the extent of the TCH method owing to the relatively more empowered position of the caregiver
<b>Interviewer</b>	Not necessary owing to the structured nature of short questions in this method	An important role during the caregiver's narrative in which the interpreter acts as interviewer, clarifying aspects of the caregiver's narrative before translating it
<b>Team Member</b>	Subordinate role in relation to the clinician, elevated status in relation to the caregiver	Equal member of the team striving towards mutual partnership between the clinician, interpreter and caregiver in which each are recognized for their own strengths : The caregivers as authors of their own stories; the interpreter as a member of both cultures with understanding of each; and the clinician as facilitator
<b>Within an Institution</b>	Interpreter's role more closely aligned with the institution and the biomedical model of health care to which the clinician belongs	Interpreter's role more closely aligned with the caregiver and the cultural and socio-economic culture to which she belongs
<b>Within a Health Care System Focused on Primary Care</b>	Instrumental in ensuring patient understanding, compliance and referral procedures	Instrumental in ensuring patient understanding, compliance and referral procedures

### 5.4.1 Linguist

Crawford (1994) reported that doctors were using the model of the interpreter as a linguist, i.e., within an empiricist approach (Swartz, 1998). This is a common perception of an interpreter's role, in which the interpreter is almost regarded as being invisible (Swartz, 1998). This has been equated to the 'black box' model of interpreting, in which the interpreter is regarded as a channel for the transformation of words from one linguistic system to another, without an appreciation for crossing cultural boundaries. This role fails to acknowledge that there is not necessarily equivalence between the cultural constructs of the two languages and the ways of perceiving the world from one language to another.

Within the consultations in which the TCH method was used, the role of the interpreter as linguist predominated. It appeared as if the interpreter's primary function was to provide a direct translation from the clinician to the caregiver and vice versa. This finding supports that of Sishi (2001), who stated that the interpreter played primarily a linguistic role in the TCH consultations. This role is in line with the traditional role of the interpreter, that is the norm in a clinical setting and is considered to be the most obvious of all the interpreter roles (Swartz, 1998). In contrast, the role of the interpreter as linguist was not a feature of the consultations in which the CN method was used. The increased lengths of the utterances in the caregiver's language and the story-like nature of the caregiver's narratives resulted in the interpreter not providing a direct translation from the one language to the other. In the post-consultation interviews with the participants, WC acknowledged the role of the interpreter as linguist within the TCH consultations.

**WC :** *[The interpreter's role in TCH's is] "More of a translator. More of a direct translator. You know. I'm trying to think of a nice metaphor. For some reason the cultural narrative is more of a circle. And you're having a chat. And I wouldn't describe that situation I wouldn't use the word 'triad' in that sort of situation [Cultural narrative]but in the [traditional] case history I would describe more of a triad. Because in a triad there are three definite roles in the triad and it's more*

*formal and there are more definite points in the translation well in the information exchanging process.”*

#### **5.4.2 Cultural broker**

Cultural brokerage involves providing explanations of cultural beliefs to clinicians, as well as explaining aspects of medical culture to patients (Kaufert & Koolage, 1984). The cultural change approach advocates an eclectic approach, owing to the complexities involved in interpreting (Erasmus, 1999). Swartz (1997) states that an analytic approach is needed in order for there to be an understanding of the positive and negative aspects of language practices. Studies have shown that there are unrealistically high expectations of the cultural brokerage role of the interpreter (Drennan, 1998).

In this study, the role of the interpreter as cultural broker in the TCH consultations was prominent only in the direction from the clinician to the caregiver in the explanation of complex terminology and concepts. There was no evidence of mediation in the direction from the caregiver to the clinician. This could be explained by the fact that the caregiver's shorter utterances within such a method did not include sufficient information about the caregiver's explanatory model to enable the interpreter to identify any aspects that required cultural interpretation. In the CN method, the reverse was true. The lack of complex terminology and medical jargon meant that cultural brokerage from the direction of clinician to caregiver was unnecessary. However, the increased content of the caregiver's narrative enabled the interpreter to act as a cultural broker in the direction from the caregiver to the clinician.

The role of the interpreter within the CN method was acknowledged by the clinicians in the post-consultation interviews.

**WC :** *[the interpreter's role in the CN method] “Probably more of a cultural broker or a mediator rather than interpreter or translator. Because they're not translating little bits backwards and forwards and I think their role is also more informal it's*

*more of a discussion between the members of the triad. It's more of a sort of chat session."*

### 5.4.3 Patient Advocate

A number of models fall within the umbrella term of advocacy models, namely the client-centred model (Sanders, 1998 in Erasmus, 1999) and the "add-on" and "add-in" models (Swartz, 1997 in Erasmus, 1999). Advocacy models vary in their degree of involvement (Erasmus, 1999). In extreme cases, interpreters are expected to act as lay psychologists or social workers, whereas others expect the interpreter to act as junior clinicians (Swartz, 1998), which is similar to the concept of link workers (Sanders, 1998 in Erasmus, 1999). The concept of 'link workers' is along the same lines as that of the interpreter acting as a team member within a multi-disciplinary team (Drennan, 1999).

It has been documented that clinical encounters can often be bewildering experiences for patients (Crawford, 1994; Drennan, 1999) and this is even more the case if one does not understand and one cannot communicate with the staff at the clinic. Advocacy is considered to be necessary for patients from different cultures and languages. Both Erasmus (1999) and Sanders (1998 in Erasmus, 1999) were critical of the advocacy approach as it can only work within a very supportive organization or interpreting service.

The relative empowerment of the caregiver in relation to the clinician was affected by the method used. When the TCH method was used, it was significant that a greater amount of patient advocacy was needed owing to the relatively disempowered position of the caregivers. Furthermore, the TCH method was not conducive to patient advocacy, as there was little discussion between the interpreter and the caregiver and little opportunity for the interpreter to attempt patient advocacy. Within the consultations in which the CN method was used, a degree of patient advocacy was needed, but not to the extent required in the TCH method. Ironically, this method would have been better suited to facilitating cultural brokerage, owing to its discursive nature.

Another role of the interpreter is to function as the voice of the caregiver in the direction from Xhosa to English (Evans, 2000). The feeling that the interpreter should function as the voice of the caregiver is consistent with the findings of the studies conducted by Muller (1994) and Evans (2000). Drennan (1999) states that Muller's research indicates that the employment of interpreters may be seen as a means of providing the patient with a voice in clinical assessment.

In this research, the interpreter acted as the voice of the caregiver in the CN method specifically. This is also consistent with findings reported by Crawford (1994), that the interpreter reproduces the subjugated status of the patients' knowledge, voice and stories. However, with an untrained interpreter, Crawford (1994) felt that the input they provided was not enabling of the patient's voice.

#### **5.4.4 Interviewer**

Penn (2000) suggested that the interpreter should be given the power to sit and listen to the caregiver in the presence of the clinician and not be compelled to translate every single detail. The clinician should distance herself from the client, whereas the interpreter should sit close to the client and engage him/her directly. This would allow for a flow of talk between the interpreter and the client (Penn, 2000). Penn (2000) states that interesting aspects could emerge from these informal moments, which could shed some light on attitudes and power issues. A further suggestion was the use of narratives as an effective means of enabling the caregiver to open up to the interpreter (Penn, 2000).

The short, structured nature of the TCH questions meant that there was little reason for the interpreter to act as the interviewer. However, the longer, more in-depth narratives of the caregivers in the CN method resulted in the interpreter acting as an interviewer on her own. After the caregiver had finished her story, the interpreter frequently spent one or two minutes clarifying aspects of the caregiver's story before explaining what she had said to the clinician. This role is significant, in that without it it is likely that there would

have been more negative mistranslations by the interpreter. The usefulness of this role of the interpreter as independent interviewer has been previously documented by the researcher (see Evans, 2000).

#### 5.4.5 Member of a Team

Drennan (1998) reported that there was a range of views on the role of the interpreter within a multi-disciplinary team. The reasons expressed for why the interpreter should not be a full member of a multi-disciplinary team included debate over whether interpreting was a *profession* in the traditional sense of the word and concern that lack of training within the field would prevent the interpreter from acting as full team member. Evans (2000) showed that within the health professional team it was evident that the interpreter's role was as a junior clinician. The clinician felt that the interpreter did not see herself as being equal to the interpreter, but rather as a junior partner in the relationship.

Within the TCH consultations, the interpreter appeared to be in a position somewhere subordinate to the clinician, but elevated to that of the caregiver. This was because, although all of the questions were clinician-directed, placing the interpreter in a more subordinate position, the interpreter was required to explain these to the caregivers, thereby demonstrating her biomedical acumen. In the consultations in which the CN method was used, the interpreter acted as a more equal member of the triad, in which mutual partnership was the goal. All of the participants were recognized for their own strengths within this method. The caregiver was the expert as the author of her own story. In addition to acting as an interviewer, the interpreter acted as an expert in linking the cultures of the caregiver and the clinician, and the clinician facilitated the discussion.

Although the CN method enabled the interpreter to approximate a more equal role, this was still not entirely equal. The barriers to mutual partnership could account for this. In the post-consultation interviews with the participants the interpreter has commented that she needed a 'permit' from the clinician that would allow her to have more control in the

consultation. There is a need for increased discussion between the interpreter and the audiologist in this regard. The clinician also commented that, regardless of the method used, she was still '*the clinician*'. It seems that the clinician, whose entire training was grounded within the biomedical model of health care, is not comfortable with completely abandoning this position of power to embrace fully the biopsychosocial model of health care.

#### 5.4.6 Within an Institution

There is some debate as to the neutrality of the interpreter in clinical encounters. Some researchers believe that the neutrality/invisibility of the interpreter has an ideological function that may mask relations between participants in the encounter (Drennan *et al*, 1991; Meintjies, 1991, Simon, 1992 in Muller, 1994). Some researchers believe that the recent move to make translation visible is a political one (Venuti, 1992 in Muller, 1994). Proponents of the advocacy model of interpreting (Sanders, 1991, Shackman, 1985 in Drennan, 1998) advocate that autonomy from the service provider is crucial for interpreters, so that they are free from the constraints of employee status.

In this study, TI did not have autonomy as such, as the clinicians with whom she worked were her employers within the organization in which she was employed. This was found to be problematic, as there was role conflict in instances in which TI was needed to act as a patient advocate, while still feeling loyalty to the establishment in which she was working. Some studies indicate that this arises out of attempts on the interpreter's part to align herself with the functioning of the organization in order to be helpful (Drennan, 1998). It was felt that in this study this was not the case. Instead, it is proposed that the researcher felt a need to defend her employers, who had become her friends to whom she felt a sense of loyalty.

Even within the institutional setup of the programme the interpreter's role could be shown to vary. When the TCH method was used, the interpreter's role appeared to be more closely aligned to the institution and to the biomedical model of health care to

which the clinician belonged. This was partly due to the interpreter's position as 'explainer' of medical terminology, which located her within a biomedical model. In contrast, when the CN method was used, the interpreter's position was more closely aligned with whomever she shared a similar cultural and socio-economic background.

#### **5.4.7 Within a Health Care System Focused on Primary Health Care**

Regardless of the method used, the interpreter was instrumental in ensuring patient understanding of the referral system and procedures to be followed that ensured greater patient compliance. It would appear that the position of Xhosa-speaking patients as relatively disempowered within the primary health care system, will require the interpreter to act as an institutional liaison, regardless of the method used. In repeating instructions to the caregivers, in showing them where they can fetch their folders or just in explaining the role of the professional to whom they are being referred, the interpreter's role as institutional liaison is critical to the success of primary health care.

Part of the clinician's role as team leader appeared to be to ensure that there was good liaison with the other professionals at the clinics, especially the nursing staff. Without the support of the nursing staff, the programmes were less likely to be successful. For BC, this role was easy to facilitate. For WC, this was more complex because of the language barrier. This was the case in both formal and informal meetings with other staff members. Even merely asking which patients or how many patients were to be attending the clinic on a particular day was problematic without an interpreter. Consequently, the interpreter's position as an institutional liaison was a crucial one.

One difference between how BC and TI facilitated this role appeared to be their attitude towards carrying out this duty. BC was very positive towards the nurses, attempting to include them and to gain their support for the project. TI was more dismissive and complained about the way the nurses acted towards her and the problems that they sometimes had with the nurses. Once again, this could be linked to the interpreter not feeling appreciated and not being respected by other staff members. It also reflects on institutional tensions and how they can potentially influence service provision. From the

post-consultation interview with BC, it was apparent that there was a difference in the degree to which nurses in the rural clinics would assist her, in comparison to the nurses at the urban clinics. The rural nurses seemed to have a genuine interest in the well-being of the patients, many of whom lived near to them and whom they had known for a long time. This was also the case with the school nurses, who knew the patients by name and were genuinely concerned about the management of each child. BC expressed that without the support of the nurses the clinics would not run as smoothly, as the patients would not feel as positive towards them.

**BC:** *“Ya, I think so, but that school nurses that we work with, they really need our services, so they are really positive towards us, which makes the patients more positive towards us, uh, I think that if the nurse didn't trust you then they wouldn't trust you either. So I think you need to have a good relationship with the interpreter. The therapist needs to have a good relationship with the interpreter, that's very important, otherwise it wouldn't work.”*

**BC:** *“Ya, and the rural nurses have a real interest in the patients and they're, they're not just there to get the money, and actually, what we've found, like the community health worker, he was fantastic, because he had brought the patients to us. And they had been his patients in the, um, the little rural village down the road with these discharging ears for five years and he didn't know what to do with them, and now we're providing this service, so his care for the patients was amazing.”*

It would appear that the interpreter's role as institutional liaison could be a crucial one to the overall success of the service provision. The interpreter should be trained to do in this role and should be encouraged to be positive in her approach to other health professionals. The recent drive towards the professionalization of interpreting should be taken into consideration (Fisch, 2001). If interpreters are accredited as professionals, they

might feel that they are valued as team members and this could impact positively on their position within a team.

#### **5.4.8 Impact of the Interpreter's Role on the Clinician's Role**

As the role of the interpreter changed in the two methods, so too did the roles or positioning of the other members of the triad. In the TCH consultations, the interpreting triad, which is an established symbol in liaison interpreting, was evident (Erasmus, 1998). However, in the CN consultations, the interpreter's additional autonomy meant that this triad was broken. Sishi (2001) alluded to this shift in roles in a diagrammatic representation of the shift in roles and power. Sishi (2001) argued that unless the clinician was able to relinquish her autonomy to the interpreter, the CN method would not be effectively administered. Within this study, however, it was evident that the clinician did not completely relinquish all power and autonomy to the interpreter and that, in turn, the interpreter did not appear ready to embrace a mutual partnership. However, the CN method was still successful. The method alone, regardless of the clinician's attitude or the interpreter's willingness to adopt a more prominent role, results in a shift in participant roles. With increased autonomy being handed over to the interpreter, interactions within the triad would shift again. Whether or not this shift would enhance the interaction is not known. However, the readiness for the clinician and the interpreter to shift their roles even further is something that would need to be negotiated between them.

Penn (2000) suggested that it is possible to administer the CN method using an interpreter. However, the interpreter should be seen as a valued and respected member of the health care team, who should be given autonomy to act in the way that she feels appropriate. In this study, the interpreter was given more autonomy than many other clinicians would have been willing to relinquish. In addition, she had been working in the field for over a year and so had plenty of field-specific knowledge. At present, when the CN method is used, WC and TI have a slightly clinician-dominated partnership. This differs considerably from their relationship in the strongly clinician-dominated TCH method. It remains to be seen whether the clinician and the interpreter can abandon their

preconceptions that the clinician should be dominant. These preconceptions were formed in their biomedical training.

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## CHAPTER SIX

### GENERAL SUMMARY, CONCLUSION AND IMPLICATIONS

#### 6.1 GENERAL SUMMARY

The model of health care within which one is working, is reflected by the tools and the methods within which one works. Hence, a summary of the findings is presented, with an attempt to highlight and relate the major findings within broader models of health care. This is illustrated graphically in Figure 6.1 and 6.2, followed by a more in-depth discussion.

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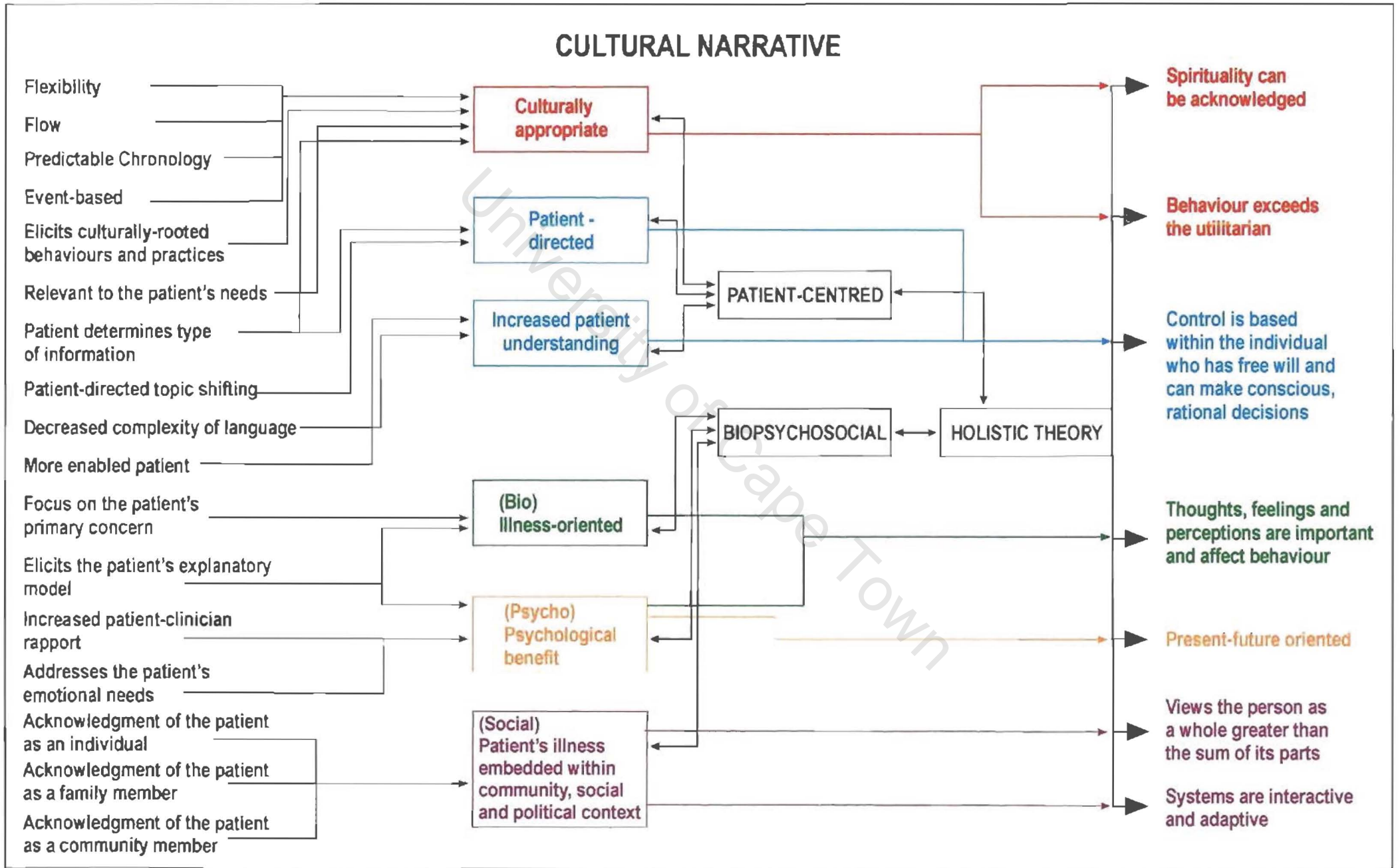


Figure 6.1 Summary of the Cultural Narrative Method

In this study, the CN method was found to have characteristics that indicated that it was in line with a biopsychosocial and a patient-centred approach to health care. Evidence to support this claim was revealed in the findings that the CN method was culturally appropriate and illness oriented and that it addressed psychological and social issues. Through this method the patient's illness experience was embedded within a community in a social and political context.

The cultural appropriacy and sensitivity of the CN method was established through its elicitation of the patient's cultural beliefs and the fact that it was in line with an oral tradition, which is of particular appropriacy in African cultures. The findings in this study clearly indicated that the CN method was event-based and addressed issues that were relevant to the patient's needs. In addition, the flexibility of this method, as well as its flow and predictable chronology, ensured that this method lent itself to an oral presentation or *story telling*. The cultural appropriacy of the CN method and its ability to elicit cultural beliefs ensured that it was in line with a holistic perspective of the individual, in which spirituality and behaviour were acknowledged as exceeding the utilitarian (Hagedorn, 1992). Furthermore, the holistic emphasis that thoughts, feelings and perceptions are important and affect behaviour, emerged through the use of this method.

The finding that the CN method was patient-directed is a critical link to the fact that it was illness- and not disease-oriented. Because the patient (caregiver) directed the type of information to be discussed through his/her topic control and control over the level of complexity of the language in the consultation, the CN method was found to be particularly relevant to the patient's needs. This relevance focused on the patient's primary concerns and ensured that the clinician was able to elicit the patient's explanatory model. As a result, the information contained in the consultation was found to be centred around the patient's experience of his/her affliction, resulting in the consultation in which the CN method was used being illness-oriented. The illness orientation of the CN method was directly linked to the increased patient control that the

CN method facilitated. This increased patient control ensured that the CN method was firmly embedded within the holistic viewpoint, which acknowledges that control is based within the individual, who has free will and can make conscious, rational decisions (Hagedorn, 1992).

The increased patient control ensured that the patients were able to be more equal partners in the CN consultations and that the information in the CN consultations was more accessible to the relatively disempowered Xhosa-speaking patients. This increased patient understanding and enabled the patients to participate more actively in the consultations. The increased patient understanding, coupled with the increased patient control, ensured that the CN method facilitated patient-centred care.

The CN method allowed the caregivers to express themselves. This was believed to be of therapeutic benefit to the patients in that it enabled the caregivers to speak freely about topics that they had chosen. This cathartic benefit is in line with the holistic perspective, which places emphasis on being present- and future-oriented (Hagedorn, 1992).

In this study, the CN method was shown to elicit information pertaining to the patient's position as a family and community member. Social relationships were reflected in the patients' descriptions of their illnesses and their family's ability to cope with them. The patients' descriptions enabled the clinician to treat them holistically, by acknowledging the patient both as an individual and as a community member.

In conclusion, the CN method can be shown to be in line with the biopsychosocial and the patient-centred approaches to health care. In addition, this method was shown to be culturally appropriate and firmly entrenched within the constructivist, holistic metamodel.

In contrast, the TCH method can be shown to be firmly entrenched within the reductionist, biomedical approach to health care. This is illustrated in Figure 6.2.

# TRADITIONAL CASE HISTORY

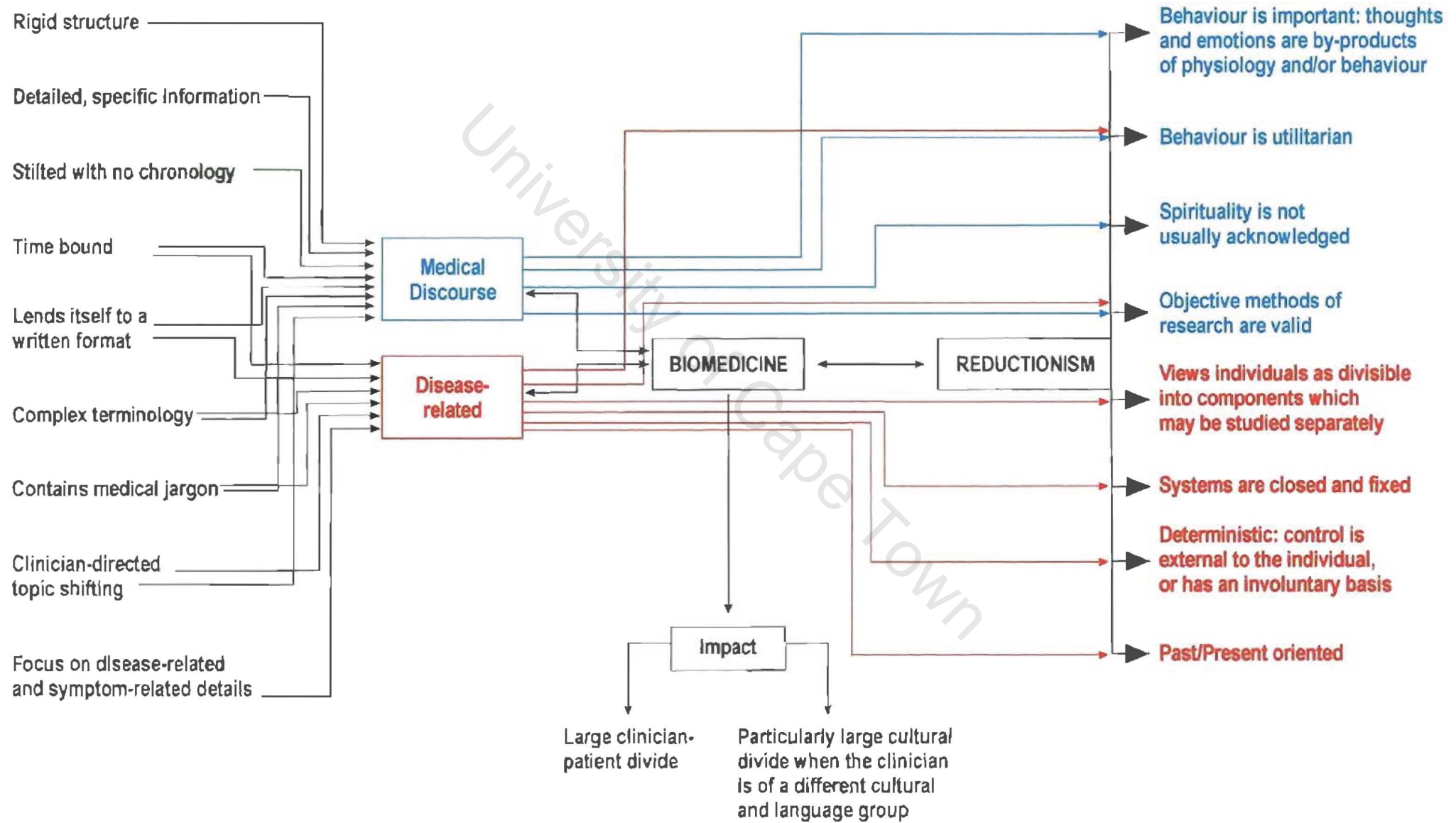


Figure 6.2 Summary of the Traditional Case History Method

In this study, the TCH method was shown to be characterized by medical discourse and the elicitation of disease-related information. The TCH method resulted in a consultation that had a rigid structure, elicited detailed, specific information that was stilted with no chronology and lent itself to a written rather than an oral format. The information elicited from the TCH method was time-bound, rather than event-bound. The clinician's language included complex terminology and contained medical jargon, which resulted in its being less accessible to the patient than the CN method. This was further emphasized by the almost total clinician control that was evident in the clinician-directed topic shifting and the focus on disease and symptom-related details. It was in this aspect in which the reductionist nature of the TCH method was most apparent. Instead of addressing the patient holistically, the TCH method addressed the issue of the patient's disease as the primary concern. This is in line with the reductionist viewpoint that individuals are divisible into components that may be studied separately. The focus on the patient's history of the disease and its course, was past- and present-oriented. The lack of discussion of the cultural, psychological and social implications of the disease in the TCH method resulted in this method being firmly entrenched within a biomedical approach.

The impact of the TCH method was that there was a large clinician-patient divide and a particularly large cultural divide when the clinician and the patients were of a different cultural and language group. This contrasted with the CN method, which was useful in reducing the clinician-patient divide in consultations in which the clinician and the patient were of the same or different cultures.

## **6.2 CONCLUSION**

This study set out to explore and to document a potentially more culturally-appropriate procedure, the cultural narrative, for gathering information in multilingual, multicultural initial consultations in the field of SLHT. It is necessary to consider the South African context of this study, in which health service providers are focused on transformation of existing services to ones more relevant and culturally appropriate to the majority of the population. The CN method was examined and compared to the existing method of

gathering information, the TCH method. Furthermore, this was explored within the field of SLHT across a black, Xhosa-speaking clinician with Xhosa-speaking patients, and a white, English-speaking clinician and a trained interpreter with Xhosa-speaking patients. The researcher felt that it was necessary to explore the use of the CN method in interpreted consultations because it was questionable whether the CN method could be used to cross linguistic barriers within the special dynamics of triadic mediated consultations. It was necessary to determine whether the CN method could be applicable in interpreted consultations as the use of interpreter mediated consultations has arisen out of necessity, because the majority of the service providers do not speak the language of the majority of the patients they serve. Although interpreting services are not yet widely available in health care in South Africa, the use of interpreters in multilingual consultations is one step in the move towards more accessible health care.

In this study, the perceptions of all of the participants in the TCH and the CN consultations were considered and the consultations were recorded and analyzed qualitatively. The inclusion of all the participants' views and the multiple methods of analyses resulted in the accumulation of very rich data.

The major findings of this study are that the CN method is more culturally appropriate than the existing TCH method, and furthermore, the constructivist nature of the CN method is in line with both a biopsychosocial and a patient-centred approach to health care. This was evident from the increased patient understanding and greater patient control when using the CN method. It is considered to be particularly critical in the South African context that the patient's illness is embedded within a social, cultural and political framework. In contrast, the TCH method was found to be in line with a biomedical approach to health care that is not patient-centred. The CN method was found to be applicable to interpreted consultations, and furthermore, was found to be particularly beneficial in narrowing the cultural divide between clinicians and patients in mediated consultations.

The CN method is a practical step towards adopting a more culturally, biopsychosocial and patient-centred approach to health care. It is easy to administer, inexpensive and requires no special training or equipment. It is believed that this method can have immediate social and clinical benefits. It could be used very well within current health care reforms that are focused on providing primary health care as the CN method embraces the community spirit of primary health care and is not culture-bound or culture-specific. The CN method is not bound to any level of health care and, as demonstrated in previous studies, is effective across disciplines within health care.

This study highlighted the clinical usefulness of the CN method and casts doubt on the usefulness of the TCH method that has been considered the cornerstone of biomedicine. It would appear that in light of current health care trends and the approach within which the TCH method falls, the TCH method is an inappropriate method of gathering information from patients in the South African health care context. The findings from this study challenge the existing practice of teaching students to use a traditional case history approach in consultations with patients.

This study has dispelled the myth that, owing to the increased lengths of the utterances in a narrative, interpreting would be compromised when the CN method was used. In contrast, it was shown that the CN method is beneficial in interpreted encounters as it bridges the divide between the clinicians and patients, regardless of the cultural or linguistic divide. This study adds knowledge to the field of interpreting and to adopting a more linguistically and more culturally appropriate approach. Investigation into the two methods sheds some light on interpreting practices within the field of SLHT and, likewise, knowledge on the two methods was gained from investigating the interpreting aspect of the consultations.

It is believed that this study acknowledged the direction in which health care is moving through its investigation of consultations with a black, Xhosa-speaking clinician and interpreter-mediated consultations with a white, English-speaking clinician and Xhosa-speaking patients.

The multiple methods of analyses and the stringent measures of reliability ensured that this area was comprehensively and reliably documented. The depth of analysis of the interpreting aspect of the initial consultations was possible owing to the researcher's prior experience in analyzing interpreted consultations. The researcher's knowledge of interpreting was particularly important in the data collection and the analysis process. Without this, the complexity of the interpreted consultations might not have been apparent. Until recently, the issue of interpreting within SLHT has not been formally documented. This study is unique in its in-depth analysis of interpreting, using the cultural narrative method. This analysis is felt to be beneficial to the field of SLHT, as well as to informing knowledge in the areas of both narratives and interpreting.

Although attempts were made to record consultations which were realistic and reflected the existing health care situation, the reader is reminded that the clinicians selected and employed in this research had good interpersonal skills and were both culturally sensitive and very open to suggestions for making their interactions with patients more culturally appropriate. Furthermore, the clinicians and the interpreter were working in programmes that were geared towards providing patient-centred care. This provided a platform upon which to examine both methods in an optimum environment. The use of clinicians with poorer interpersonal interaction skills and who were less focused on providing patient-centred care, or the use of an untrained interpreter, might have had less positive results for both methods. Likewise, had the clinicians and the interpreter had additional experience with working with the CN method, the results might have favoured the CN method to an even greater extent.

The impact of language and culture on clinical assessment and diagnosis has been previously documented. However, it is felt that much of this past research remains within a theoretical and academic realm. In contrast, this study is believed to have direct clinical applications that can be employed immediately and provide one small step towards practically executing 'Cultural Speech Language Pathology'. This study differs from other studies exploring the use of narratives in gathering information in terms of its

comparative design, multiple methods of analysis, and the context in which it was carried out. This study adds to the existing research on narratives in clinical practice, which have been critical in increasing the interest in this burgeoning area of research.

It was felt that the findings in this study are particularly relevant to the existing South African context in light of the move towards transforming health care services and the drive towards providing more patient-centred care. Although this study was conducted in the field of SLHT, it is believed that the results are applicable to other disciplines in health care.

### **6.3 IMPLICATIONS**

Numerous theoretical, clinical and future research implications emerged from this study.

#### **6.3.1 Theoretical Implications**

This study highlighted the need to use clinical methods that are in line with the theoretical framework within which one is working. The clinician's outlook and sensitivity alone are insufficient to achieve biopsychosocial healthcare; instead constructivist methods, which are in line with the holistic biopsychosocial approach, are needed to this end. Obviously, the sensitivity of the clinician to the patient's needs impacts on the cultural appropriacy and patient-centredness of consultations. However this can be optimized through the adoption of more appropriate procedures.

The findings in this study highlighted the need for linguistic and culturally appropriate methods to be adopted in medical encounters, and for tools that will facilitate the execution of such an approach. This study demonstrates that qualitative research should be seen as a useful means of documenting the CN and the TCH methods. The methods of analyses accumulated in rich data that provided new information on the TCH and the CN methods.

### 6.3.2 Clinical Implications

This study highlights the applicability of the CN method to the South African situation. It is believed that this method can be accepted with confidence in clinical practice and in the training of clinicians to gather information from patients. It is hoped that this research has furthered the knowledge within the field on SLHT on how to conduct more culturally appropriate consultations and has provided a step in the right direction for how to answer this 'how' aspect that had been lacking. This research suggests a need to revise existing case history-taking methods, and to put an end to the lip service paid towards providing more culturally appropriate practices. The use of narratives as a procedure in case history taking could form a practical part of clinicians' training towards being more culturally sensitive. Without practical changes such as this, our profession is at risk of remaining entrenched in the dogma of biomedicine.

This study has particularly important implications for interpreted consultations. There is a need for interpreters to have more autonomy. To this end, within our field, clinicians need to be trained to work with interpreters and to acknowledge the positive contribution that interpreters play in cross-lingual consultations. There is a need for both the interpreters and the clinicians who work with them to be less concerned about the accuracy of interpreted consultations, and more focused on the positive contribution that interpreters play.

From this study, a number of needs within the field of SLHT emerged as practical implications, namely:

- The need to explore new and existing but non-traditional methods of patient assessment and intervention from a variety of disciplines
- The need for patient-centred care to become a priority of health professionals, and training institutions
- The need to use appropriate measures, such as using interpreters as mediators and the CN method, to reduce the problems of multilingual and multicultural consultations.

Ultimately though, the narrative method has the most significant clinical implications for the patients with whom it can be used. This method suggests that medical consultations, which have traditionally been associated with patient disempowerment, could provide a platform upon which to build on patients' self-esteem and sense of community so that the patients are ultimately empowered and acknowledged as experts in their own right. The narrative method could have immediate social and community benefit to previously disadvantaged groups of patients.

### **6.3.3 Future Research Implications**

The use of the narrative method, which has been informed by the fields of anthropology, linguistics and sociology among others, provides the opportunity for collaboration between disciplines in researching this method. It is the researcher's belief that in future research, the SLHT can bring specialist discourse skills to exploring this method even further, from which all of the health-related disciplines would benefit.

It is believed that continued research regarding the provision of culturally relevant services is important for improving the quality of health services. The narrative method needs to be explored further across different cultural groups and the health disciplines. Further research into the application of the CN method in consultations with untrained interpreters is needed. In addition, research centred round the training of students and clinicians to work with the CN method and into the effects of this training is required. The applicability of the cultural narrative as an appropriate tool in a diverse and developing country such as South Africa suggests that it could form the basis of both future clinical interactions and research initiatives.

*"Stories may have endings, but stories are never over."*

(Bruner, 1986: 59)

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## APPENDIX A INTERPRETER JOB DESCRIPTION

### Job description: Cultural Broker

The role of the cultural broker is twofold, namely **translation and cultural mediation**.

#### 1. TRANSLATION of:

##### a) Communicative interactions between:

-Therapists and caregivers

(e.g., in taking a case history, counseling, explanations and instructions)

-Therapist and patients

(e.g., instructions in hearing testing)

-Therapists and other professionals

(including health care workers, nurses, doctors, teachers, etc)

##### b) Written Material

(e.g., public awareness material, resource material for patients, caregivers and other professionals)

##### c) Presentations

(e.g., presentation on project, hearing impairment etc. to various professionals and members of the public)

#### 2. CULTURAL MEDIATION by assisting:

a) the audiologist in the understanding and interpretation of cultural beliefs and translations

b) the client in the understanding and interpretation of information mostly related to the medical model.

## APPENDIX B TRADITIONAL CASE HISTORY FORM

### CASE HISTORY FORM

#### 1. GENERAL AND BIOGRAPHICAL INFORMATION

Date: \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Name of Parent/ Caregiver – Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Occupation of the Caregiver – Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Referred By: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Onset, Duration and Possible Cause of the Current Problem: \_\_\_\_\_

Please list the people or clinics you have consulted about your child's problem. This should include paediatrician, psychologist, neurologist, and social worker

Date	Name and Address	What were you told
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## 2. PRENATAL AND BIRTH HISTORY

During your pregnancy were there any problems? \_\_\_\_\_

If Yes, Please specify: \_\_\_\_\_

What was the length of the pregnancy? \_\_\_\_\_ Baby's Weight: \_\_\_\_\_

Type of Delivery:

Normal: \_\_\_\_\_ Forceps: \_\_\_\_\_ Caesarian \_\_\_\_\_ Breech: \_\_\_\_\_

Other (specify): \_\_\_\_\_

Agpar score: \_\_\_\_\_

Were there any problems during labour? (if so please specify) \_\_\_\_\_

Illness at birth and during the 1<sup>st</sup> Two weeks of life:

- \_\_\_\_\_ Cry (strong, week, high) \_\_\_\_\_
- \_\_\_\_\_ Jaundice
- \_\_\_\_\_ Difficulty with breathing
- \_\_\_\_\_ Feeding difficulties
- \_\_\_\_\_ Convulsions
- \_\_\_\_\_ Infections (specify) \_\_\_\_\_
- \_\_\_\_\_ Medication
- \_\_\_\_\_ Tube fed
- \_\_\_\_\_ Haemorrhage
- \_\_\_\_\_ Convulsions
- \_\_\_\_\_ Oxygen
- \_\_\_\_\_ Intravenous fluids

How long did the child stay in hospital? \_\_\_\_\_

### 3. MEDICAL HISTORY

How is the general health of your child? \_\_\_\_\_

Has your child had any unusual illnesses? (If yes please specify) \_\_\_\_\_

Has your child ever been hospitalized for any illness? (if yes please specify) \_\_\_\_\_

Has your child ever had any of the following illnesses:

Illness	Age	Hospitalization
_____ Earaches	_____	_____
_____ Middle ear infections	_____	_____
_____ Allergies	_____	_____
_____ Frequent colds	_____	_____
_____ Measles	_____	_____
_____ Diphtheria	_____	_____
_____ Unusually high fever	_____	_____
_____ Epilepsy	_____	_____
_____ Tonsillitis	_____	_____
_____ bronchitis	_____	_____
_____ Polio	_____	_____
_____ German measles	_____	_____
_____ Encephalitis	_____	_____
_____ Meningitis	_____	_____

### 4. DEVELOPMENTAL MILESTONES

**When did your child?**

Sit alone (6-8 months) \_\_\_\_\_

Crawl (7-10 months) \_\_\_\_\_

Walk unaided (11-14 months) \_\_\_\_\_

Become toilet trained \_\_\_\_\_

Start to babble \_\_\_\_\_

Start to say his first words (9 -14 ) \_\_\_\_\_

Combine words into sentences (18-26 months) \_\_\_\_\_

Is your child's motor development normal in comparison to your other children/ his peers? \_\_\_\_\_

## 5. SCHOOL HISTORY

Which school does your child attend? \_\_\_\_\_

What is the medium of instruction in the school? \_\_\_\_\_

Has your child ever attended any other schools (if Yes, please specify) \_\_\_\_\_

Has your child repeated any grades? \_\_\_\_\_

What is his or her progress at the school? \_\_\_\_\_

Are there any school subjects that your child has difficulty with? \_\_\_\_\_

Does your child enjoy reading books? \_\_\_\_\_

## 6. HEARING, SPEECH AND LANGUAGE HISTORY

Does your child prefer to use gestures or words when speaking? \_\_\_\_\_

Which does your child prefer to use? Give examples

- Complete sentence \_\_\_\_\_
- Phrases \_\_\_\_\_
- One or two words \_\_\_\_\_
- Sounds \_\_\_\_\_

Does your child understand directions and conversations? \_\_\_\_\_

Do you think your child can express himself? \_\_\_\_\_

How well can the child be understood:

- By his brothers and sisters? \_\_\_\_\_
- By his friends? \_\_\_\_\_
- By other adults? \_\_\_\_\_

Has your child's hearing ever been assessed? \_\_\_\_\_

If yes, please specify: \_\_\_\_\_

Has your child ever had any ear infections? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Has your child ever been exposed to very loud noise? \_\_\_\_\_

If yes, please specify: \_\_\_\_\_

Does your child ever complain of fullness in the ear or describe the noise in the ear?

Is the child's voice quality normal? \_\_\_\_\_ Laugh? \_\_\_\_\_ Cry? \_\_\_\_\_

Is his/her voice unusually loud? \_\_\_\_\_ Soft? \_\_\_\_\_ Monotonous? \_\_\_\_\_

Does your child become confused with the direction of sound? \_\_\_\_\_

Does your child hear less well in noise? \_\_\_\_\_

Do the noisy environments or loud sounds irritate the child? \_\_\_\_\_

#### 7. GENERAL BEHAVIOUR

Does your child play well with other children? \_\_\_\_\_

Is it difficult to discipline the child? \_\_\_\_\_

Does your child cry often? Describe \_\_\_\_\_

Does your child have temper tantrums?

Does your child seem unusually active or quiet? Describe \_\_\_\_\_

**APPENDIX C THE CULTURAL NARRATIVE QUESTIONNAIRE  
(Xhosa Translation)**

**CLINICAL CULTURAL NARRATIVE ( IsiXhosa)  
IPHEPHA LENCUBEKO LOKUBALISA INDABA**

IINCUKACHA NGawe

Igama lakho: \_\_\_\_\_

Umhla wakho wokuzalwa: \_\_\_\_\_

Ubudala: \_\_\_\_\_

Idelesi: \_\_\_\_\_

Ikhodi yokuposa: \_\_\_\_\_

Inombolo Yemfonomfono: \_\_\_\_\_

Abaegcini bomntwana (bomntu):  
\_\_\_\_\_

IMIBOZU

*„Ndixele konke ngeenxaki zomntwana wakho, uqale ekuqaleni?”*

*„Ingaba umntwana wakho unazo ezinye iingxaki ezizezinye okanye ubunzima?”*

*„Ingaba wena kunye nosapho lwakho/abanye abantu ninxibelelana njani nomntwana wakho kwaye ingaba umntwana wakho unxibelelana njani kunye nawe okanye kunye nosapho lwakho”*

## APPENDIX D CAREGIVER INTERVIEW QUESTIONNAIRE

### POST ASSESSMENT INTERVIEW WITH THE CAREGIVER (ENGLISH)

"I WOULD LIKE TO FIND OUT FROM YOU HOW THIS INTERVIEW WENT, WHETHER YOU THINK THE SPEECH PATHOLOGIST/AUDIOLOGIST DID HER JOB, DID IT GO WELL, WAS IT BAD ETC. PLEASE FEEL FREE TO BE COMPLETELY HONEST, SINCE I VALUE YOUR OPINION AND APPRECIATE YOUR INPUT."

#### THEMES:

##### Information

- How do you feel the interview went today?
- Were you able to tell the speech pathologist/audiologist all about your problems?
- Do you feel the speech pathologist/audiologist knows all about your problems?
- Is there anything important that you were not able to tell the speech pathologist/audiologist about your problems?
- Do you feel that the speech pathologist/audiologist gave you a chance to speak about all your problems?

##### Interpersonal

- How did you feel about the speech pathologist/audiologist? Did you relate to her?
- How did the speech pathologist/audiologist make you feel?
- What would you have changed about the interview today?
- How do you think the interview would have gone if the speech pathologist/audiologist had spoken the same language as you?
- How do you think the interview would have gone if the speech pathologist/ audiologist had the same culture as you?

##### Cultural Appropriateness

- A number of questions were asked about you and your child during the interview. Are there any questions you feel were inappropriate?
- Is there any part of you or your child's illness that you feel it was inappropriate to talk about to the speech pathologist/audiologist?
- Are there any questions that you feel should have been asked about you or your child's illness during the interview?
- Can you tell me why you think your child has this problem?
- Were you happy with the explanations that the speech pathologist/audiologist gave you about the child's problem?
- Is there any other person that you wish to consult about your child's illness?

### **Interpreter**

- There was an interpreter during the session. Do you feel that the interpreter understood everything that you wanted to say?
- Do you think the interpreter explained everything that you said to the speech pathologist/audiologist?
- Do you feel that anything was left out when the interpreter passed on the information to the speech pathologist/audiologist?
- Have you used an interpreter before in the hospital?
- How was the interview different from the last time you used an interpreter? (If applicable)
- Did you feel comfortable during the interview with the speech pathologist/ audiologist and the interpreter? (If applicable) Why?
- Were you happy with the way the interpreter gave you the information?
- How did you feel about the speech pathologist/ audiologist and the interpreter being in the room at the same time during the interview?

University of Cape Town

## POST-CONSULTATION INTERVIEW WITH THE CAREGIVER

(Xhosa)

### INGXOXO-MIBUZO NOMGCINI-MNTWANA EMVA KOKUHLOLWA

„NDITHANDA UKWAZI KUWE UKUBA INGABA LENGXOXO-MIBUZO IHAMBE NAGANO NA, UKUBA UGQIRHA WOKUTHETHA NEENDLEBE UWENZE KAKHULE NA UMSEBENZI WAKHE. INGABA KONKE KUHAMBE KAKUHLE, BEKULUNGILE, BEKUNGALUNGGANGA NJALONJALO. NCEDA KHULULEKA EKUBENI UNYANISEKE NGOKUPHELELEYO, NGOKUBA NDIZIXABISILE IIMBONO ZAKHO”

#### **IZIHLOKO:**

##### **Amava akho**

- Ingaba ucinga ukuba ihambe njani ingxoxo-mibuzo yanamhlanje?
- Ingaba ube nakho na ukuxelela ugqirha wokuthetha neendlebe ngazo zonke iingxaki zakho?
- Ingaba ucinga ukuba inenekazi leendlebe nokuthetha lazi konke ngeenxaki zakho?
- Ingaba kukho enje into ebalulekileyo othe awabi nakho ukuyixelela ugqirha wokuthetha neendlebe malungana neengxaki zakho?
- Ingaba ucinga ukuba igqirha wokuthetha neendlebe ukunikile ithuba elaneleyo lokuthetha ngazo zonke iingxaki zakho?

##### **Okwengamelene nawe**

- Ungaba uziva njani ngogqirha wokuthetha neendlebe, ube nakho ukuqondana naye?
- Ingaba ugqirha wokuthetha neendlebe ukwenze waziva njani?
- Ingaba bunganokutshintsha ntoni na namhlanje malunga nengxoxo-mibuzo?
- Ingaba ucinga ukuba ibinokuhambe njani lengxoxo- mibuzo ukuba ugqirha wokuthetha neendlebe ubisithetha ulwimi olifanayo kolwakho?
- Ingaba ucinga ukuba ibinokuhamba njani lengxoxo-mibuzo ukuba ugqirha wokuthetha neendlebe ubenengcubeko efanayo kweyakho?

##### **Okwamkelekileyo ngokwencubeko yakho**

- Iqela lemibuzo liye labuzwa malunga nawe kunye nomntwana wakho ngexa lengxoxo-mibuzo. Ingaba xa unokukhumbula iye ykhona imibuzo ocinga ukuba ayamkelekanga?
- Ingaba kukho into ngawe okanye isigulo somntwana wakho ocinga ukuba ibingamkelekanga ukuba kungathethwa ngayo?
- Ingaba ikhona imibuzo ethile othe awayonwabela ngelixa lengxoxo-mibuzo?
- Ingaba ucinga ukuba yintoni unobangela weengxaki zakho?

- Ingaba wenelisekile ngengcaciso othe wayinikezwa ngugqirha wokuthetha neendlebe ngonobangela weengxaki zomntwana wakho?
- Ingaba ukhona omunye umntu oceba ukudibana naye malunga neengxaki umntwana wakho anazo?

#### **Umntu otolikayo**

- Bekukho inenekazi elitolikayo ngexa lengxoxo-mibuzo. Ingaba ucinga ukuba uolika ukwazile ukuthetha yonke into obucinga ukuyithetha?
- Ingaba ucinga ukuba utolika uthethe yonke into obucinga ukuyithetha kugqirha wokuthetha neendlebe?
- Ingaba ucinga ukuba kukho into othe wangayithetha utoloka kugqirha wokuthetha neendlebe?
- Useke waba naye umntu otolikayo xa usesibhedlela ngamphambilini?
- Ingaba lengxoxo-mibuzo ike yahluka kunjani nezinye othe waba nazo ngamphambilini?
- Ingaba uzive njani kwingxoxo-mibuzo ngelaxesha kukho ugqirha weendlebe kanye namntu otolikayo na?
- Ingaba njani ngendlela umntu otolikayo akunike ngayo ingcaciso?
- Ingaba ukufumana kunjani ukubakho ugqirha wokuthetha neendlebe kanye nenenekazi elitolikayi egumbini alinye ngexa lengxoxo-mibuzo?

## APPENDIX E

### ASSESSMENT OF POST-CONSULTATION INTERVIEW

Session:                      Caregiver:                      Length of interview:                      Language:

1. Others present during the interview:

- No
- Husband/partner
- Other adults
- Children

2. Other distractions during the interview:

- No
- Noise
- Noise of others outside interview
- Other (specify)

3. Interviews affected by others present and distractions:

- Not affected
- Moderately affected
- Severely affected

4. Informant characteristics:

- Very cooperative
- Quite cooperative
- Not cooperative, difficult to interview
- Nervous respondent
- Physical disability

5. Equipment:

- No Problems
- Poor sound quality
- Poor lighting
- Poor visuals

6. Ideas from interview which need to be followed up:

8. Overall rating of session:

- Above average
- Average
- Below average

## APPENDIX F

### DURATIONS OF THE CONSULTATIONS

#### Overall Duration of Consultations

	1	2	3	4	Avg
WC TCH	34 mins	40 mins	36 mins	60 mins	42.5 mins
WC CN	30 mins	22 mins	58 mins	40 mins	37.5 mins
BC TCH	42 mins	34 mins	14 mins	22 mins	28 mins
BC CN	11 mins	9 mins	12 mins	8 mins	10 mins

#### Duration of the Case History Section of the Consultations

	1	2	3	4	Avg
WC TCH	26 mins	40 mins	24 mins	40 mins	32.5 mins
WC CN	18 mins	12 mins	50 mins	24 mins	26 mins
BC TCH	36 mins	24 mins	10 mins	22 mins	23 mins
BC CN	5 mins	5 mins	8 mins	4 mins	6 mins

#### Duration of the Feedback Section of the Consultations

	1	2	3	4	Avg
WC TCH	8 mins	None	12 mins	20 mins	13 mins
WC CN	12 mins	10 mins	8 mins	16 mins	11.5 mins
BC TCH	6 mins	10 mins	4 mins	None	7 mins
BC CN	6 mins	4 mins	4 mins	4 mins	5 mins