

# **INTERPRETING AND THE CLINICIAN**

## **A conversational analysis of the interpreted consultation in a paediatric hospital**

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## DECLARATION

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## DEFINITIONS AND EXPLANATIONS OF TERMS

<b>SANPAD</b>	South African Netherlands Programme on Alternatives in Development
<b>PPI</b>	Provider patient Interpreter Interaction
<b>NLP</b>	National Language Project

## ABSTRACT

The utilization of interpreters in medical interviews has increasingly become a focus of research, both globally and in South Africa. Effective communication lies at the core of the delivery of a patient-focussed approach to health care and this has been a factor in the drive to improve service delivery, especially from a communication perspective. A number of studies in health care have focussed on the medical interaction between health professionals and their patients. In this study, the aim was to describe and analyse interpreted diagnostic consultations, specifically focussing on the interactions between the health professional, trained interpreter and caregiver. The research was conducted at a tertiary level children's hospital in Cape Town. A qualitative research design was employed in this study. The participants were three health professionals [medical doctors], and a trained interpreter, all employed at a tertiary level children's hospital in the Western Cape, and three caregivers of the children attending the outpatients department. Video recordings of initial assessment consultations were made and thereafter each participant in the consultation, was interviewed. Detailed analysis of the consultations was done using the methods of conversational analysis. Thematic analysis of the post-consultation interviews was done and the findings triangulated with the themes emerging out of the conversational analysis. The findings resulting from the conversational analysis, suggest that interactions taking place in this study could be described as institutional interactions. This was suggested on the basis of the patterns of interactional behaviour, which emerged in the communications of the participants, the interactional strategies used and the interpreter models employed. The need for training for health professionals in interactional strategies also became apparent and highlighted aspects, which may be included in future training of health professionals, which may serve to advance the quality of communication in medical interactions.

**Keywords:** trained interpreter, medical interaction, conversational analysis, institutional interactions, interactional strategies, interpreter models

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## CHAPTER 1: INTRODUCTION

Since the enactment of the Interim constitution in 1993 and subsequently the adoption of the final constitution in 1996, the focus on upholding the rights of previously disadvantaged languages has started a new trend in all spheres of society. The principles contained in the constitution promoted amongst other aspects, the promotion of multilingualism and the provision of translation facilities. (Cf. Section 3[9][d], 1993 Constitution cited by Du Plessis in Erasmus, 1999) The provisions in the constitution had initially led to much optimism and excitement among language practitioners, specifically, interpreters and translators. The prospect held within it the promise that the new language policy, which would come later, would encompass these principles amongst others. Although, there have been initiatives to address language issues especially in legal and political arenas, in the health care field, the changes have been slow in coming and the impact of language differences is still quite significant.

Effective communication lies at the core of the delivery of a patient-focussed approach to health care. Historically in South Africa, the delivery of effective communication has been hindered by language differences between health professionals and their patients. South Africa has 11 official languages of which English and Afrikaans are the two most commonly used in formal communication, although the majority of the population are unable to speak either language. English, which is one of the languages used for governmental purposes, is reported to be the home language of only 9% of South Africans (Schering, 1993 in Drennan, 1998). Given the current language situation, the need for interpreters has long existed, primarily because it is the majority and not minority of the populace who requires interpreting (Drennan, 1998). Certain health care institutions have started addressing this need in recent years, by training and employing interpreters. The paediatric hospital in this study is one such health care institution. This study, therefore aims to describe and analyse interpreted diagnostic consultations, specifically focussing on the interactions between the doctor, trained interpreter and caregiver. It is hoped that the analysis will provide a deeper understanding of what occurs in the interaction and perhaps also highlight aspects, which impact negatively or positively on the interaction.

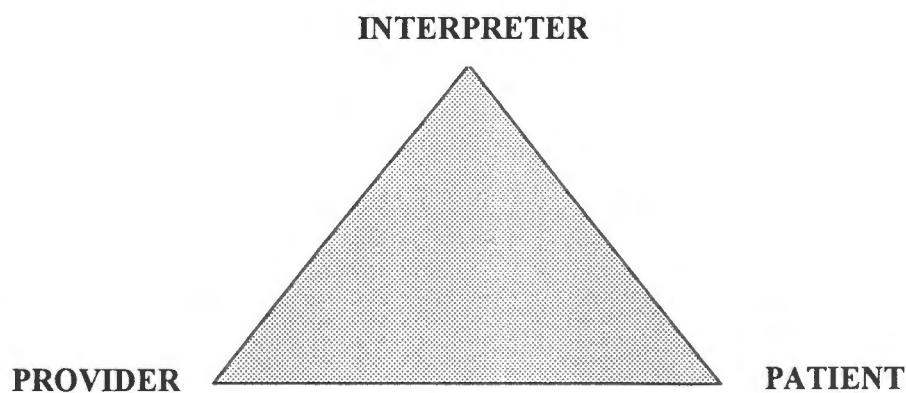
This study forms part of a larger research project, namely the South African Netherlands Programme on Alternatives in Development (SANPAD), Health Care Interpreting Project, called *Interpreting in the Health Sector: Towards the development of policy and Training in South Africa*, funded by SANPAD South Africa. The purpose of this larger project has three primary aims. The first of which is to document the environments in which interpreters are used within the health sector. The second aim is to document the mediated interview focussing on the health professional. Finally, the projects aims to implement and conduct formative evaluations of the training of health professional's in the use of interpreters. Previous studies have focussed mainly on the interpreting practices in health care and comparisons between trained and untrained interpreters (Evans, 2000; Fisch, 2001).

In both these studies, caregivers were involved in the interactions with the health professionals and trained and untrained interpreters. Another concurrent study in this project has focussed on achieving the first aim mentioned above, namely to document the environments in which interpreters are used within the health sector. This study was conducted utilizing ethnographic means of investigation. Whereas studies by Evans (2000) and Fisch (2001) were focussed on the speech and language therapy and audiology professions, this study is the first in this project to focus on the medical profession. This study has therefore endeavoured to achieve the second aim in the project, namely documenting and describing the mediated interview. The combination of the two studies provides detailed information as well as general information, both quantitatively and qualitatively.

In the South African healthcare system, there is a vast language barrier between patients and clinicians in all spheres of health care. Most health care professionals, with the exception of nurses, are either English or Afrikaans speaking. Consequently, they are unable to communicate with patients who are speakers of indigenous languages (Drennan, 1998). Given the current language situation in South Africa, it is well recognised that the extent of the South African interpreting problem is far greater than anywhere else in the world (Erasmus, 1999). According to Wood (1993), many interactions between doctors and patients in South Africa are conducted through interpreters, albeit informally. Lesch (1999) has indicated that community

interpreters would be the ideal option to address the complex linguistic situation in South Africa and the relatively deprived level of education of patients. The use of community interpreters thus enable a health professional and a client from very different backgrounds and an unequal relationship of power and knowledge to communicate their mutual satisfaction, thereby improving their inter-cultural understanding (Shackman, 1987:18 in Boloka, 1999).

It is, however, important to recognise that even when a patient and clinician share a language and culture, communication between the two is fraught with complexity arising from differing expectations, backgrounds, educational levels, age and class among other factors. Furthermore, even when a health professional is able to communicate with a patient in his/her own language, combined with cultural qualities of communication, this impacts on the effectiveness of the medical encounter. When the interpreter joins the interaction, communication becomes even more complex (Faust and Drickey, 1986). The provider, patient and interpreter triangle represents the triad, which occurs in a mediated situation. The Provider Patient Interpreter interaction (PPI) can also be viewed as a set of dyads, which occurs in an interpreted situation.



**Figure 1 PPI diagram depicting the triad in a medical situation**

In a situation where the patient and the health professional share the same language, having a successful interaction has been shown to be difficult within itself. Global moves, to change to a patient centred approach to health care has highlighted effective communication as being central to this approach. As a result there has been a surge of research exploring the interactions between health professionals and their patients. The purpose of this being that the obstacles, which prevent effective communication,

may be overcome through information and education. According to Jones (2003) it is because of this that the study of discourse in health care has gained attention in recent years. It is still, however, regarded as an under-researched area in health care. Conversational analysis has been identified by Drew, Chatwin and Collins (2001), as a methodological approach, which offers new insights into medical interaction and communication. The argument is that conversational analysis is able to identify patterns of behaviour, which health professionals could take into account more consciously when interacting with their patients. In addition, conversational analysis is suggested to identify interactional strategies, which may facilitate patient involvement in discussions and decisions about health care. Finally, conversational analysis allows exploration of the association between certain interactional styles and certain outcomes (Drew et al., 2001). Conversational analysis has therefore been shown to be a research approach which allows not only for an understanding of the medical interaction, but also serves to provide knowledge which can be used to improve communication strategies adopted by health professionals. In terms of research into interpreting in health care, to the best of the researcher's knowledge, this study is the first to use conversational analysis as an analytical approach to an interpreting study.

Although the act of interpreting has been occurring in health care for a long time, the interpreting systems different institutions rely on are not easy to specify. Robert (1997 in Drennan, 1998) coined the term *ad hoc* to describe the interpreting system used. This most often involves haphazard interpreting arrangements as the need arises, where anyone who speaks the language is called to interpret (Swartz, 1992a). This particular situation is not specific to South Africa, but has been reported in other parts of the world as well (De Ridder, 1999; Fernando, 1995). Despite the *ad hoc* appearance of the interpreting situation, there has always been a degree of informal organisation in particular settings (Crawford, 1994). Nursing staff, paramedical, or non-medical ancillary staff are often called on to interpret for patients, to such an extent that African black nursing staff view interpreting as a routine part of their job. (Drennan, 1998) The problem with this is that such personnel are not paid to interpret and receive no formal training or recognition for their service. Furthermore, the arrangement can be criticized on two counts. Firstly, interpreting is not part of their

job description and this often leads to tension between interpreting and requirements of their formal duties. Secondly, issues of confidentiality may arise (Wood, 1993). De Ridder (1999) has also indicated that both accessibility and quality of a service deteriorate when communication breaks down or when ad hoc interpreters are used.

The current situation in a multilingual, multicultural society like South Africa therefore makes it necessary for interpreted interviews to remain the primary method of bridging the communication barrier (Ntshona, 1999). Although, the Constitution brings language to the forefront in striving for equity, the reality is that the process is very long and tedious and that without the use of interpreters, speakers of indigenous languages are multiply disadvantaged (Drennan, 1999). Good quality health care is therefore seriously compromised by the inappropriate use of language or by inadequate verbal communication. In order to facilitate equity as well as accessibility to health care services, professional interpreting service providers need to become permanent members of the multi-disciplinary team. As idealistic as that may seem, it is a necessity as the present utilization of interpreters in health care institutions is still more ad hoc than organized and trained interpreters are still few and far between (Ngqakayi, 1994).

A number of health related professions have published research on the issue of interpreters. These include the fields of clinical psychology and psychiatry (Muller, 1994, Drennan, 1998, Swartz, 1998), public health (Petros, 1998 in Ntshona, 1999), social work (Devenish, 1999); pharmacy (Smit, 1999); nursing (Herselman, 1994) and medicine (Wood, 1993). The majority of research on interpreting in the health sector has focussed on the problems associated with the interpreters (Penn, 2000). Lang (1975) found that interpreters were prone to initiating their own questions, either for purposes of clarifying a previous answer or to demonstrate their own medical knowledge. Interpreters were perceived as displaying little sensitivity, interrupting the flow of patients' responses indiscriminately when the amount to be translated became substantial. Kline, Acosta, Austin & Johnson(1980) conducted a study in a psychiatric facility on the perceptions of patients and psychiatric registrars on the use of interpreters. Their findings indicated a disparity between the registrars who felt that the presence of the interpreter reduced the potential for a therapeutic relationship to develop and the patients who felt quite positive and were keen to return under the

same circumstances. Muller (1994) postulates that focussing on the problems associated with using an interpreter may be the case as accuracy of the interpretation is considered to impact heavily on diagnostic assessment and management. Hence, past research has referred often to mistranslation in a range of different ways (Ebden, Carey, Bhatt & Harrison, 1988; Price, 1975). These have been referred to as "errors" (Vasquez and Javier, 1991; Price, 1975), "distortions" (Marcos, 1979) and "illegitimate advances" (Launer, 1978).

According to Evans (2000) these terms suggest negative connotations. Evans (2000) and other researchers such as Marcos (1979); Vasquez & Javier (1991); Swartz (1998) and Fisch(2001) have focussed on other aspects of the interpreting situation. These include errors, their possible causes, who should be interpreting, need for interpreters within the health sector, strategies to improve interpreted consultations and the benefits of using trained interpreters as opposed to untrained *ad hoc* interpreters. A recent study by Bolden (2000) also examined the role interpreters play in structuring the interaction between doctors and patients. She too moved away from focussing on the problems associated with using interpreters and aimed at analysing the interpreter's involvement in the interaction with a view to understanding the interpreter's actions. Bolden concluded that interpreters' participation in the interaction is organized by their understanding of the goals of the interaction, in that case, history taking, rather than by the task of the translation task alone. Interpreters were thus shown to pursue issues in the interview, which they regarded as relevant to the purpose of the interview.

The focus of research on interpreting has therefore moved away from the problems associated with using interpreters to the issue of how to make interpreters meet the needs of the community they serve. Westermeyer (1990) has gone as far as making recommendations regarding the training of potential interpreters. Recommendations such as familiarity with general medical care, ability to work as a team member, fluency and literacy in both languages use in the interaction, didactic and in-service training and supervision by an experienced interpreter. Furthermore, he suggests that that the interpreter should understand the task at hand, it's purpose and the means for achieving it, training in medical terminology and various aspects of the doctor-patient relationship (Goodenough, 1980). Westermeyer(1990) suggests that training with

regard to techniques of interviewing, the importance of non-verbal communication, cultural influences and methods about asking about matters, which do not come up in ordinary conversation, should also be included in training. Although, the recommendations are relevant and would clearly lead to a highly trained interpreter, it places all the responsibility on the interpreter. There is a lack of expectation from the health professional to contribute toward a successful medical encounter. Recently, this focus has shifted from blaming the interpreter for inaccuracies to addressing the involvement of the clinician in the mediated interview (Muller, 1994), an aspect, which has been largely overlooked, as well as the involvement of the institution as a whole. The shift has therefore come full circle to recognise the complexity of the interpreting situation. The mediated situation introduces a third person to the consultation, which could have a lasting effect on the relationship between the clinician and patient.

Varieties of interpreter roles have also been identified (Evans, 2000; Fisch, 2001). Conflict within the interpreter because of these multiple roles has also been documented (Kaufert & Koolage, 1984; Swartz, 1998). Apart from acting as multi-disciplinary team members, interpreters also have to act as *cultural brokers* in some contexts. This is useful for establishing meaningful links in the provision of health care in cross-cultural settings where there are members of different language and socio-economic groups. (Herselman, 1994) Recent literature has focussed on the complexity of the interpreting issue as being embedded within the institutional and societal discourse associated with race, identity, community, alienation and the practice of health care (Kaufert & Putsch, 1997; Swartz, 1998; Drennan, 1999a, 1999b). The organisational processes and the structure of services need to be considered, as any interpreter could be limited in efficiency by this complexity. (Drennan, 1999) Power relations or hierarchy and cultural sensitivity within an institution can affect the interpreted consultation. There has also been a wealth of research on interpreter training programmes, which have been developed specifically for the South African situation; based on local needs and international expertise. (Swartz, 1994; Corsellis, 1999; Ntshona, 1999, Van Dessel, 1999; Ulyyat, 1999) The ethical necessity for available interpreting services has been recognised and it has argued that a failure to provide such a service could be construed as racism (Drennan, 1999b).

Theory and research on interpreting within a clinical setting is both sparse and highly technical in nature (Muller, 1994). In the past, the issue of interpreters has been discussed largely within the basic tenets of the medical model as opposed to a patient-centred model. The basic tenets of the medical model are scientific rationality, with emphasis on objectivity and numerical data (Helman, 1996). The recent medical trend has, however, shifted away from the medical model to a more patient-centred approach. It has been shown that this patient-centred approach is even harder to achieve in interpreted consultations than in non-interpreted consultations, as the questions are usually closed, thereby emphasising the clinician-led focus of the interview. The power of the clinician in interpreted interviews has been examined as a result of the power relationship between the clinician and patient. This fits into the Black Box model of interpreting (Westermeyer, 1990 & Wood, 1993) wherein the doctor retains control of the interaction and requires as direct a translation of his or her questions and the responses of the patient. This model has proven to be limiting in a medical context as many basic concepts in medicine are not directly translatable into another language and the same applies to the patient's conceptualisation of the disease. Many authors, however, consider this to be the appropriate way for an interpreter to function (Wood, 1993).

In Kleinman's terms (1980) the patient's explanatory model of her illness or condition is not engaged as she occupies a minimally powerful position in relation to the clinician's knowledge and power. As Foucault(1977) insists, power engenders bodies of knowledge.

*"Knowledge is Power"*  
*Sir Francis Bacon(1561 – 1626)*  
*Religious meditation of Heresies, 1597*

Although, the patient is in the position to seek alternative treatment to an extent, there is an imposing reality of two staff against one patient (Westermeyer, 1990). In the South African context, these power relationships may be further complicated by the remnants of racial disempowerment: a legacy of apartheid (Evans, 2000).

Although the aspects mentioned by Drennan (1998) will differ in other medical settings, some will be as apparent in mainstream medical practice as they are reported to be within the field of Psychiatry. There is however, a paucity of research on interpreting in other para-medical health services such as physiotherapy and occupational therapy. Research on interpreting in recent years in speech and language pathology has grown. Penn (2000) presented a paper titled "*Cultural narratives: Bridging the Gap*" at the second international symposium on communication disorders in multilingual populations. Penn (2000) focussed on the new field of Cultural Speech Language Pathology and the use of narratives as a cross-cultural tool. It was acknowledged that the special characteristics inherent in the interpreted consultations should form part of the clinician's training. Furthermore, training of clinicians should involve teaching them strategies to find out their patient needs in a variety of intercultural communications, as opposed to just learning the specifics of a culture (Penn, 2000). Research by Evans (2000), has focussed on the positive mistranslation of interpreters and the roles undertaken in the interpreted situation. Focus was also made on using untrained versus trained interpreters and the resulting benefits of the latter (Evans, 2000). Evans (2000) devised the *Mistranslation Analysis Tool (MAT)*, which proved to be a useful tool to assess the success of an interpreted interview. Later research by Fisch (2001) further used the *MAT* to develop a set of guidelines for training of interpreters and clinicians in health care.

In contrast to other types of discourse analysis, Conversational Analysis (CA) as a research tradition has focussed on the discovering the organization of the meaningful conduct of people in society, that is, how people in society produce their activities and make sense of the world about them. Conduct is not limited to informal talk, but includes formal or "institutional talk" as well (Pomerantz and Fehr, 1997). Conversational Analysis extends interest to include both the verbal and paralinguistic features of talk, such as pauses, gaps and restarts. Some researchers have extended the scope of CA to include the visually available features of conduct such as gesture, orientation and posture (C. Goodwin, 1981; Heath, 1986). Similarly to other approaches, CA has shifted away from the search for causes of human behaviour toward the explication of how conduct is produced and recognized as sensible and intelligible.

Similarly, other than the research into the field of speech and language pathology, clinical psychology and psychiatry, nursing and social work, to the best of the researcher's knowledge, within the fields of physiotherapy, occupational therapy and medicine, little research has focussed on interpreting. In the medical field, some research has been done, focussing primarily on the problems associated with the interpreter on a global level. Crawford (1994) studied the interpreting situation with doctors and nurses on a global level from the perspective of social science. The study was undertaken at two hospitals in the Western Cape. Interviews with medical doctors indicated that generally doctors felt that the interpreting processes in their hospitals were satisfactory and that the presence of an interpreter, usually a nurse, was very helpful as it helped them to acquire a working knowledge of Xhosa, the predominant African language spoken in the province. Doctors also felt better once they could hear whether an interpreter was omitting, adding or changing information in an interpretation. The problems reported by doctors, however, outweigh any of the positive aspects reported. Time constraints were reported to significantly affect the interpretation process. The pressures of time prevented doctors from eliciting a full account of the problem from the patient. This could be seen as a result of poor communication skills and certainly moves away from the patient-centred approach.

Crawford (1994) suggests that although the time pressures are a valid concern, citing the lack of time is also an automatic first line of defence against change. Another problem reported was a vast divide of cultural differences between the patient and the doctor. Doctors referred to the difficulty of establishing the onset of symptoms in taking a history because of patients' different concepts of times. Time would not be measured in days and weeks, but in terms of significant events in the patients' lives. Some also reported finding that most patients' had a deep-seated idea that illness was related to a dislocation in their spiritual context. The western biomedical model was therefore not easily applied and could not help to explain all cases, because of the incompatibility between natural and supernatural explanations of disease.

Cultural differences therefore played an enormous role in miscommunications between doctors and patients and thus served to broaden the divide between doctor and patient. Although doctors often related cultural differences, there was no mention made of the culture of dominion and the culture of marginalisation, which was

responsible for the power relations, which emerged in the consultations. Some doctors also indicated that the moral values of some of the nurses, who acted as interpreters, intruded in the situations, to the extent that they would not interpret certain information which embarrassed them or which conflicted with their moral values. Others complained that some nurses substituted their own sentiments when giving information to the doctors and antagonised or intimidated patients. The one aspect reported by all doctors in this study probably encapsulated the frustration of working with interpreters. Interpreters often had lengthy discussions with the patient and then would say two or three words to the doctor. A limited knowledge of Xhosa was enough to indicate that the interpretation had been inaccurate. Although the study by Crawford (1994) goes further and relates the problems patients and nurses had with regard to the interpreting process, the problems related by doctors' highlights the necessity for knowledge and training regarding the effective use of interpreters in consultation. Many of the problems associated with the communicative breakdowns in the interpreting scenario have been attributed to errors on the part of the interpreters. The communicative responsibility and skills of the clinician as a contributory factor to a successful mediated situation has seldom been a focus of past research.

Although many of these studies on interpreting have adopted qualitative approaches in their methodology, a study by Friedland and Penn (2003) has been one of the most recent to use conversational analysis as a technique to explore the dynamics of a mediated interview. Conversational analysis as an approach can be differentiated from other forms of discourse analysis in a number of ways. Firstly, it rejects the use of investigator stipulated theoretical and conceptual definitions of research questions. In contrast, conversational analysis attempts to explicate the relevance of the parties to an interaction. Secondly, conversational analysis also considers the temporal organization of an exchange and the interactional contingencies that arise in the development of action and interaction. Finally, conversational analysis treats rules as situationally invoked standards that are part of the activity being analysed rather than seeking a theoretically given form of explanation for human behaviour (Pomerantz and Fehr, 1997). The nature of the analysis is therefore essentially data driven within a grounded theory approach. Friedland and Penn (2003) used conversational analysis to identify the facilitators and inhibitors of a successfully mediated interview. They

suggest that conversational analysis has the potential to remove the cultural bias with which researchers may sometimes approach and analysis and to expose positive and negative dynamics specific to a particular interaction. Furthermore, it is suggested that conversational analysis provides objective measures of conversational success and highlights interview dynamics in ways in which checklists may not do. Conversational analysis therefore allows a full understanding of the dynamics, social and power aspects, shifting roles and pace of the interview (Friedland & Penn, 2003).

As mentioned before, conversational analysis has frequently been used in studies of interactions between doctors and patients, patients and nurses and other health professionals and their patients. Conversational analysis has also been applied quite widely in the field of speech and language pathology. In a study by Goodwin (1995), conversational analysis was applied to describe the conversational success of a person with severe aphasia. Goodwin showed that by using only three lexical devices and other interactional resources and strategies, with a competent speaking partner, the individual was able to make all his/her needs and desires known. Another study by Oelschlaeger and Damico (1998a) used conversational analysis to show how conversational dyads are able to overcome aspects of communication breakdown due to aphasia. In another study in the field of speech and language pathology by Radford and Tarplee(2000), a case study of a 10-year-old child presenting with pragmatic difficulties was analysed using conversational analysis techniques. Findings indicated that their subject used some helpful devices to generate and manage conversational topics but had difficulty collaborating with his conversational partners. In addition, findings suggested that a difficulty in the development of social cognition underlies the interactional problems experienced by children with pragmatic language impairment. The study showed how conversational analysis techniques can be used in the assessment of speech and language difficulties, while providing clear directions for subsequent therapy intervention. Another study by Tarplee and Barrow(1999) used conversational analysis techniques to analyse the interactional work accomplished by delayed echoing of utterances occurring between a 3-year-old child with an autistic disorder and his mother at home. It was argued that the child's echoes served him in important ways as a resource for engaging in reciprocal talk with his mother. They showed how delayed echoes, for this dyad, had an important part to play in the construction of intersubjectivity. Conversational analysis as a

research tradition has analysed communication of both 'normal' and 'disordered' populations. The value of conversational analysis is thus indicated by its use as a tool for analysing disordered communication. Damico & Simmons-Mackie (2003) have suggested that the findings of conversational analysis research in aphasia may be employed in assessment of the conversational abilities of individuals with aphasia. In addition, the work may be valuable in planning and implementing aphasia treatment.

Conversational analysis therefore suggests that a detailed understanding of an interaction may be acquired when applied in research. Whereas prior focus in interpreting research has been on the interpreter, this researcher attempted to understand the interaction as a whole, focussing on the doctor to a greater degree. Similarly in conversational analysis research, the focus has been on the health professional and the patient, whereas this study applied the research tradition to the mediated interaction. The focus on the doctor attempted to identify the demands that the interpreted situation placed on the clinician, which could or could not be met and the reasons for this. In a paediatric setting, the caregiver is the person involved in the mediated situation and this is quite different to a situation in which, patients speak for themselves. Within the medical situation, the doctor is obligated to the child as the patient. The doctor is dependent on the caregiver to provide accurate information and also to fulfil any suggestions or prescriptions made by the doctor. Already the interaction is changed from the simple mediated interview to a more complex interaction.

The fact that the caregiver represents the 'patient' in the initial assessment interviews adds additional complexities to the interaction between the doctor, interpreter and the caregiver. The doctor in this situation not only has to care for the child as the patient, but also take into consideration the caregiver's concerns and feelings in the interaction. The doctor, to some degree is also dependent on the caregiver to follow prescribed advice given so that the patient's health will improve. In some way therefore, fostering a good interaction with the caregiver is almost imperative to providing effective health care and positive outcomes.

Although this may be considered beyond the scope of only this study, the complex nature of interpreting required that the investigation be undertaken at a communicative and interpersonal level. Conversational analysis was therefore selected as a means to achieving the former and interviews with participants for the latter. The research was not confined to any specific indigenous language, although Xhosa is the only official indigenous language in the Western Cape Province. The interpreted language was therefore, not specified beforehand, but was confined to an English translation for purposes of the research.

It is hoped that the findings of this study will contribute to the development of health professionals in the use of interpreting services.

## **CHAPTER 2: METHODOLOGY**

This chapter describes the aims, methodological design and informant selection criteria employed in this study. Description of methods of data collection and methods of analysis are also included in this section. The study was conducted within the healthcare field, in a tertiary level paediatric hospital.

### **2.1 AIMS**

The aims of the study were as follows:

- To describe and analyse the interaction in an interpreted diagnostic consultation through a detailed conversational analysis
- To compare the perceptions of the caregivers, trained interpreter and health professionals with the findings of the conversational analysis.
- Identify the conversational processes which impact on the mediated interview

### **2.2 RESEARCH DESIGN**

The research design employed qualitative research methods. Qualitative research refers to a range of analytic procedures designed to systematically collect and describe authentic, contextualized, social phenomena with the goal of interpretive adequacy (Damico & Simmons-Mackie, 2003). Qualitative research design has proven to be effective in establishing hypotheses for future research, especially when used on an exploratory basis. A major contribution of qualitative research is that it allows one to develop a conceptual framework for understanding what people think of a particular phenomenon, but still leaves room for exploration of new information, which may emerge, from the research (Joubert, Katzenellenbogen and Yach, 1991).

By nature, qualitative research is equated with data gathering techniques which generate narrative as opposed to numerical data. Qualitative data therefore usually takes the form of verbatim interviews and/or field note transcripts. The methods employed include ethnography, in-depth interviews and participant observation, all of which were included in this study (Silverman, 1993). The objectives of qualitative research is to describe and explain the essence of a social phenomenon and its meaning in the participant's lives and by extension in the overall scheme of social

activity. The qualitative researcher adopts a learning role rather than a testing role (Damico & Simmons-Mackie, 2001).

Conversational analysis is a methodology within the qualitative research tradition of enquiry. Conversational analysis is designed to study social interaction through a detailed examination of conversation. The methodology employed focuses on various interactional devices and resources that an individual might use during a time-at-talk. The methodology is described as 'straightforward': a conversational interaction is observed, a question about the interaction is formulated and the interaction is analysed in detail, to establish the methods the participants employ for producing orderly social interactions. Consequently, conversational analysis is reported to provide insightful analysis (Damico & Simmons-Mackie, 2001). The detailed nature of the analytical technique led the researcher to limit the scope of this study as it was deemed sufficient to achieve the aims of this study.

## **2.3 INFORMANTS**

Three distinct categories of informants participated in the study. The first category of informant consisted of health care professionals working at Red Cross Children's Hospital. The second category consisted of the primary caregivers of the children attending consultations at the hospital. The third category of informant consisted of the trained interpreters employed at the hospital.

### **2.3.1 Sample Size**

The study sample consisting of the following:

- Three medical doctors
- One trained interpreter
- Three caregivers attending the consultations at the hospital

Observations of interactions were made in the initial case history consultation.

A total of three assessment consultations and three post session interviews were included in the study.

### **2.3.2 Informant Selection Criteria**

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

#### **2.3.2.1 Interpreters**

The trained interpreters were required to meet the following criteria:

- To be First Language Xhosa speakers (Known as L1)
- To be proficient speakers of English
- To be employed at the paediatric institution in question
- To have received formal training through the NLP (National Language Project)

#### **2.3.2.2 Caregivers**

Caregivers were required:

- To be the primary caregiver of the patient
- To require an interpreter

#### **2.3.2.3 Health Professionals**

In the initial proposal for this study, South African doctors, physiotherapists and occupational therapists not fluent in the language of their patients were to be selected for the study. Difficulties with practical and logistical issues, which will be discussed in chapter 4, resulted in only medical doctors participating in the study. A number of inclusion criteria were, however, set out for health professionals. Health professionals were required:

- To have at least two years experience in the institution. The reason for this was to reduce the effect of acculturation. Acculturation refers to an individual's ability to adapt to an unfamiliar cultural and linguistic environment. Negative acculturation results in "culture shock", which is a temporary feeling of discomfort due to unfamiliar surroundings and the lack of familiar cues in the environment. This feeling of disorientation is usually followed by a period of cultural adaptation wherein the individual goes through the process of adjusting and adapting to the environment. Throughout the process, the individual's perception of the environment changes. Newly appointed health professionals may still have been going through this process and would therefore perhaps not provide a true account

of the experience in the hospital. This would have affected the outcomes of the study (Wichert, 2003).

- To have South African citizenship, although it is acknowledged that foreign practitioners working in South Africa are faced with the same interpreting challenges.

### 2.3.3 Informant description

#### 2.3.3.1 Interpreters

One trained interpreter was employed in the study. Hereafter, she will be referred to as TI. Biographical details describing the trained interpreter are presented in the Table 1.

**Table 1** Biographical details of the trained interpreter

<b>Geographical Area</b>	Khayelitsha
<b>First Language</b>	Xhosa
<b>Other languages spoken</b>	English, Zulu, Afrikaans
<b>Proficiency in English</b>	Good
<b>Medium of instruction at school</b>	Xhosa, English
<b>Level of Education</b>	Matric [12 years of schooling]
<b>Training</b>	NLP Interpreters Course
<b>Length of training course</b>	1 month theory 1 month in-service
<b>Medical Training</b>	HIV Information Workshop for one day
<b>Job description</b>	Interpreter
<b>Experience in job</b>	2 years

The information provided by the trained interpreter was retrieved in the post-session interview and was therefore not controlled. The level of proficiency was determined by conversing with the interpreter for a significant period of time, discussing her

language history, interpreting experience, biographical information and proficiency in English. Specifically, questions regarding her use of English, age of acquisition, exposure to English and her use of English in adulthood were also directed at the informant. The questions for this part of the questionnaire were adapted from Paradis(1987) English History questionnaire and Fisch's(2001) questionnaire. Based on the responses to the aforementioned, a subjective assessment of proficiency was made by the researcher. To the best of the researcher's knowledge, the proficiency of the interpreter who participated in this research was considered sufficient for the purposes of this research.

The interpreter who participated in the study had received secondary education up to a Grade 12 level. She had also received a recognised interpreting qualification, following a training programme, run by a non-governmental organization in Cape Town (Ntshona, 1999). The organization's aim is to facilitate access to healthcare services for linguistically marginalized Xhosa-speaking patients and simultaneously create job opportunities for individuals from disadvantaged backgrounds. No medical training had been undertaken except for a workshop about HIV/AIDS, which was not specifically directed at interpreters. The interpreter in question had been working in the hospital as an interpreter for a minimum of 2 years, and had regularly worked in the outpatient clinics participating in the study.

According to the interpreter, the training programme comprised one month of theory and one month of practical experience. The theoretical course comprised of lectures, group discussions, case studies and role-play. The practical component involved a one-month placement at a hospital under supervision of the course coordinators. Some of the aspects included in the training included advocacy, empowerment, the transmission of information to service providers and patients, communication support and networking (Sanders, 1996 in Ntshona, 1999).

#### 2.3.3.2 Caregivers

The three caregivers who participated in the study will hereafter be referred to as CG1, CG2 and CG3. Biographical details pertaining to the caregivers are presented in Table 2 below.

**Table 2 Biographical details of caregivers**

	<b>CG 1</b>	<b>CG 2</b>	<b>CG 3</b>
<b>First Language</b>	Sotho	Xhosa	Xhosa
<b>Employment</b>	None	None	None
<b>Relation to child</b>	Mother	Mother	Mother
<b>Education level</b>	Grade 8	Grade 7	Grade 7

Caregivers were approached in the waiting rooms of the clinics after having been identified by clinic staff or the trained interpreter as being in need of interpreting services. The participant interpreter assisted the researcher by approaching caregivers for participation in the study.

#### 2.3.3.3 Health Professionals

The medical doctors who participated in this study will hereafter be referred to as D1, D2 and D3. Biographical details describing the medical doctors are presented in Table 3 below.

**Table 3 Biographical details of medical doctors**

	<b>HP 1</b>	<b>HP 2</b>	<b>HP 3</b>
<b>First Language</b>	English	Afrikaans	English
<b>Other languages</b>	Afrikaans	English	Afrikaans
<b>Proficiency in Xhosa</b>	Basic	Basic	Basic
<b>Training regarding interpreters</b>	None	None	None
<b>Years of experience in the field</b>	2 years	> 2 years	>2 years
<b>Frequency of working with the interpreter</b>	Ave 3 times per day	Daily/weekly	Daily/weekly

A basic level of Xhosa includes being able to communicate basic needs or expressions, such as greeting, enquiring about biographical details, such as name, age, address and some medical terminology. Significantly, a basic level of competency does not provide the skills for participating in a conversation. Health Professionals in the clinic were approached in advance and asked to participate in the study.

### **2.3.4 Additional Participants**

In addition to the informants listed above, a number of additional participants were involved in the collection, transcription and translation of data. These include:

- (i) **Participant Interpreter (PI)** for approaching caregivers in clinics and interpreting in post-session interviews with the caregivers.
- (ii) **Transcribers** who transcribed the data verbatim from the video recordings
- (iii) **Translators** who translated data from Xhosa to English and vice versa for back translation employed as a measure of reliability.

### **2.3.5 Participant Consent**

The research was conducted in accordance with the principles embedded in the Declaration of Helsinki. The investigator therefore explained the following to each participant, namely caregiver's, the interpreter and the health professional:

- the nature of the study
- procedures involved, for example that the interaction would be videoed
- expected duration
- potential risks or benefits

There were no medical risks to the participants involved in the study, as data collection was observational and they were therefore only videotaped, once during the initial assessment consultations and for some once thereafter during the post-session interview. The participants were not required to travel in order to partake in the research. There were therefore no travelling costs involved for participants. The participants were informed that participation in the study was voluntary. The participants were required to give consent in writing by a signed statement approved by the ethics committee. If written consent was not possible, verbal consent witnessed by a signed statement from a person not involved in the study would have been accepted. The videotapes were stored by the leader of the 'umbrella' project in the Speech and Language therapy department at a university with restricted access. All the videotaped materials will be destroyed at the completion of the research project.

### **2.3.6 Pilot Study**

A pilot study was carried out with one health professional, an interpreter and a caregiver in the Medical Outpatients Department of the paediatric hospital. The aims of the pilot study were as follows:

- To estimate the time required for the initial assessment interview
- To evaluate the practicalities involved in terms of equipment needs. e.g. video recorder battery life, charging, etc.
- To identify any technical difficulties, which might arise from the video recording or sound quality.
- To measure the effectiveness, appropriateness and time requirements of the semi-structured interview questionnaire developed for the post-session interview.

Based on the pilot study, the following was determined:

- An estimate of the time required to record a consultation and time required to conduct an interview.
- Arrangements had to be made to meet the requirements of the equipment used.
- Although, most of the questions in the semi-structured questionnaire were relevant and appropriate, there was an element of repetition coming through across different themes and questions were therefore modified.

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

## **2.4 INSTITUTIONAL CONSENT**

The project leader of the SANPAD interpreting project obtained the ethical approval and permission to conduct the studies from the Department of Health and the ethics committee and management of Red Cross Children's hospital. A proposal for the research was submitted to the Ethics Committee at the University of Cape Town for approval. A copy of the ethics approval letter can be found in the appendix.

## **2.5 SITE OF STUDY**

The study took place at a tertiary level children's hospital in secondary and tertiary levels of healthcare. Two clinics were involved in the study.

- Medical Outpatients (MOP)

The MOP clinic is involved in providing primary level treatment and serves as an overnight ward for serious cases, where patients may be discharged or moved to another ward for inpatient care.

- **Developmental Clinic**

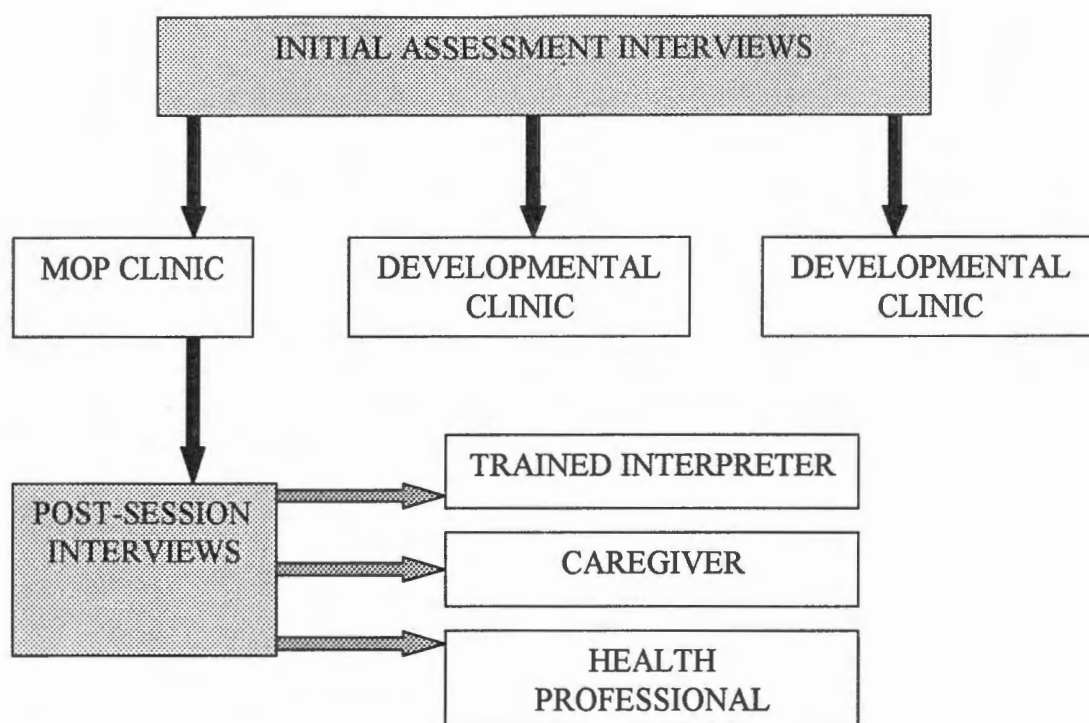
In the developmental clinic, children are assessed by a team of health professionals, to determine whether they have any special needs.

## **2.6 DATA COLLECTION**

The data collected in this research project consisted of two main components, namely:

- Recording of initial assessment interviews
- Conducting and recording of post-session interviews

Each health professional and caregiver participated in one of the three initial assessment interviews recorded. The trained interpreter participated in all three initial assessment interviews. Thereafter, each of the informants in one of the initial assessment interviews was interviewed to obtain their feelings and impressions of the interpreted interview. Three post-session interviews were conducted by the researcher. The participant interpreter (hereafter referred to as PI) was employed to interpret for the caregiver and the researcher in the post-session interview. The post-session interviews were used primarily for triangulation purposes to validate that which was revealed in the Conversational Analysis of the data. The process of the data collection is represented in Figure 1.



**Figure 2** The data collection procedure

## 2.6.1 Procedure

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

### 2.6.1.1 Setting

#### (i) Initial Assessment Interview Setting

The initial assessment interviews were conducted in the treatment rooms used by health professionals in the clinics mentioned above. The reason for this was so that the consultation could take place in a natural environment.

#### (ii) Post-session Interview Setting

All the interviews with the interpreter, caregiver and health professional were conducted in the treatment room or in a private room in the clinic. The post-session interviews were conducted immediately after the initial assessment interview. The frequency of disturbances was controlled as far as possible, but interruptions did occur, usually as a result of actions of people other than the participants. Lutz, Chalmers, Lockerbie & Hepburn (1992) recommend that interviews should preferably be conducted individually with the informant in a reasonably comfortable place away from disturbance.

### 2.6.1.2 Time

The length of time taken for the initial interviews ranged from 20 to 30 minutes. The post-session interviews were 30 to 40 minutes long.

### 2.6.1.3 Interview Recording and Equipment

All sessions and interviews were recorded onto digital videotape. This method was selected over audiotape recording, as it would provide the additional visual cues, which would not only assist in the transcription process, but also allow study of non-verbal behaviours of the informants. The quality of digital recordings was also felt to be better than conventional videotape recordings.

## **2.6.2 Materials**

A questionnaire was constructed for the semi-structured interviews. Questionnaires consisted of five separate sections with a range of eight to twenty questions per section. Separate questionnaires were constructed for health professionals, interpreters and caregivers. Examples of these can be found in the appendix.

### 2.6.2.1 Construction of questions for post-session interviews

The questions included in the questionnaire were based on themes, which had emerged out of the literature (Penn, 2000) as well as guidelines from previous studies (Fisch, 2001). Additional themes were added which were felt to be pertinent to this particular study. A separate questionnaire was developed for the trained interpreter, caregiver and health professional, although the basic themes were employed in each of these. The questionnaires were translated into Afrikaans and Xhosa.

**Table 4 Themes included in the questionnaire**

<b>BIOGRAPHICAL INFORMATION</b> Language History Education/Training Work Experience/Institutional History
<b>ACCURACY OF INTERPRETING</b>
<b>INTERPERSONAL DYNAMICS</b>
<b>SATISFACTION WITH SERVICE</b>
<b>CULTURAL FACTORS</b>

(i) Themes included in the study

The inclusion of the different themes served both a singular and holistic purpose. The inclusion of biographical information in the questionnaire was to provide the background information or 'history' for each participant. It was felt that this would contribute toward social and cultural understanding of the individual's perspective. Language history was included on the recommendations of Paradis(1987) study. The inclusion of biographical information at the beginning of the interview also served to develop rapport between the researcher, participant interpreter and the caregiver.

The participants' perspective on the accuracy of the interview was also considered to be an important issue, in order to compare discrepancies with findings of the conversational analysis. Triangulation between the findings of the conversational analysis and thematic analysis would show any discrepancies between participants' reported perspectives and their actions within the interaction. Similarly, interpersonal dynamics, satisfaction with the service and cultural factors were included to triangulate with findings from the conversational analysis. These themes had emerged in studies by Fisch (2001) and Evans (2000) as the prominent themes for all participants, and were therefore included to ensure that all aspects of significance were addressed.

(i) Principles underlying construction of the questionnaires

*Semi-structured vs. Unstructured Interviewing*

All interviews were conducted in a semi-structured manner, thus following the structure of the questionnaire, but allowing for some deviation from the questionnaire, should matters of interest emerge. The rationale for using a semi-structured manner of interviewing was as follows:

- A degree of structure in questioning is sometimes necessary when participants are interviewed (Marshall & Rossman, 1995)
- 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 and this was therefore beyond the scope of this study (Joubert, Karim & Katzenellenbogen, 1997).
- According to Skinner and Van der Walt (1994 in Joubert et al., 1997) an hour long interview can take up to eight hours to transcribe. The length of the interviews could therefore be limited by employing a semi-structured interviewing method, thereby also limiting the length of the transcription. This was a significant factor bearing in mind the time constraints and the scope of the study.

*Types of Questions*

The questionnaires were developed using the guidelines proposed in Joubert and Katzenellenbogen (1997). Both open and close-ended questions were included in the study. The close-ended questions were less prevalent and were restricted to factual biographical information, while the majority of questions were open-ended. Open-ended questions allowed the researcher to discover the viewpoints of the interviewees without predetermining their viewpoints through prior selection of questionnaire categories. Open-ended questions also allowed for more subjective responses from the informants.

*Phrasing of Questions*

Questions were phrased in a manner, which eased translation into Xhosa. Questions were therefore concise, unambiguous and did not demand a high

level of sophistication from the caregivers. As far as possible, sentences were short and to the point.

### *Language of Questionnaires*

The interpreter and health professionals responded to the questionnaire in English as all felt competent speaking English. This avoided the researcher having to use an interpreter for these interviews. In the interviews with the caregiver, the participant interpreter was employed to interpret in the interviews.

### *Minimising the Interpreter effect*

In order to accurately document the perceptions of the Xhosa-speaking caregiver a Participant Interpreter (PI) was employed to interpret in the post-session interviews. Inaccuracies in interpreted interviews are reported by a number of researchers (Vasques & Javier, 1991; Wood, 1993; Crawford, 1994) and was therefore of concern to the researcher. In the literature reviewed, several authors have recommended a number of techniques to minimize the negative effects of interpreters (Marcos, 1979; Lutz et al., 1992, Swartz, 1998 and Evans, 2000).

Strategies to minimise the interpreter effect:

- The researcher selected the PI based on criteria of language proficiency, previous experience of interpreting for research purposes in Speech and Language therapy and knowledge of the caregiver's culture.
- After selecting the PI who also happened to be a qualified Speech and language therapist, the researcher spent some time working through the aims of the research project, description of the procedures, the target population and a copy of the questions to be asked in the interview.
- The PI also participated in the pilot study to identify any potential problems, which might have arisen later in the study.
- In order to facilitate accuracy in the post-session interviews, the PI was also the person who approached the caregiver in the waiting room,

arranged for consent and answered any questions the caregiver might have had. This created an opportunity for developing rapport, which, impacted positively on the post-session interview.

### *Participant Interpreter*

The PI was a 28 year old, female who is a Xhosa L1 speaker, newly qualified as a Speech and Language Therapist.

## **2.7 TREATMENT OF DATA**

The data from the recorded consultations and the data from the interviews were analysed separately.

### **2.7.1 Transcription of raw data**

Each recorded consultation 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). Two university graduates who were Xhosa L1 speakers carried out transcription of the recorded consultations and post-session interviews conducted in Xhosa. The researcher transcribed the post-session interviews, conducted in English. This proved to be useful in terms of familiarising the researcher with the data as well as beginning the process of analysis as recommended by Minichiello, Aroni & Timewell (1990). Selection criteria for transcribers of the Xhosa dialogue were as follows:

- Xhosa L1 speaker
- University graduate/student

### **2.7.2 Translation of raw data**

University graduates who were L1 Xhosa speakers also translated all transcriptions into English. This assisted the researcher who is an L1 English speaker.

Selection criteria for translators were:

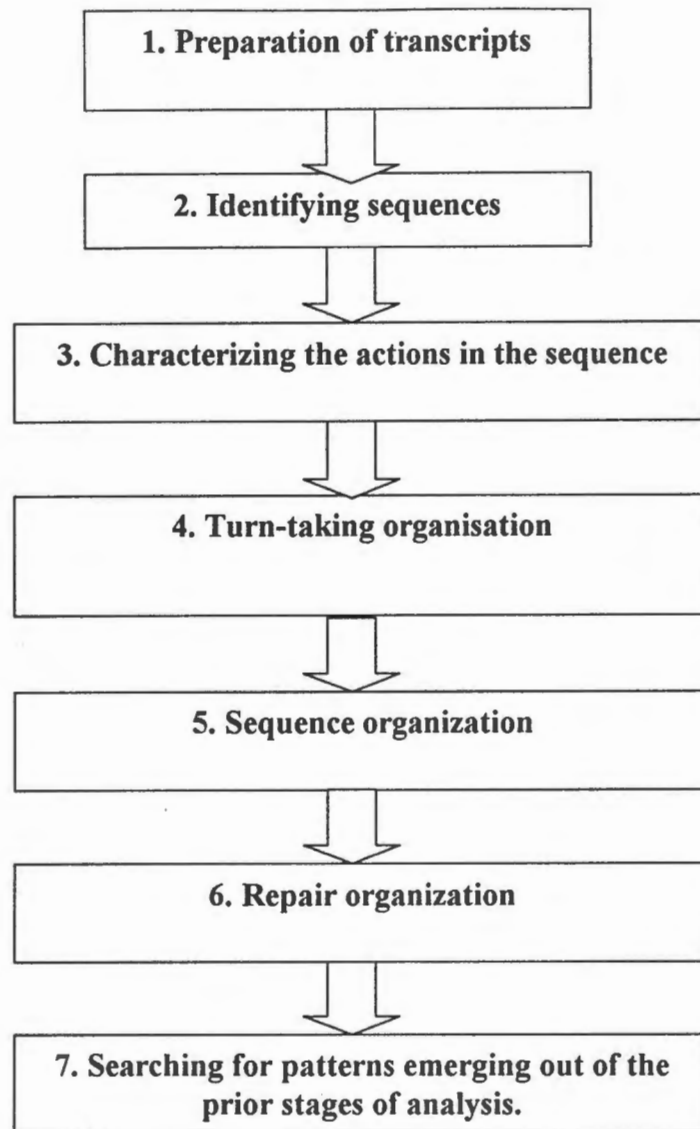
- Xhosa L1 speaker
- University graduate/student

## **2.8 ANALYSIS OF DATA**

### **2.8.1 Analysis of Transcribed data from initial assessment interviews**

A Conversational Analysis should illuminate the understandings that are relevant for the participants and the practices that provide for those understandings. Analysis should involve describing both the knowledge that the participants use, and when and how they use it. The researcher should draw upon their own knowledge of language use and interaction as a resource in developing analyses (Pomerantz & Fehr in Van Dijk, 1997).

Although Conversational analysis was the method of analysing the data, according to the literature there is no prescribed method for the analysis. Conversational analysts use different approaches in developing analyses and concede that there is no right way of doing it (Pomerantz and Fehr, 1997). The limited experience of the researcher in this study, however, deemed it necessary that a fairly structured analytical approach be employed. The analytical process was therefore divided into a series of steps based on methods suggested by Pomerantz & Fehr (1997) and Ten Have (1999). Consequently, the analytical process involved a series of stages depicted in the flow diagram, which follows.



**Figure 3** Flow diagram depicting stages in conversational analysis

*Stage 1: Preparation of transcripts*

Prior to beginning the analysis certain information such as such as overlap, intonation, pauses, linking and intensity of speech had to be indicated through the use of transcription symbols. Non-verbal behaviours were also indicated in the transcripts.

In addition turns were numbered to ease later analysis. This was central to later stages in Conversational Analysis. The symbols used were based on a system established by Jefferson (1985). The transcription notation used in extracts included in this paper, are indicated in the table below. An example of a prepared transcript can be found in the Appendix.

## 1.1 EXPLANATION OF TRANSCRIPTION NOTATION

(.)	The shortest audible pause, less than 0.2 seconds
(4.7)	Example of an exactly times pause
[]	Square brackets indicate overlapping speech
No:	Colons indicates a prolongation of the preceding letter or sound
Today=	The “equals” sign indicates that one utterance runs into another
?	Indicate rising intonation at the end of an utterance
.	Indicates falling intonation
,	Comma indicates rising intonation at then end of a word.

Figure 4 Transcription notation

### *Stage 2: Identifying Sequences*

According to Pomerantz and Fehr(1997), a sequence can be found by looking for identifiable boundaries. The start of a sequence is identified by locating the turn in which one of the participants initiated an action or topic, which is subsequently taken up or responded to by co-participants. Locating the place in which the participants were no longer specifically responding to the prior action and/or topic then signifies the end of the sequence.

In this study, sequences were randomly selected for further analysis. This was limited to three sequences in one consultation, given that the analyses were fairly detailed and analysing all the sequences in each transcript was beyond the temporal scope of the study. Although, some researchers may select sequences, which, are novel, funny or topically interesting, it has been documented that the quality of one’s findings is unrelated to the apparent interest in the sequence (Pomerantz & Fehr, 1997).

### *Stage 3: Characterizing the Actions in the Sequence*

Any utterance and indeed many aspects of non-verbal behaviour are considered to be performing social action. Actions form the basic analytic concept for conversational analysts. An action is identified by asking ”What is the participant doing in this turn?” Examples of actions include: greeting, announcing news, acknowledging news, complaining, disagreeing, correcting, telling a joke and telling a story. In this

stage of the analysis, for each turn in the sequence, the action or actions that the participant performed is characterized.

#### *Stage 4: Characterizing the Turn-taking Organisation*

According to Ten Have (1999), the idea of turn taking as an organized activity is one of the core activities of the Conversational Analysis enterprise. In this part of the analysis, an analysis of how speakers' turn taking is maintained is made. In addition, how speaker change is organized, by the participants in the interaction is analysed and recurrent patterns of turn taking behaviour are identified. The 'units' of the turn taking system are also defined.

#### *Stage 5: Sequence Organisation*

Sequential organization is a second core principle in conversational analysis. It is suggested that sequences often appear to have stable patterns. The desire is therefore to highlight the sequential patterns in an interaction (Drew, et al., 2000). This part of the analysis aims to determine how sequences are made up, whether adjacency pairs are evident, sequence expansion and whether there were patterns of subsequent actions.

#### *Stage 6: Repair Organisation*

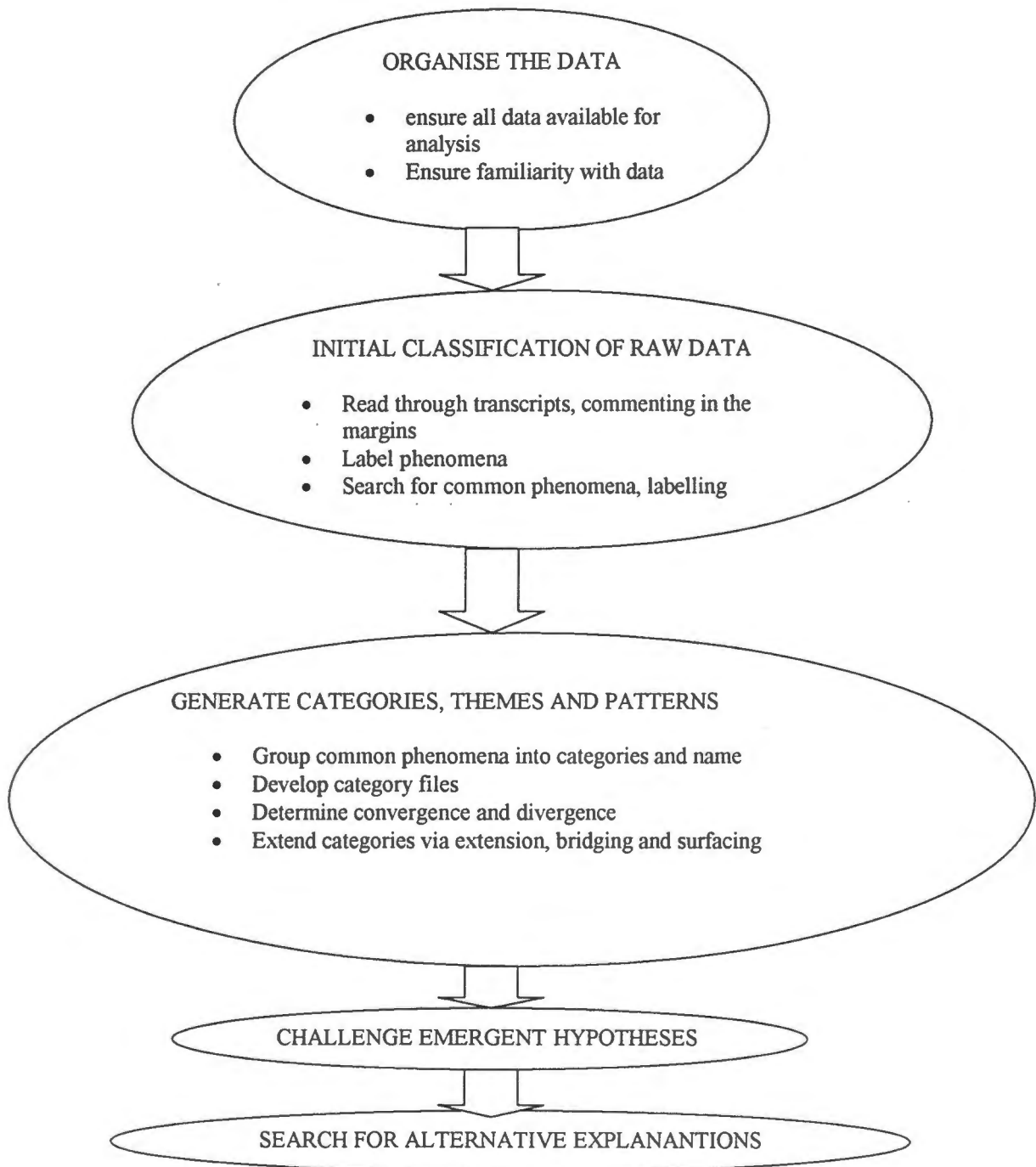
This stage of the analysis looks at how speakers' use organized ways of dealing with various kinds of troubles in the interaction's progress, such as problems of mishearing or misunderstanding. In this stage the researcher also looks at who initiates repairs in the interaction and how repairs are made in the interaction. Furthermore, the analysis attempts to establish whether any patterns surrounding the repair organisation, emerges.

#### *Stage 7: Searching for patterns emerging out of prior stages of analysis*

This final part of the analysis explores what the findings in each stage, suggests about the interactions as a whole as well as what impressions are conveyed through the patterns that emerge and their impact on the study as a whole.

### 2.8.2 Analysis of data from semi structured interviews

The analysis of the data from the semi-structured interviews was primarily for purposes of triangulation with the results of the conversational analysis. The analysis of the data from the interviews involved a series of depicted in the flow diagram below.



**Figure 5** Flow diagram representing the stages involved in the data analysis

The procedure was adapted from Fisch (2001) who had developed the procedure following examination of a number of sources (Corbin & Strauss, 1990; Patton, 1990; Marshall & Rossman, 1995; Michelson, 1998). A discussion of the stages follows in greater detail:

#### *Stage one: Organisation of the Data*

The initial step in the procedure was to ensure that all the data to be analysed was available for analysis. The researcher was also responsible for the drafting of semi-structured questionnaires for use in the interviews and for the transcription of those interviews. Subsequent read-throughs of the raw data also facilitated familiarity with the raw data, which would assist in further analysis. Two copies of each transcript were made, one as an original and another meant as a working transcript (Patton & Rossman, 1995).

#### *Stage Two: Initial Classification of Data*

This stage of the analysis involved the researcher reading through the transcripts and making comments in the margin including ideas or perceptions about the exchanges between the participants (Patton, 1990). Each idea or perception was then labelled as a representation of a phenomenon. Different incidents in the transcripts were compared so that common phenomena would receive the same labels (Corbin & Strauss, 1990). This stage marked the beginning of the coding process, which is an intrinsic part of thematic analysis.

#### *Stage Three: Generation of categories, themes and patterns*

In the next stage of the analysis procedure, the phenomena, which had arisen out of the coding process, are grouped together in categories. The names of the categories were more abstract than the phenomena names, but were selected to reflect the raw data.

Following this, themes were derived from joining certain categories, while other categories were reduced to variables in the study. According to Ely(1991), themes are defined as statements that run through all or most of the important data.

#### *Stage Four: Challenge Emergent Hypotheses*

In this stage the data was searched for any information that would challenge the established hypotheses (Corbin & Strauss, 1990).

#### *Stage Five: Search for Alternative Explanations*

Alternative explanations were sought to challenge the patterns that seemed to be apparent, as it was necessary to demonstrate the plausibility of a particular explanation (Corbin & Strauss, 1990).

## **2.9 RELIABILITY AND VALIDITY**

In order for research to be reliable, the research process has to be carried out fairly and be representative of the informants involved. A number of methods were therefore employed to enhance and determine the rigour of the data analysis procedure. This occurred at different levels of the research to ensure accuracy throughout.

### **2.9.1 Confirming the accuracy of the Transcription and Translation of the Data**

The Xhosa and English data were checked separately. It was assumed that the risk of breakdown in the Xhosa data was greater as it could break down at two levels – in the transcription and translation phase, whereas the English data had one potential level of breakdown, namely the transcription phase.

#### **2.9.1.1 Xhosa Data**

According to Muller (1994) there can be no authoritative translation from one language to another. Brislin (1986) goes further by stating that there is a need for conceptual as opposed to purely linguistic data when translating from one language to another. Consequently, detailed revisions of the Xhosa data were necessary to ensure accuracy. This was achieved firstly through rechecking of data by the original translator and transcriber (intra-rater reliability), and additional rechecking of 100% of the data by two additional first language Xhosa Speakers for inter-rater reliability (Brislin, 1986). This served also to eliminate any ambiguities in terms of translations. Certain terms in the data were deemed to have more than one meaning, which affected the meaning of the exchange. In addition, there were not always one-to-one

equivalents across languages to be found. Discussion with the translators and transcribers highlighted these instances and provided a platform for discussion in order to decide upon the most accurate interpretation, not linguistically, but rather conceptually. Consequently data was revised several times before it was ready for analysis. The participants who assisted with the checking will hereafter be referred to as P1, P2 and P3.

In addition, field notes based on observations in the interviews were added to the final set of data to assist the researcher in the Conversational Analysis and in making accuracy judgements. Field notes recorded additional information not necessarily observed on tapes. The information from field notes was then compared with the impressions captured in the videotaped recordings and used to add contextual information to the consultations.

#### 2.9.1.2 English Data

The researcher validated all the English data from the Xhosa Sessions whilst working with P1 on validating the Xhosa data (Intra-rater reliability).

In addition, an L1 English speaker, to ensure inter-rater reliability, reviewed 20% of the English data from the English only interviews and the English-Xhosa interviews. A randomly selected sample of data was selected for this purpose.

### **2.9.2 Confirming Accuracy of data preparation for the Conversational Analysis**

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

#### 2.9.2.1 Intra-rater reliability

A total of 28 pages of translated transcription from the initial assessment interviews were prepared for data analysis. The researcher rechecked 20% of randomly selected data to ensure reliability.

#### 2.9.2.2 Inter-rater reliability

An external conversational analyst rechecked 20% of the data that had been prepared for conversational analysis.

### **2.9.3 Confirming the Accuracy of the Conversational Analysis**

#### **2.9.3.1 Intra-rater reliability**

The researcher rechecked 20% of randomly selected data that had been prepared for the analysis.

#### **2.9.3.2 Inter-rater reliability**

An external conversational analyst rechecked 20% of the data that had been used for the preparation of the data.

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

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

#### **2.9.4.1 Data on characteristics of the informants**

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

Research demonstrates that in our everyday communications and social interactions we take an enormous amount of cultural context for granted, and we tend to assume it as common sense. When the cultural backgrounds of individuals diverge, the understanding of personal meaning becomes less obvious. Consequently, we need to establish what cultural backgrounds the participants in the study come from and what their previous training and experience are, in order for their perceptions to be analysed in context (Polgar and Thomas, 1991).

#### 2.9.4.2 Audit trail

According to Polgar and Thomas (1991), the researcher forms a more intrinsic part of the research being investigated in qualitative research than in quantitative research. Human beings are more valuable as measuring instruments as they 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 in the audit trail. An audit trail involves the researcher reporting on his/her train of thought (De Poy & Gitlin, 1994). This will be achieved through the following:

- Post-session field notes
- Notes on procedures in the methodology
- Notes on the construction of materials, i.e. tool for analysis
- Notes on the utilisation of the constructed materials in the methodology

The role of the researcher can form an important part of the study (Cassel, 1989; Cassel and Fitter, 1992; in Cassel & Simon, 1997). Qualitative methods by nature are more interactive, more intensive and involve a longer-term commitment, thus allowing researchers to build up a social relationship with the organisational members and gain more insights into their collective understanding by actively sharing that experience.

#### 2.9.4.3 Triangulation

Triangulation is a process whereby one source of information is checked against one or more other sources of information (De Poy & Gitlin, 1994). According to Patton (1990), the combination of methodologies in the study of the same phenomena strengthens the study design. It can involve using several kinds of method of data, using quantitative and qualitative approaches. Any given study can include several mixes of the approaches by including several measurement approaches, varying design approaches and varying different analytical approaches to achieve triangulation. Using triangulation denotes recognition that the researcher needs to be open to more than one perspective. Denzin (1978b in Patton, 1990) states that no single method ever adequately solves the problem of rival causal factors. Each method reveals different aspects of empirical reality, multiple investigations (Denzin, 1978b in Patton).

Four basic types of triangulation as specified by Denzin (1978b in Patton, 1990) will be employed in this study.

- Data triangulation – the use of a variety of different data sources in one study.
- These include video recordings, transcriptions from interviews and consultations, field notes, the tools for analysis or measurement that will be developed and the questions formulated for the semi-structured interviews.
- Investigator triangulation – the use of several different investigators or evaluators such as different raters or multiple translators or transcribers.
- Theory triangulation – the use of multiple perspectives to interpret a single set of data. The importance of this has been emphasised by Cassel and Simon (1997). The research will be data driven as opposed to theory driven. Theory will be generated from the data. This allows for the formulation of new hypotheses.
- Methodological triangulation - the use of multiple methods to study a single problem. The importance of this was argued by Patton (1990) and Polgar & Thomas (1991).

Patton (1990) suggests that through participant observation, the researcher is able to understand a situation to an extent not entirely possible using only the insights of others obtained through interviews. The observational data should have depth and detail, serving to take the reader into the setting observed. Observation should include focussing on non-verbal messages, the effect of the setting on what transpires and subtleties of the interaction and relationship between the interviewer and interviewee (Patton, 1990).

A number of different observer roles were identified by Polgar and Thomas(1991) Two different roles were undertaken in this research which are:

- Participant as observer: Participates fully in the situation in the study and discloses intentions to the other participants e.g. researcher in the semi-structured post-session interviews

- Observer as participant: Observer makes no pretence of participation, but does observe and examine records e.g. the researcher in the initial assessment interview was present in the consultation as an observer.

#### 2.9.4.4 Subjective assessment of interviews immediately after the recording

Immediately after each interview, the researcher recorded brief field notes about the positive and negative aspects of the interview, the researcher's feeling about the responsiveness of the informants and any other observations or incidents determined to affect the interview. Particular attention was given to the following aspects:

- Those present in the interview
- Description of the environment
- Distractions or disturbances during the interview
- Incidents which needed to be probed in the post-session interview
- General feelings about the interviewer

#### 2.9.4.5 Missing Data

Although fairly minimal, there was a percentage of data from the initial assessment consultations and post-session interviews, which could not be transcribed. This amounted to less than 5% of the data. This could be attributed to either of the following:

- Speaker variables: Reduced volume of voice and poor speech clarity contributed to poor sound quality at times, for example, coughing, baby crying
- Environmental/Situational variables: Background noise in the clinics or disturbances by other hospital staff sometimes interfered with the sound quality.

## **CHAPTER 3: RESULTS AND DISCUSSION**

In this section the findings from the Conversational Analysis of initial assessment consultations and the post-session interviews are discussed. The findings of the Conversational Analysis are discussed under each of the stages of analysis. Thereafter the findings of the post-session interviews are considered under each of the themes that emerged from the thematic analysis.

### **3.1 FINDINGS EMERGING OUT OF THE CONVERSATIONAL ANALYSIS**

All the transcribed data from the initial assessment interviews were analysed according to stages one to three of the conversational analysis procedure set out in the methodology section. The findings are discussed under the stage headings below with excerpts from the transcript used to support the findings.

#### **3.1.1 Stage 1: Preparation of the transcripts**

In this stage, the transcripts from the consultations and their corresponding audiovisual tapes were further examined to capture certain aspects of the interaction such as intonation, pauses, linking and intensity of speech, through the use of transcription symbols. The symbols used were based on a system established by Jefferson (1985).

Another feature of the transcripts is that the translation of Xhosa utterances by both the trained interpreter and the caregiver are indicated in italics. This was solely for the researcher's benefit, who as mentioned before, does not speak Xhosa. In addition, certain abbreviations are used in the transcriptions, which will be seen in the excerpts throughout this paper. These are D for doctor or health professional, TI for trained interpreter and CG for caregiver.

#### **3.1.2 Stage 2: Identifying sequences in the transcript**

This stage of the analysis was essentially still part of the preparatory phase of the analysis. Consequently, sequences were identified in all three transcriptions. The reason for this was to prepare for later analysis of sequence organisation. Sequences were identified, by locating the turn in which the topic was initiated by a participant and which was then taken up and responded to by a co-participant. The termination of

the sequence was identified, by locating the place in which participants were no longer responding to the topic previously initiated (Pomerantz and Fehr, 1997).

### 3.1.3 Stage 3: Characterizing Actions in the Sequence

As in stage one, the characterization of actions in sequences, also formed part of the preparatory phase of the analysis. All the data therefore underwent this stage of analysis, primarily because it is necessary for the identification of sequences. In order to identify the boundaries around a sequence, one needs identify the actions, which make up those boundaries.

A range of actions occurred consistently throughout the transcriptions. It may be argued that the interview situation by nature places limitations on the range of actions the participants may perform. This was evident in the data where only a limited range of actions were performed. These are depicted in the table below where the occurrence of different actions are represented as they occurred in each consultation.

**Table 5** Frequency of different actions in each consultation across a maximum of 250 turns

Actions Performed	Frequency of Actions in each consultation		
	Consultation	Consultation	Consultation
	1	2	3
Request for information	20	33	37
Response to request for information	19	34	35
Request for clarification	5	1	11
Clarification	3	5	9
Acknowledgement	8	5	9
Confirmation	9	7	4
Elaboration	2	6	13

Moreover, certain participants tended to perform certain actions repetitively throughout the data. This will be discussed in greater detail, later on in the discussion. The research is however, based on interviews and therefore is focussed on the social

organization of interpreted interviews. The actions, which the participants undertake can therefore be accepted as those, which characterize the social organization of the interpreted interviews.

#### **3.1.4 Stage 4: Turn-taking organization**

Turn taking amongst other aspects is fundamental to conversational analysis. A turn is considered to be the basic analytical unit in conversational analysis. A turn may equate a full sentence, a single word or utterance or even a set of sentences. The effective management of turn taking contributes significantly to helping the participants in “doing what they are doing and getting it done” (Schlegoff, 1992, p. xviii).

Sacks, Schlegoff & Jefferson(1974) proposed a model, which demonstrates that the organization of turns in an ordinary conversation is highly structured and ordered. They stipulate the features of turn taking to include:

- One speaker speaks at a time
- The number and order of speakers vary
- Turn sizes vary
- Turns are not allocated in advance but also vary
- Turn transition is frequent and quiet
- There are few gaps and overlaps in turn transition

The organization of turn taking in this study was discussed in terms of these features of turn taking organization outlined above. In terms of one speaker speaking at a time, the data reflects this feature throughout. This was generally acceptable to all speakers as indicated by the absence of objection to this pattern through attempts to overlap inappropriately by participants. This can be seen in the excerpt below. The same cannot be said for the health professional in this particular excerpt, but generally this principle was held true in the data. The overlap into another speaker’s turn by D in line 27 in the particular excerpt below, was therefore more of an exception rather than the norm. In addition, examination of the rest of the transcription, suggests that D was trying to speed the consultation along a little and perhaps perceived that the

consultation was progressing too slowly. The role played by D in the interview may explain why she felt she had the right or responsibility, depending on the motive of course, to speed along the interview.

21	D	:	[okay [alright
22			(0.3)can she tell us about ehm when the baby was born how was
23			he delivered?
24	TI	:	okay (0.3) umntwana waye wawuzi wawuzibelekele ngokunokwakho <i>Okay was the child did you did you give birth on your own</i>
25	CG	:	e-e <i>Yes</i>
26	TI	:	okay (0.3)yah she delivered [on her own .....
27	D	:	[normally (0.3) okay was the baby
28			9 months, or was he born before time
29	TI	:	wawuzele ngenyaga zakhe zolithoba okanye phambi kwexashe <i>Did you give birth on his 9 months or was it before time</i>
30	CG	:	ha-a ngen 9 months <i>No in 9 months</i>
31	TI	:	[9 months
32	D	:	[okay (0.3) and where did you deliver?
33	TI	:	wawumbelekele phi <i>Where did you give birth to him</i>

**Figure 6** Excerpt 1 from the data: Consultation in MOPD

In the above extract it can be seen that D consistently took the lead in establishing the turn taking organization (lines 21, 27, 28, 32). Across the data from all three interviews, D always took the first turn in a sequence beginning with the first part of an adjacency pair. This obligated the CG to respond with the second part of the pair. The difference in this case was that TI automatically took up the next turn, interpreting the first part of the adjacency pair and consequently also interpreting the second part of the pair. This was not deemed inappropriate in this context, as this was acceptable to all the participants. It could be argued, that the nature of the interpreting process, results in an understanding that this organization of turn taking is what is appropriate in this situation. In addition, there may be power relations at play in this situation. The power relations inherent in the South African context, inherited from the past may also explain the turn-taking interaction occurring in this interaction. Historically, social and racial barriers exist between D and CG and the power is held

by the one who is educated or has authority, namely D. The prevalence of adjacency pairs in the data suggests a cyclical nature to the turn organization. It may be argued that this is due to a pre-allocation of turns.

A number of turn-taking phenomena support the patterns in the data. Significant pauses were present in some instances and were limited to the turns of the D and TI on occasion. The pauses were seen to perform different functions. Firstly, in D's turn, the pauses can be seen to separate two actions present in the same turn, for example, an acknowledgement serving to terminate the prior sequence, followed by a pause and then a request for information initiating a new sequence. An example of this is seen in line 32 of the above extract. Secondly, in TI's turn the pause served to separate her acknowledgement to D of what she was about to interpret to CG or vice versa, for example in lines 24 and 26. In other instances, pauses served as fillers or continuers of another speaker's turn. In some cases also the longer pauses were as a result of the D filling in paperwork or taking notes in between asking questions. The data shows that the other participants did not take this up as an opportunity to initiate a turn, but merely waited for D to finish and take up the speaker's turn again. This again suggests that there is a pre-allocation of turns in the medical consultation. Similarly, the absence of initiation by CG and TI may also suggest that D has control of the consultation and therefore has the authority to start or end a sequence.

Instances of overlap were also indicated to take place rarely, but two notable examples were highlighted. Overlap generally only occurred in a dyad, either in the D/TI dyad or the CG/TI dyad, but never between the CG/D. An example of the overlap between the D and TI can be found in the preceding excerpt in lines 27 and 32. In both instances this takes place as TI is delivering a response from CG. It may be argued that D understood CG's response to her request for information in the first place and the translation by TI was unnecessary, but part of the routine in the interpreted consultation.

The following excerpt indicates overlap between CG and TI.

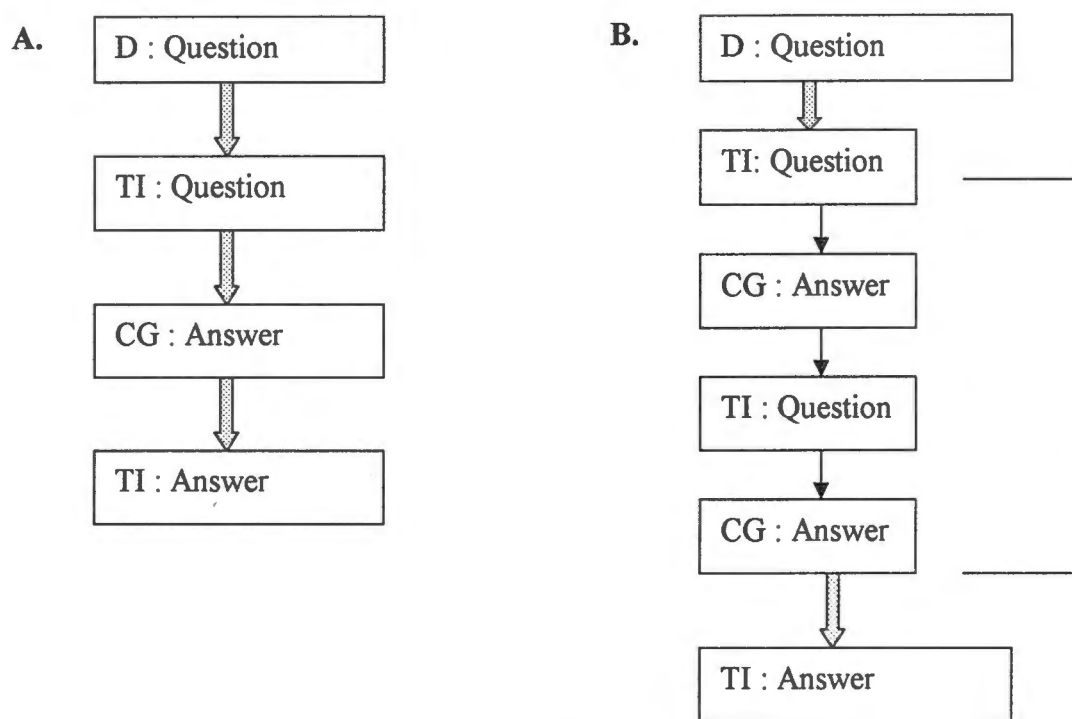
84	D	: okay (0.3) and ehm and does she think that the baby can
85		hear and see?
86	TI	: xa usowucinga uyabona uyeva ? <i>Do you think he can see and he can hear</i>
87	CG	: eh uyeva ngendlebe uyabona . <i>Yes he can hear with his ears and he can see</i>
88	TI	: [yes.
89	CG	: [yonke into [uyayenza <i>He is doing everything</i>

Figure 7 Excerpt 2 from the data: Consultation in MOPD

In the preceding excerpt, there appears to be an element of impatience, either with the length of the interview or with the tediousness of the interpreting process. This suggestion is based on more than one occurrence of this type of overlap in the data. It is also indicated by the content and tone of the CG's utterance in line 89. Generally, however, overlap was smooth whenever it did occur.

Variations also occurred in terms of intonation. One of the D's very clearly indicated the end of her turn with her intonation (rising or falling) whereas another's intonation pattern was not really evident and therefore did not play a part in indicating the action of the turn. This was primarily attributed to speaker variability. It suggested that intonation was not always an indicator of the action being performed in a turn and therefore should not be viewed in isolation, but in relation to all other aspects of the speaker's turn.

The turn-taking patterns emergent in the data followed two specific patterns:



**Figure 8** Two patterns of turn taking (A&B) emergent from the data

The patterns above are the same as those found in interpreted doctor-patient interactions in a study by Bolden (2000). According to Frankel (1990) the case history part of consultations normally consists of sequences of doctor-initiated questions pertaining to various aspects of the patient’s condition. Bolden (2000) suggests that an interpreter can function in two ways in an interpreted consultation. The first is similar to a “translating machine” where the interpreter’s participation is restricted to providing close translations of the previous turns. This results in the turn taking pattern such as in A in the figure above. The second way in which an interpreter may function is depicted in Fig 4 B. Here a doctor-initiated question in English is followed by, in this case, a questioning sequence between the TI and CG in Xhosa. The sequence comes to a close when the TI summarises the CG’s replies in answer to the initial question. Both turn-taking patterns were evident in the data.

The patterns above are similar to the doctor-patient interactions discussed by Ten Have (1999). He argued that sometimes the fact that doctors ask more questions than

patients could be looked at as an aspect of professional dominance. As mentioned before, this pattern can also be discussed in terms of a turn type pre-allocation. Societal norms dictate that when one goes to a doctor with a problem one will be subject to questioning and in order to be helped, one needs to answer the questions. Ten Have further argues that taking this belief to the extreme means that subtleties in the exchange are overlooked as all the participants are geared toward achieving a specific goal. This mutual understanding or inter-subjectivity can therefore explain why this pattern of turn taking emerges in the data. This pattern of turn taking is common in the talk of institutions or more specifically in interactions where there is an expectation of service provision.

### 3.1.5 Stage 5 Sequence Organization

A second core idea in conversational analysis is that utterances are sequentially organized. This means that in a conversational utterance in interaction is considered to have been produced for the place in the progression of the talk where it occurs, especially just after the preceding one, while at the same time it creates context for its own next utterance. Sequences therefore are patterns of subsequent actions where the subsequentity is not arbitrary, but the realization of locally constituted projections, rights and obligations (Ten Have, 1999).

The first aspect, which was quite evident in all three consultations was that, the consultations could be divided into three main parts. These were expressed as the following:

- Opening
- Body
- Closing

An excerpt from the opening of the MOPD consultation is shown below, followed by the opening sequences from both interviews from the developmental clinic.

1	D	: This is Ms Mati Zodwa neh,
2	CG	: [ewe (nods) yes
3	D	: [she is just going to ask you a few questions (1.0) alright can you ask
4		her how old is the baby

**Figure 9** Excerpt 3 from the data: Consultation in MOPD

In the above excerpt, the opening is clearly indicated with D making the introductions in line 1. At this stage, TI is unknown to CG and vice versa, and D is the only participant who has some knowledge of both the other participants. Even though CG cannot communicate with D she does know who she is in terms of her role in the consultation and may know her name. This former can be derived from the way she is dressed (a white coat) and the latter she may have been informed about by the reception staff or D, prior to entering the room. D therefore introduces CG and TI by name and briefly explains TI's purpose.

In the following opening however, there is a different progression of actions. Below, D heads directly into the questioning of her patient line 1, before stopping the questioning in line 5 to check that TI has introduced herself. Whereas, in the previous consultation, D took on the role of making the introductions, in this consultation, D distances herself from the introductions. Furthermore, her reference to CG as "she" in line 8, excludes herself from the introduction. TI, however, mediates the introduction by making the introduction of D to CG without prompting and possibly without knowledge of D.

1	D	: Ask this mother (1.0) how old the baby is
2	TI	: Unangaphi umntana sisi <i>How old is the child</i>
3	C	: Unonyaka oneveki eziyi two <i>One years two weeks</i>
4	TI	: one year two weeks
5	D	: Did you introduce yourself
6	TI	: uyandazi ke mos, ndinguZodwa
7	C	: ewe
8	D	: Did she understand what I said without
9	TI	: NgyGqirha ke lo, uDr Van Onslen <i>The doctor's name is Dr Van Onslen</i>

**Figure 10** Excerpt 4 from the data: Consultation 1 in development clinic

In the third extract from the second consultation in the developmental clinic, the interaction starts with a discussion between TI and CG about TI's purpose in the consultation. CG indicates a certain indifference to TI's presence in the consultation, suggesting that her presence is of no consequence as in line 3. D tries to make sure that CG understands TI's presence in the consultation in line 4, and is unaware of the exchange between the two participants. Based on the excerpt, it is assumed that no

introductions were made as the ensuing turns show D starting the questioning procedure. It is possible that introductions took place before filming started which would explain why no introductions are made in this excerpt.

1	C	: ndifuna nje umntu ozandanceda xa ndinendawo endingazivayo <i>I only need someone who can help on concepts that are unclear to me</i>
2	TI	: ndikolo ba nto ngoku apha xa umntu engakwazi (nodding) ukuzithethela <i>I'm here for the person who can't express him or herself</i>
3	C	: ayinamsebenzi xa usenzela bona. <i>It doesn't matter if you working for them</i>
4	D	: and she understand why you are here we are working together I don't
5		understand Xhosa (1.0) so shall we bring the blocks for Yamkela so
6		he can sit there? (using hands)
7	C	: hlala apha (pointing to floor close to her) <i>Sit here</i>

**Figure 11** Excerpt 5 from the data: Consultation 2 in development clinic

The three extracts above indicate that there is no specific pattern of introductions. This, although, perhaps an insignificant event temporally in the consultation, must impact on the attitudes of the participants in the consultation. It is suggested that it may affect the credibility and importance attributed to the TI and certainly contributes to establishing a rapport between the participants. Inconsistency in how the opening sequences are managed can be argued to be a factor impacting on the interpersonal aspects of the rest of the consultation.

In examining the body of the interactions in the consultations, patterns emerged about different conversational analysis phenomena. The concept of adjacency pairs is one which, illustrates the normativeness of paired actions in conversations. This means that the social norm dictates that once the first part of the adjacency pair is uttered, the second part becomes relevant and expected immediately (Sacks, Schlegoff & Jefferson, 1974). Social norms are largely invisible but deeply influential in shaping the social behaviour of its observers. This becomes obvious only when a norm is broken. Adjacency pairs are the major instruments for the analysis of sequential organization, but a sequence quite often extends beyond just two pair parts. In many instances a third utterance may be added to two utterances in AP format, quite often as an acknowledgement or evaluation by the first speaker to the response in second

position. Ten Have (1999) suggests that an essential part of the AP format is that the relationship between the two parts is normative. When there is no second pair part there is a noticeable absence. The third position acknowledgement, although possible is, however, not normatively required to the same extent as the second pair part. Another kind of sequence like structure consists of repetitive cycles of similar sequences, for example, question – answer sequences in an interview. In relation to this Sacks has written the following:

*A person who has asked a question can talk again, has as we may put it 'a reserved right to talk again,' after the one to whom he has addressed the questions speaks. And in using the reserved right he can ask a question. I call this rule the "Chaining rule,". Sacks, 1972:343*

68	D	: okay (1.0)uhm can the baby sit.
69	TI	: uyakwaz ukuhlala? <i>Can the baby sit</i>
70	CG	: ha ah
71	TI	: no doctor
72	D	: has he tried to hold, the bottle.
73	TI	: uyakwazi ukuzibambel ibhotile? <i>Can he hold the bottle has he tried to hold the bottle</i>
74	CG	: akakwazi nokubamba kwanto uke uba ndimenzela kanje ngoka . <i>He can't hold anything that's why I have done this for him</i>
75	TI	: he's [he's...
76	D	: [so he's not even putting up his hands?
77	TI	: akokh aphakamise nesandla [ngoluhlobo <i>Does he ever lift his hand like this</i>
78	CG	: [ewe ngoku selena
79		bekukhona azamayo ukuphakamisa ingalo akwazi ukwenjenje <i>yes now that his 9 he is starting to try and lift his arm and do this</i>
80	TI	: yha he started when he was 9 months to see that he can lift up his
81		hand [and ..
82	D	: [but
83		he doesn't try to hold the bottle
84	TI	: akakwazi kodwa ukuzama ukubamb ibhotile <i>So he still cannot try holding the bottle</i>
85	CG	: ha ah
86	TI	: no

**Figure 12** Excerpt 6 from the data: Consultation in development clinic

In the data from the interactions, adjacency pairs formed an essential part of the sequence organization. Moreover it can be shown that the repetitive use of adjacency pairs is consistent to the “chaining rule” as found by Sacks (1972). In the preceding extract, the chaining rule is observable. In the preceding excerpt, D consistently takes the first turn initiating a new sequence with a request for information. It has been stated that laughter can also function as an adjacency pair. In the extract which follows it is shown how laughter is responded to by all the participants in the consultation. The action is initiated by CG following a questioned, which is funny to CG. The laughter is responded to by TI and conveyed to D through the translation and through observation. The result is that even though the interaction is mediated and not all parties speak the same language, a common aspect, namely humour, can be shared by all participants.

124	D	:	[he
125			is fine okay good eh in in the father or even in her family is there
126			anyone with a big head.
127	TI	:	akukho mntu kwifemeli yakho okanye kwifemeli yakulotat'akhe
128			onetloko Enkulu? <i>is there anyone in the family or in the father's family who has a big head</i>
129	TI	:	utat'akhe intloko yakhe inkulu (laughs shyly) <i>His father's head is big (laughs shyly)</i>
130	TI	:	it's the father (laughs)
131	D	:	does she think the child's head is big
132	TI	:	xa usowucinga wena ingaba intloko yomntwana ingakanani <i>How much big do you think the child's head is</i>
133	CG	:	(starts to laugh) inkulu intloko yakhe (laughs again) <i>(starts to laugh) his head is big (starts to laugh)</i>
134	TI	:	yes
135	D	:	hmm?
136	TI	:	yes it's big (all laughing)

**Figure 13** Excerpt 7 from the data: Consultation in MOPD

Closely linked to the phenomena of adjacency pairs is the preference structure. The concept of preference structure can be described as the idea that the second parts of Adjacency pairs can be categorized as either preferred responses or dispreferred responses. The preferred response is therefore that which the speaker expects from the respondent and where the dispreferred response is either an unexpected response or a non-answer. In the preceding excerpt, D responds to a dispreferred response by changing the question(line 76) and then when CG has responded asking the same

question again (line 82). The preferred response in this sequence would have been a “yes” or “no”, and even though the response that follows may provide the necessary information, D persists in asking the same question until the preferred response is given by CG.

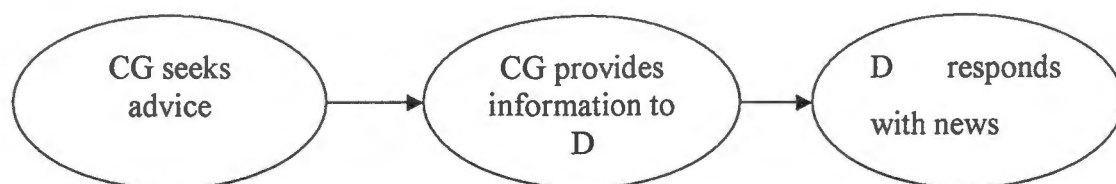
**Table 6 Preferred vs. dispreferred responses (Jones, 2003)**

<b>Characteristics of preferred responses</b>	<b>Characteristics of dispreferred responses</b>
Response produced with a minimum of delay	There is a delay component
Response is brief with answer delivered straight away	There is normally a preface before the response such uhm /well
No hedging of the answer	Disagreement is formulated weakly
	Response includes some justification for not producing preferred response.

The use of adjacency pairs flowing consistently in one direction in the data, that is from D to CG, draws attention to another phenomena present in the data. The flow of questioning gives privileged access to the first position in the consultation to D. That being the case, implies the following:

- D has control of what can be said in the second position as an answer to a question
- If the answer does not match what is wanted or required, D has the possibility to come back with a third position response
- D is provided with the opportunity to ask a next question if the second position question is acceptable

These implications have a significant impact on the equality of the patient’s involvement in the interaction. Ten Have (1999) has argued that various interactional asymmetries exist within lay-professional consultations. Conversational control can therefore be displayed through these asymmetries. Alternatively, it may be argued that the understanding the hospital context, leads to acceptance and understanding that conversational control is held by the D. In a typical healthcare setting the diagram below depicts what is typically expected and received by the CG.



**Figure 14** Flow diagram of medical interaction

Entering into the consultation with this in mind means that there is an understanding that when D makes a request for information a response is expected. The importance of this is indicated by having a specific appointment time, the formal influences, such as filling in forms and the reason for the visit in the first place.

A further aspect, which emerged from the data, is that of reformulation. This refers to when speakers attempt to describe and summarise tracts of conversations with the intention of demonstrating understanding (Beach and Dixon, 2001 in Jones, 2003).

91	D	: okay. (1.0) alright(0.3) can the baby sit by himself
92	TI	: uyakwazi ukuzihlalela ngokunokwakhe ? <i>Is he able to sit on his own</i>
93	CG	: ha-a (0.3)akakwazi ukuzihlalela uthi nje umzuzu (1.0) (trying to
94		show how the Baby sits) uphinde ( trying to show how the baby is
95		falling on his back) uyawa <i>no he cannot sit on his own he can do this for a little while (trying to</i> <i>show how the baby sits ) and again (trying to show how the baby</i> <i>falls on his back) he falls</i>
96	TI	: no: just(0.3) just for a few minutes= (gestures)
97	D	: =for a few minutes then he falls over?
98	TI	: yes.

**Figure 15** Excerpt 8 from the data: Consultation in MOPD

In line 97 D uses reformulation to confirm her understanding of CG's response to her prior request in line 91. Although, Ti did not translate the complete exchange between herself and CG, D uses the gesture observed combine with TI's response to reformulate CG's response. The reformulated response acts as a request for clarification from TI, which she then confirms. This suggests to D that her understanding of CG's response is correct.

In an interaction various strategies can be used to lengthen a sequence. In practical terms the reasons for longer sequences was largely related to the information that was required by different speakers. In the data the turn organization (B) discussed in Fig 4 is typical example of how sequences were expanded in the data. In the extract below, TI probes CG with additional requests related to D's prior request before providing D with the answer to the initial request. This type of expansion would be more specific to an interpreted interaction rather than an interaction between two participants.

112	D	: okay (0.3) alright (0.3) were there any other symptoms like headache
113		ag you know vomiting or fevers, or coughing
114	TI	: khang 'akhohlele abenobushushu [abene <i>Has he not been coughing, feverish and have</i>
115	CG	: [uyakhohlela <i>He is coughing</i>
116	TI	: akanabushushu <i>Is he not feverish</i>
117	CG	: uyakhohlela abenobushushu ndakha ndamsa apha ku doctor
118		(unintell) Apha e-Site B wathi u-doctor ane Asthma <i>He is coughing and he is also feverish I once took him to the doctor</i> (unintell) here in Site B and the doctor said he has Asthma
119	TI	: uyakhohlela ngoku. <i>Is he coughing now</i>
120	CG	: no kodwa ungcono ngoku <i>No but he is better now</i>

**Figure 16** Excerpt from the data: Consultation in MOPD

From line 114 to line 120 an exchange between TI and CG excludes D. In this exchange TI goes about questioning CG in order to provide D with an answer to her initial request. In line 121, TI then goes about summarises a response, which encompasses all the information that CG has shared in the exchange and fully answers the initial question. The purpose of the sequence expansion is clearly shown to be a way of getting the right information from CG so that it fulfils D's request. TI initiates this expansion without being prompted and the prevalence of this in the data suggest that this is a regular way of working in the consultation. As discussed by Bolden (2000) this is the way an interpreter would work more efficiently in an interview, instead of acting as a "translating machine" and translating each participant's

response. The purpose of the sequence expansion in the consultation is therefore solely to meet the information requirements and ultimately the accuracy thereof.

In terms of the content, sequences were also observed to follow a specific format, which correlated with that of a case history format. The topics of the sequences were observed to follow roughly the same order, depicted in the table below.

**Table 7 Topics of sequences**

<b>Reason for coming/Concerns</b>
<b>Pregnancy/Birth History</b>
<b>Developmental History</b>
<b>Medical History</b>
<b>Family History</b>
<b>Socio-economic background</b>

### **3.1.6 Stage 6: Repair Organization**

Repairs essentially are organized ways in which various kinds of difficulties in the interaction are dealt with. Schlegoff et al. (1977) analysed phenomena of repair in great depth. He concluded that amongst other things, in its simplest form, a repair sequence starts with a repairable – an utterance which can be considered a trouble source. Any utterance can, however, be turned into a repairable. The initiative to repair can be a self-initiated repair, taken up by the speaker of the repairable or another initiated repair where others in the interaction can take the initiative. Re-starts in mid-utterance to correct an obvious mistake are common examples of this. A speaker may also use the transitional relevance place, after an utterance is completed to initiate self-repair. A third type of self-repair is when the recipient reacts in a way which demonstrates some kind of misunderstanding. The speaker then recognizes the trouble from the uptake and initiates self-repair on his or her previous turn (Ten Have, 1999).

14	CG	: ke ngoku unok – simane somnantsika ph’endlini simsekela unento
15		Yokusoloko athi (shows head extension) ngathi apha ( pointing at
16		the back of the neck) kubuhlungu. <i>and now he likes- to we usually do the thing a majig there at home we support him with things he has this thing that he always does (shows head extension) and it seems as if it is sore here (pointing at the back of the neck)</i>
17	TI	: zezonto zombini? <i>Those two things</i>
18	CG	: ewe mama. <i>Yes mama</i>

**Figure 17 Excerpt 10 from the data: Consultation in MOPD**

36	D	: [okay (0.3) did you have any ehm were there problems
37		with the baby after the delivery.
38	TI	: emveni kokuba umbelekile umntana ingaba zikhona iingxaki othe
39		Wazifumana <i>After you gave birth to the child were there any problems that you experienced</i>
40	CG	: ha-a bandikhupha msinya naphaya esibhedlele. <i>No they even released me straight away there at the hospital</i>

**Figure 18 Excerpt 11 from the data: Consultation in MOPD**

In the two extracts above examples of self repair by the CG and D can be observed. In the first example, CG uses a restart to initiate self-repair in line 14 to her response to a prior request. In this example the repair is not due to an obvious mistake, rather it appears that CG starts by responding and then starts her response again by providing some explanation to her response. It may be that CG starts to respond and then feels that her answer may not be understood and therefore provides some elaboration to her response with the aim of being understood, but her reason for making the repair is not observable in the extract.

In the second extract, D also initiates self-repair to her request for information in line 36. She essentially starts out making a request and then restarts in the middle of the request rephrasing her request. The motives may well be similar to that of CG or may just be that she started out saying something that she didn’t really want to and therefore rephrased her request. In both instances the need for repair is perceived by the speaker and is pre-emptive. Both are examples of self-initiated self-repair.

When another participant initiates repair, this is most often done in the next turn, by a *next turn repair initiator* (NTRI) This may often be carried out by a short turn, such as “Hmm” or “Huh”, providing the original speaker an opportunity to self-repair by repeating or rephrasing his or her utterance. As an alternative another speaker can also offer an understanding of the original speakers turn, which the original speaker can then accept, reject or rephrase (Ten Have, 1999). An example of this follows.

92	D	:	[when did he start smiling?
93	TI	: uqale enangaphi ukuncuma= <i>How old was he when he started to smile</i>	
94	CG	: =Uqale ngoku analeven months ukukwazi ukhe ahleke .....	
95		Nje encuma ngoku sey nenyanga ezi yi 9= <i>He started to laugh now at eleven months before he would just smile at 9 months</i>	
96	TI	: =ukuncuma nokuhleka akufani uqale nini ukuncuma <i>Smiling and laughing are not the same when did he start smiling</i>	
97	CG	: Uqale enenyanga ezi si 9 amane enuma <i>He started to smile at 9 months</i>	

**Figure 19** Excerpt 12 from the data: Consultation 1 in development clinic

In the above extract, one can see how any utterance can be turned into a repairable. In line 93 TI translates a request for information made by D. CG responds in line 94 with an answer to the question and in addition provides additional information which is related but not asked for by TI. TI then responds in a way which suggests that a repair is necessary, by suggesting that the question has not been answered. CG then repairs her response by responding to the initial request in line 98.

In the data there were also instances where repair did not occur. The difficulty in the interpreted consultation that language differences mean that not all the participants will be aware that a repairable has occurred and consequently will not be able to initiate a repair. This relates to mistranslations, which may occur in the interpreted consultation. In the extract that follows an example of this is shown.

36	D	:	[okay (0.3) did you have any ehm were there problems
37			with the baby after the delivery.
38	TI	:	emveni kokuba umbelekile umntana ingaba zikhona iingxaki othe
39			Wazifumana <i>After you gave birth to the child were there any problems that you experienced</i>
40	CG	:	ha-a bandikhupha msinya naphaya esibhedlele. <i>No they even released me straight away there at the hospital</i>
41	TI	:	[no problems

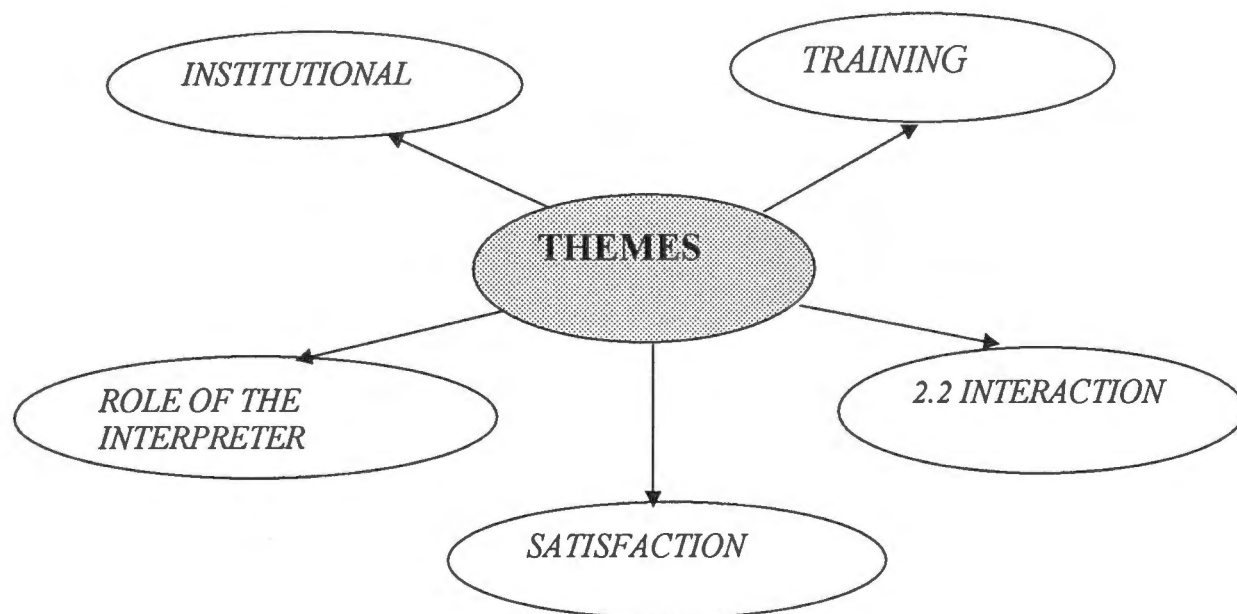
**Figure 20** Excerpt 13 from the data: Consultation in MOPD

75	D	:	okay ehm (0.3) when the baby after he was born can she remember at
76			what age was he when he first smiled.
77	TI	:	umntana uqale enangaphi uncuma <i>How old was the child when he started to smile</i>
78	CG	:	lona (pointing at the baby on her back) <i>This one (pointing at the baby on her back)</i>
79	TI	:	(nods)
80	CG	:	e-ena[.... <i>He was..</i>
81	TI	:	[3 months neh?
82	CG	:	eh <i>Yes</i>

**Figure 21** Excerpt 14 from the data: Consultation in MOPD

In the first extract, TI rephrases the request in line 38-39 made by D in lines 36-37, which subsequently changes the meaning of the question. As a result CG responds to TI's request rather than the request made by D. The information provided is therefore inaccurate. D also therefore missed the opportunity to initiate repair, as she did not understand what TI or CG was saying. If she had understood what CG was saying she would know that the question TI had asked was not the same as hers. In the second extract, the same occurs where TI suggests an answer to CG before she responds and then translates the response as though it is CG's response. It appears that D remains oblivious to what has occurred. It may be argued that the interpreted consultation lends itself to missed opportunities for repair simply because of the language differences. It may therefore also affect the accuracy of the information exchanged in the consultation. The onus for repair in the interpreted situation lies with the speaker and if not taken up will go unrepaired.

## 3.2 THEMES EMERGING OUT OF THEMATIC ANALYSIS



**Figure 22 Themes emerging out of thematic analysis**

### 3.2.1 Training

#### 3.2.1.1 Interpreter Training Needs

Westermeyer (1990) states that using an experienced interpreter is an important first step in providing effective medical care. Interpreters working in a medical setting should ideally be trained in medical terminology, know about the different aspects of the doctor-patient relationship and be comfortable in the clinical setting. Furthermore, training should cover both theoretical aspects and include an in-service component. As discussed previously, the interpreter in this study had undergone formal training within a locally based non-governmental organization. The theoretical modules included in the training comprised interpreting, counselling and cultural issues, skills development, health information and health promotion, ethical issues, administration and constitutional affairs (Ntshona, 1999).

Following this, there was a three-month in-service training period. The training programme undergone by the trained interpreter in this study therefore covered both components recommended by Westermeyer. The medical knowledge relevant to the job was, however, not covered in training. The interpreter participating in the study

felt this to be lacking in her training. The data shows that the interpreter did have some medical knowledge based on the terminology she used and the ease with which she interpreted medical terminology used by the doctor. The interpreter acknowledged that this was based on the experience she had gained during the time she had worked in the outpatients department. She therefore felt that her medical knowledge was limited and further development in this area would impact her professional development.

*TI : ehm ya although I was just thinking of maybe if we can get more  
You know because every day it's this new things I think it's good  
maybe if I can improve myself*

From the perspective of the health professional, the interpreter's background knowledge of the process taking place, experience and presence in the consultation, brought comfort and made her feel more relaxed about the consultation. Her past experiences working with the interpreter during the history taking made her feel confident about the accuracy of the information she was receiving. The interpreter, however, stressed the need for further training in interpreting and suggested that training was too short and that further ongoing training or development would have been helpful.

### 3.2.1.2 Health Professionals' Training Needs

The doctor participating in the interview did feel that there were training needs for health professionals which needed to be addressed. Firstly, it was felt that perhaps health professionals should also be learning the language of their patients. According to Wood (1993), this is a common recommendation made by authors. Little research has, however, focussed on the results of such attempts. In practical terms it takes a long time to acquire a second language to the level of proficiency that would be required to communicate effectively. Furthermore, Wood (1993) states that language acquisition by the doctor, who then stops using an interpreter does not necessarily solve communication difficulties unless the doctor is highly proficient. Trying to implement acquisition of the second language at a graduate or post-graduate level would also be very difficult, especially in South Africa. The workload of health

professionals is already barely manageable and leaves little time to pursue this training.

*D :.....well I'm of the opinion that we should also be learning  
So if they not available then at least you not stuck*

In addition, learning Xhosa, although overcoming the language issues avoids the cultural issues associated with communication. This brings us to the other training need expressed by the health professional. "Learning about the Xhosa culture" as was stated would help in understanding a lot of what the patients do. It is, however, clear that learning the language alone will not overcome the communication aspects in terms of the cultural understanding whereas having cultural knowledge without language can create understanding in the interpreted consultation. This was acknowledged by the doctor as the least that could be done, where learning the language would be ideal, but not very easy to do.

### **3.2.2 Role of the interpreter**

One of the most prominent themes emerging from the post-consultation interviews was that of the role of the interpreter. Wadensjo cited by Erasmus(1999) has described the role of the interpreter as a combination of two central functions: on the one hand, *translating* and on the other hand co-ordinating other's talk. Drennan(1998) amongst others have focussed on the multiple roles and sometimes-conflicting roles interpreters are expected to play. He further states that in striving to fulfil this function, for which there is an unspecified definition, interpreters are subject to an enormous amount of stress.

The perceptions of the roles played by the interpreter from the perspective of the three informants participating in the post-session interviews are discussed below in relation to the previous literature and findings of the conversational analysis where possible.

#### **3.2.2.1 Interpreter as a translator**

When the situation requires the interpreter to function as a translator, the doctor retains direct control of the interaction and requires as direct a translation as possible of his or her questions and the caregiver's responses from the interpreter. This fits the

criteria for the Black box model of interpreting, where the interpreter functions as an instrument of the provider. This model is commonly found in a medical context and many authors believe that it is the way for an interpreter to function. It is, however, limiting in a medical context as many basic concepts in a medical context are not directly translatable into another language (Wood, 1993). Although popular, this model is in conflict with what many authors consider “true” interpreting. Westermeyer (1990) regards interpreting to be a more subtle skill than just translating as it requires the interpreter to transmit connotative as well as denotative meaning. In order to do this the interpreter requires an understanding of the task at hand, its purpose and the means for achieving it (Goodenough, 1980).

*CG : Kutolika.*

*It's to interpret.*

From the perspective of the caregiver, this was a very important role that the interpreter played. From her perspective, not being able to express herself was an important issue and having someone who shared her language essentially gave her a voice to express her concerns and answer questions. This was regarded as the primary role that she played. Essentially it is the most obvious role and the first that comes to mind when thinking about interpreting. It was evident that the caregiver was not really aware of other roles that the interpreter played and needed to consider this carefully before identifying other roles. The doctor also considered translation as the most obvious role, but both acknowledged that this was obvious and that the other roles the interpreter played were of equal importance.

The findings of the conversational analysis indicated that the interpreter functioned as a translator in many instances. The medical context, especially in case history taking, involved a series of questioning sequences. In those sequences, questions were direct, unambiguous and very specific. In those cases the interpreter could be observed to function more as a translator than an interpreter, but this was deemed appropriate to the context of the interaction. The perception of functioning as a translator therefore substantiates the findings in both the turn-taking organization and sequence organization, where the emergent patterns correlated to the participants' perceptions.

### 3.2.2.2 Interpreter as a cultural broker

Often in an interpreted interaction, a substantial cultural gap exists between the doctor and the patient, of which the interpreter is aware. The doctor and the patient are often unaware of their own cultural determinations. The role of the interpreter as a cultural broker is therefore to help the doctor and patient understand each other's cultural perspective in the interview. Swartz (1998) states that the interpreter's role is to assist the clinician in making assessments of the patient's beliefs and to try and put the context and meaning of aspects of the patients' life into perspective. This was something about which the clinician could not have any knowledge or understanding.

*HP: Yes, because there are many things that they do before they come to hospital – not all of them – many have things that they may do before child who is sick before they come to hospital for example, traditional medicine and we tend to, well..I shouldn't say we, I should say I, have a judgemental attitude towards traditional healers and using traditional medication, but hmmm, I think in the last few years I've tried to understand why people go to traditional healers and it is part of health-seeking behaviour and so I think that knowing that helps me not to be so judgemental*

The doctor expressed relief at having the interpreter present in the session, not only to overcome the language barrier, but also to bridge the cultural gaps between the caregiver and the doctor. The doctor had reported that her previous experiences working with the interpreter had helped her to understand the Xhosa culture much more especially in relation to medical issues, that is, traditional medicine. Her experiences with the interpreter had helped her to understand why patients use traditional medicine and therefore created a greater sense of tolerance and understanding. This correlates with findings by Kaufert and Koolage(1984). They argued that cultural brokerage involves providing explanations of indigenous cultural beliefs to clinicians as well as explaining aspects of medical culture to patients.

*TI : I should explain to that or you know the doctor the reason why she use this ehm traditional medicine is because of this and this and this, because of believing this and this and this and the doctor should just take it like that.*

The interpreter in this study, who said that often caregivers did not understand why the case history or questioning had to take place or why it was so long, indicated the latter and she then had to explain the procedures to them and the reasons for this. The interpreter also perceived cultural brokerage to be a vital part of her role as an interpreter. In this study, the interpreter saw herself as a cultural broker for both the doctor and the caregiver as she provided cultural understanding for both. This is similar to Fisch's (2001) study. She was however unable to relate any examples and seemed a little unclear as to what the role really meant. The expectations and demands placed on the interpreter as a cultural broker are therefore very high.

Determining the relation between conversational analysis and the role of the interpreter as a cultural broker is not an easy task. What can be derived from the thematic analysis is that through turn construction, the interpreter tries to adapt her turn for each speaker so that she matches their cultural understanding. For example, when directing her speech to the doctor, she was observed to use medical terminology familiar to both herself and the doctor and therefore part of the culture of the medical institution. Similarly, when addressing the caregiver her language was made simpler. She also matched the caregiver's intonation and intensity of speech. The reference terms she used when addressing each participant were also matched to their roles and their respective cultures, in the former the culture of a medical institution in the latter case, the Xhosa culture.

#### 3.2.2.3 Interpreter as an advisor

The interpreter in this study also felt that she had an advisory role to play in this context. The advisory role extended mainly to caregivers and related to directing them about where to go and what to do next. She perceived this to be important as she mentioned that many of the caregivers attending the hospital were doing so for the first time and were therefore in unfamiliar territory.

*TI : and thirdly, anything that they want to know they come to me and ask me so there's a lot it's not only interpreting*

Part of her role as an advisor was also to make sure that the caregivers knew when their next appointment was and what they needed to do when they came in a next time, e.g. fetching folders. The interpreter is shown to educate caregivers about hospital procedures or hospital culture. No parallels were drawn between the conversational analysis and the interpreter's role as an advisor.

#### 3.2.2.4 Interpreter as a team member

In this study the doctor regarded the interpreter as a valued team member in the clinic, and acknowledged the need for the interpreters in the clinic. She did, however, suggest that the role of the interpreter, although important, was not necessarily as important as certain medical roles. The view suggested that the perception of a hierarchical role structure within the medical team still exists.

*HP: Ja, definitely, but probably less so than radiology for example, because they need to do the x-rays on the patient, so it's really just in the consultation room that we use them most, 'cos at the end of the day we're the ones who have to deal with all the information and most of the ... ..when they go to other departments if it's to do an investigation they just get told to take their clothes off and so on and most people know how to say that*

The interpreter however, regarded herself as an equal member of the team and felt that other members of the team treated her as such. She noted her inclusion in team meetings as an indication of her status in the team and was therefore completely unaware of the perceptions of the doctor. The fact that she was assigned to the clinics in question on a regular basis also meant that she had formed relationships with the other staff members in the team, which cemented her position in the team. The constant demand on the interpreter's time in the different clinics also leads to a feeling of being needed and therefore of belonging to the team.

*TI : Yes they recognise us there you know they don't put us that side even when it's a meeting it's a staff meeting I'm also part of that*

This model of partnership between the interpreter and doctor offers the patient or caregiver specialized knowledge from both parties, within a team approach.

Consequently, the patient receives optimal care. In this approach the skills of the interpreter are valued and the relationship between the interpreter and doctor is more equal, resulting in a more sensitive and detailed understanding of the caregiver's problem. This model may, however, threaten the neutrality, which an interpreter is recommended to exercise. If the interpreter is to act as a patient advocate it is important that, even though the interpreter has equal status as a team member, the interpreter's responsibility should be toward the patient when necessary.

The turn taking pattern described in Figure 5 (B) shows the interpreter taking initiative in a questioning sequence, which excludes the doctor. Following this, she responds to the doctor's initial question with a summary report. The fact that this practice recurred in the consultations with no objections from the doctors suggests that this is an accepted normal practice. This practice contains the elements of a team approach, where individual members function together toward a common goal.

#### 3.2.2.5 Interpreter as a patient advocate

This particular model of interpreting is based on the work of community workers who, as well as interpreting on behalf of their clients, also represent their interest (Sanders in Erasmus, 1999). It is sometimes referred to as 'community interpreting'. Erasmus(1999) points out that this model can only succeed when the interpreter is part of a supportive organisation or interpreting service, which is able to assist the interpreter in solving the problems that arise. Drennan(1999a) has stated that when he/she cannot communicate with health professional a clinical encounter can be a bewildering experience for a patient. In view of this, advocacy is considered necessary for patients with languages and cultures different to the health professionals who treat them.

*TI : Like in and also advocacy you know because ya to advocate the patient you know 'cos sometimes you find out like with that parent I showed when she 's coming back where she must get a folder neh, and also I told her she 's gonna see you in order you gonna ask her some questions.*

The caregiver in the post-session interviews felt that the interpreter was there to help her. She felt that the interpreter was able to understand her and therefore helped her

to communicate with the doctor. Both the doctor and the caregiver expressed that the interpreter was there to help them both. Therefore, although the caregiver viewed the interpreter as a patient advocate, she acknowledged that she was also there to help the doctor.

#### 3.2.2.6 Interpreter as a helper

The use of untrained interpreters on an ad hoc basis was and still is quite common in the medical context. Often the people used to fulfil these roles work in the hospital as nurses, cleaning staff or other medical workers. In this particular context, the interpreter, although trained and regarded as a professional interpreter, also functions as a helper or assistant. The duties include filling in of forms, directing caregivers and helping out at the reception desk. The doctor reports using her for other jobs, but does not specify what these are.

*TI : like myself on the side you know at the reception I'm also helping there too for them to fill in these forms you know.*

*HP: Hmm...well, we do often use them a lot for other little jobs, but ja... I think*

Both the interpreter and the doctor report this to be one of the many roles of the interpreter in this context. It is suggested that using the interpreter in this way is perhaps patronising and does nothing to consolidate the interpreter's role in the team as professional. If the interpreter's role as a helper involves helping the caregivers to understand what will happen next, where to go and where to fetch folders, then helping could still be considered part of her as a patient advocate. The "looseness" of what is considered part of her role, however, is not a particularly good way to work.

#### 3.2.3 Interaction

The interactional aspect of the interpreted consultation has been of specific interest in this study, particularly in terms of the health professional's impact on the interaction. Interaction essentially encompasses all the aspects of how the information is being conveyed in the interpreted interview (Fisch, 2001). Sociolinguists are primarily concerned with how language is used to establish and maintain relationships. Brown & Yule (1983) state that interactional use of language can be separated clearly from a

transactional use of language where the purpose is to transmit factual information rather than form a relationship. The interpreted consultation therefore is a potentially complex situation in which a different type of interaction is necessary to organize relationships. Furthermore, everyday human interactions are largely characterized by primary interpersonal use of language. Fisch (2001) also proposed that effective communication through an interpreter is thought to be dependent on a combination of transaction and interaction.

Conversational analysis also aims to understand interaction, but the focus is on how individuals perform certain actions with language, which subsequently affects the interaction. Conversational analysis looks for patterns in the data and is therefore independent of particular idiosyncratic styles, personalities or individual dispositions. The post-session interview with the doctor, interpreter and caregiver participating in the consultation brought various aspects to light which correlate closely to the findings in the conversational analysis. Some of the themes are discussed below in relation to those findings.

#### 3.2.3.1 Non-verbal Behaviour

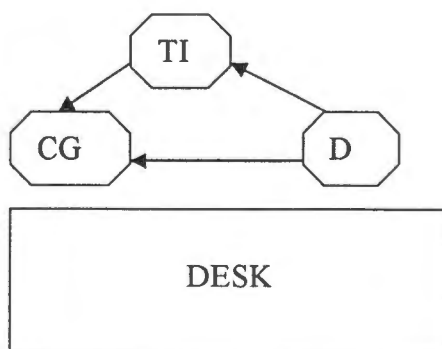
In an already complex interaction, non-verbal behaviours serve to add considerably to the complexity of an interpreted consultation. This means that in addition to trying to make sense of the verbal responses conveyed through the interpreter, the doctor also has to be aware of non-verbal cues and understand their impact on the consultation. Singelis (1994) states that in intercultural interactions, non-verbal communication becomes more important because of the difficulties in language and culture. Furthermore, Singelis argues that 93% of the social meaning of a message is carried through non-verbal cues. Cultural differences also impact on the interpretation of non-verbal messages adding further complexities to the interaction.

In conversational analysis non-verbal behaviour is considered to be the performing of a social action. The actions are generally bound to the broader activities associated with the consultation, for example, history taking. Three major themes related to non-verbal behaviour emerged from the analysis.

*HP: Ja, was with Zodwa and maybe even when you asking the question to look at the patient and not at Zodwa, because in essence the question is directed at her.*

The importance of eye contact as a visual cue, has been documented by many authors, including Tebble (1991) and Goodwin (1981 in Muller, 1994). Eye gaze was of particular concern to the doctor in the consultation. The doctor reported discomfort with the eye gaze in the session, as the caregiver's eye contact was made primarily with the interpreter. She reported feeling "dissociated" and therefore distanced from the caregiver. The doctor acknowledged the importance of eye contact and tried to make eye contact with the caregiver, but this was not returned. The doctor also varied her gaze between the caregiver and the interpreter when asking a question directed at the caregiver, even though she asked the question in the third person. This is partially in keeping with Muller's suggestion that after the initial introductions, eye contact was sporadic and not maintained by the interviewer. Although she was happy with eye contact in the consultation, the caregiver was more comfortable making eye contact with the interpreter and tended to bow her head when the doctor was speaking. The interpreter did not report any problems with eye contact. In many cultures diverting or lowering eye gaze is considered a sign of respect, whereas in the western culture it is considered as a sign that the listener is not interested in the speaker or does not really want to interact with the speaker.

The seating arrangements also emerged as an important aspect, specifically for the doctor. The seating arrangements of all the consultation are depicted in the diagram below.



**Figure 23** Seating arrangements in consultation

*HP: Yes I think what I like about (interpreter name) is that she'll come and sit in the conversation....there are some interpreters who will stand... (indicates with hand to opposite end of room at the basin) ...talk like that and talk back to you...so I like the way she interacts with the patient.*

The seating arrangements shown in fig 8 shows that the interpreter and caregiver generally sat closer together and the doctor a little further away, but still within the triad. The seating arrangements were not orchestrated by the researcher, but occurred spontaneously. The doctor later reported that this was the regular arrangement when she worked with this particular interpreter. She remarked that it was one of the things she appreciated about her, that she joined the conversation as opposed to sitting some distance away, which often happened when an ad hoc interpreter was used. This may be considered a product of the interpreter being considered part of the team in this clinic. Penn (2000) states that this seating arrangement is advantageous to the doctor as it provides an observer advantage and that indicates a degree of trust on the part of the clinician. Furthermore, this positioning shows respect for the cultural gap, which exists between the doctor and caregiver. The seating arrangements were ideal in a mediated situation, with the interpreter in the middle, and allowed access to non-verbal behaviour for all participants. The interpreter and caregiver had no problems with the seating arrangements. This was observed with the easy flow of conversation, which was evident in the consultation.

In the consultations, it was not always possible to analyse non-verbal behaviour in terms of conversational analysis. The reason being that some behaviours were not that easily observed on the videotaped recordings. Certain non-verbal behaviours were, however, found to express certain actions, which were important in creating the understanding between the participants. Gesture was an important component of the creation of social understanding in the consultations. Where words were sometimes absent, either by choice or by not being able to find the right words in the language, gesture served to overcome this and aided in explaining what the speaker was trying to do. Strangely, even though the gesture was visible to the doctor when used by the caregiver, the interpreter still "interpreted" the gestures used by the caregiver, when making the verbal translation.

### 3.2.3.2 Interpersonal Interaction

Fisch(2001) has argued that a successful interpersonal interaction within a triad is needed to contribute towards the caregiver's comfort and satisfaction with the interpreted consultation. In this study, the doctor reported feeling very comfortable and relaxed in the interview. This was attributed to her confidence and trust in the interpreter, with whom she had worked regularly. She had no concerns about the accuracy of the translations, because she knew the interpreter professionally and was therefore familiar with her interpreting style. This was demonstrated in the conversational analysis by the reference terms she used, referring to the interpreter by her first name. In the sequence organization a pattern emerged whereby a question asked by the doctor would be followed by a series of question-answer sequences between the caregiver and interpreter. The doctor was unconcerned by this and waited patiently for the interpreter to provide her with a summary answer. She reported no concerns about having missed out on the exchange or that the exchange was related to the consultation. Her "trust" in the interpreter and previous work experiences with the interpreter, meant that this was an acceptable practice in their working relationship.

*HP: Well, I would have asked about the social history (laughter) again, ja and I think for myself maybe I was a bit dissociated, because .....I try sometimes to be more ....to touch the patient while they are talking so that they know that I'm understanding what they are saying hmm, she actually turned away from me when she was speaking to (interpreter name) and I thought maybe it was because she felt uncomfortable with me – I don't know why - , but I thought maybe I could have had more closer contact with her just to say that everything was ok and that I understood what was happening*

The caregiver also expressed being comfortable in the interaction. The presence of the interpreter made a significant impression on her. The caregiver equated the presence of the interpreter with a cultural understanding of her viewpoint. For the caregiver, the doctor had made an effort to understand her culture by making provision for her language needs. This was shown to be a positive step towards creating a rapport with the caregiver, as her attitude toward the doctor was positive

and open. Having the interpreter in the room was important to the caregiver, as she had someone with whom she could identify who shared her language and her culture.

*TI : She's very nice she's a good doctor, she's so patient (smiling)*

The interpreter also expressed feeling quite comfortable throughout the consultation. As she had worked with the doctor previously and had established some sort of relationship with her she was relaxed and at ease throughout the session. She also expressed a liking for the doctor, describing her as 'kind' and 'so patient', suggesting that she enjoyed working with the doctor. Having worked with this particular doctor previously, she also commented that she was familiar with her style of working and therefore had no concern or apprehension about interpreting for her or not being able to understand the language she used. The reference terms used by the interpreter as highlighted by the conversational analysis suggested a prior professional relationship between the interpreter and the doctor. Her choice of medical terminology also suggested a shared knowledge of the situation or history taking procedure and that this was not the first time she was doing this. This was also indicated by D in her post-session interview.

### 3.2.3.3 Cultural Issues

According to Murphy(1986) culture can be defined as a system of norms, beliefs, values, customs and behaviours that members of a society use to cope with their world and one another, that are transmitted from generation to generation through learning. Cultural rules combined with the interactional style of the doctor and patient, have a significant effect on the communication in the medical interview. The doctor and the patient have different viewpoints on disease and treatment. Even if they share the same cultural background, this difference in viewpoints still remains. If this complexity exists in a dyad medical encounter, where the participants may even share the same language, the complexity will only escalate in the interpreted consultation.

*CG : Uzame umntu omntama ofana nam sizothethisana*

*She tried to bring in a black person like me so that we can talk*

Two significant cultural issues emerged from the data. Firstly, there is the notion that language can be equated with culture. As mentioned before, the caregiver felt that when the doctor made provision for her to express herself through an interpreter because of language differences between the doctor and caregiver, she essentially acknowledged to the caregiver that there was a cultural gap and that she was trying to create an understanding. This example emphasises the role of language in cultural understanding.

Secondly, the doctor expressed that she often did not have the cultural understanding of the Xhosa culture and that the interpreter played an important role in educating her about that culture. Consequently, her perceptions about the Xhosa culture have changed, resulting in a greater tolerance in her inter-cultural interactions. This was specifically in relation to medicine, an area of health care where it is common for caregivers to seek treatment from a traditional healer or wait for a long time before presenting the child to a doctor. The interpreter helped to explain possible reasons why this was happening to create understanding of the caregiver's perspective, doing so without making judgements about whether the decision was right or wrong in medical terms.

The interpreter also expressed that being the cultural bridge between the doctor and caregiver was an important part of her role. She was aware that she needed to educate the doctor, so that the doctor understood the caregiver's background and perspective and would therefore not react in a negative manner. With reference to her comments, it is suggested that this is sometimes a difficulty with some doctors, where lack of cultural understanding creates a negative reaction from the doctor. She also mentioned that caregivers from rural areas who have moved to the urban areas, may be more traditional and observe cultural practices or behaviours that were unfamiliar even to the interpreter. It followed that they would have to explain the practice to the interpreter before she could explain it to the doctor. This reflects the difficulties of the role of cultural broker and the pivotal role of a trained interpreter.

#### **3.2.4 Institutional aspects**

The data revealed that the institution impacts notably on both the health professional and the interpreter. Congruencies between the institutional aspects and the

conversational analysis were not easily determined. The institutional aspects, which emerged from the interviews, reflected issues outside of the particular consultation. Some of the aspects, which emerged are discussed under the following subheadings:

#### 3.2.4.1 Availability of interpreter services

Interviews with both health professionals and interpreters indicate that there is a significant problem with availability. Trained interpreters are often unable to assist all the health professionals or indeed caregivers who are in need of their services. In practical terms it is simply not possible to service more than one clinic simultaneously. A clear distinction was evident between the interpreters understanding of their availability and the health professionals perception of that availability.

*TI : Ya, ya , because, if I'm busy sometimes and then I've got a call so I have to answer back and tell that person that at that particular moment I'm unavailable will you please just hang on just for 5 or 10 minutes, okay they will wait, 'cos I'm alone now and they understand it's a big responsibility*

*HP: yes hmmm, I think well we do have 2 interpreters, but for the amount of work they have to do I think it's too little and it's also their availability is a problem, because as I said the workload is a lot and often when you need them they can't actually come.*

The interpreter sees herself as always being available, which could be interpreted as a willingness. This suggests that unavailability is not necessarily of the interpreter's making, but arises out of the circumstances in the clinics. The health professional's perception of the physical availability of the interpreter was less positive, although she acknowledged that she knew the interpreter tried to be available and conceded that the situation was not under the interpreters control. The caregiver had no perception about the availability of the interpreter as she was not really involved in arranging the interpreter services. She did mention that at her previous visit to the hospital, which had been her first visit, she did not have an interpreter present and indeed had no knowledge that the service was available.

#### 3.2.4.2 Interpreter Workload

The workload experienced by interpreters emerged as an important factor both to health professionals and interpreters. The excessive workload is indicated to be an underlying problem causing a range of other institutional problems, for example the availability of the interpreter. The interpreter mentioned the workload problem on several occasions. She also indicated that regular break times during the working day were inconsistent and suggested that her availability to interpret was perceived to be a priority with less regard for her personal needs. This is in conflict with the Basic Conditions of Employment Act (1997), which state that employees are entitled to one-hour meal breaks or 30 minutes if negotiated with the employee, and if employees work through rest periods, remuneration is to be paid. The pressures placed on the interpreters also increase substantially if they work without regular rest periods. In addition, the interpreter reports that there is no specific space within the hospital allocated to the interpreters, which means there is no place for her to store her personal belongings. The lack of space may be a logistical issue intrinsic to the institution, but it is suggested that this may undermine the value attributed to the interpreter in the institution. The interpreter did not report this information as a complaint, but was quite accepting of the situation. It does, however, suggest imbalances of power or entitlement in the working environment.

#### 3.2.4.3 Professionalism

The interpreter's image was also an issue, which emerged out of the data. The doctor felt that the interpreter's external image [the wearing of a green uniform], played an important role in putting the patient at ease. The doctor felt that the uniform showed that the interpreter was a professional and that she wouldn't have to worry too much about what was being disclosed in the consultation. In a sense, the doctor projected her own perception of what looks professional and the meaning thereof for the caregiver.

*D : do, ja.. hmm and I think (interpreter name) having a nice green uniform does help, because then they know she's a professionally trained person and it's not just somebody coming in from the waiting room or even one of the nurses so it's*

Cultural differences would suggest that the caregiver might feel quite different about the issue. The uniform worn by the interpreter, is a hospital issue and instantly aligns the interpreter with the hospital. This therefore removes the neutrality and could potentially cause the patient to be unresponsive to attempts by the interpreter to be an advocate for the patient. In some cases it may engender distrust as the caregiver perceives the interpreter as the hospital representative. This does not then promote the interpreter's potential role as a patient advocate.

#### 3.2.4.4 Needs

The need for more trained interpreters was raised frequently. Both the doctor and the interpreter suggested that having more trained interpreters would solve problems with workload, availability and indeed reduce a lot of the reported problems. The doctor felt that interpreter availability would improve and would address immediate problems that doctors have with respect to language and cultural barriers and this would be an easy solution as opposed to the implementation of a language learning programme. The availability of more interpreters would also reduce the demands placed on the interpreter in the outpatients department. The doctor was also of the opinion that this would facilitate a less pressured working environment and improve the interpreting service.

#### 3.2.4.5 Reliability

The use of a trained interpreter was reported to be both a comfort and a relief for the doctor. She reported that, knowing that the interpreter was trained, eliminated her fears of having inaccurate translations conveyed. The issue of confidentiality was also an important issue for the doctor.

*HP: They made me feel very comfortable and very relaxed and confident That I was..., we were going to get out of the consultation what we needed to know and just took the pressure off about, ja., being misunderstood or having the wrong information carried across.*

She reported being reluctant to use an ad hoc interpreter, firstly because the element of trust which she experienced with the trained interpreter was absent, since she did not trust the untrained interpreter, and secondly, because of confidentiality she was

reluctant to have someone in the consultation who was not familiar with the importance of this. The essence of this is the trust relationship between doctor and interpreter. The issue of trust was clearly demonstrated by the turn taking procedures shown in Figure 5 (B). The independence the interpreter is afforded in those turns, without reproach from the doctor, shows the trust and reliance the doctor has in the interpreter. When the doctor works with someone who fulfils a specific role of interpreting, trust and confidence in what the interpreter is doing develops.

#### **3.2.4.6 Status**

Fisch (2001) has indicated that interpreters often have an unrecognisable status in a medical institution and as a result do not get the recognition they deserve. The interpreter working in the hospital was confident about her status. The hospital has a policy that aims to address the needs of the Xhosa speaking patients to ensure equal access to medical care. Consequently, in her role as one of the hospital's trained interpreters, the interpreter has a job description and is a member of the team in which she works. The interpreter did not express any hesitation or doubts about her status in this regard. The doctor, expressed a high regard for the interpreter's role in the clinic and consultation, and particularly through the eyes of the caregivers. She acknowledged that the interpreter had a significant role to play, but emphasised that this role was limited to the consultation process. Furthermore, she suggested that even though she was a member of the team and played a role in the patient's care, her input could not be equated with that of a doctor. She also suggested that for hospital services in which a patient history was not taken, an interpreter was not really needed as the exchange was short and simple. It is proposed that the status of the interpreter is still not certain in the medical institution. Although, the interpreter is accepted into the team, the perception seems to be that she is not really an equal member of that team. Until such time that this perception is changed through education, the interpreter's status will continue to be inconsistent and sometimes unrecognisable.

#### **3.2.5 Satisfaction**

All the participants in the consultation reported being satisfied with consultation and the outcomes.

The caregiver expressed satisfaction at being able to understand what was being said and for being understood by the doctor. She also expressed satisfaction with the overall service received in the clinic. The fact that the interpreter shared a common culture with caregiver was also perceived as satisfying as she was helped.

The evaluation of satisfaction was subjective and very difficult to determine objectively.

The doctor and the interpreter also expressed satisfaction with the interview. Both felt confident that there were no misunderstandings in the interpreted consultation and that the caregiver understood the information and treatment protocol communicated in the session.

## **CHAPTER 4: GENERAL DISCUSSION**

### **4.1 INTRODUCTION**

It is clear that much of the success of health care provision is dependent on the interactions between health professionals and patients. Patients participation, and in this particular study, caregiver participation is important for the success of medical outcomes (Drew et al., 2000). The interaction between medical staff and patients is, however, perhaps the most difficult aspect of medical care delivery to study and measure. When language and cultural differences exist between the health professional and the patient or caregiver, the interaction increases in complexity and the pressures on the participants to make the interaction work increases significantly. The interpreter in this interaction serves to overcome these barriers so that the medical interaction can be successful and ultimately so that medical care is effective.

Wood(1993), suggests that the responsibility for the interaction being successful is that of the interpreter's. This study suggests that this responsibility for the success of the interaction also lies with the doctor in the interaction. It is suggested that sharing this responsibility will impact positively on the interaction, resulting in an improved relationship between doctors and patients with different cultural backgrounds. The manner in which doctors use the skills of interpreters in the interaction should be such that they can assume equal responsibility for the interaction. This study aimed to describe and analyse the interaction between the doctor, interpreter and caregiver. The purpose of this analysis was firstly, to determine the underlying processes and interactional strategies used in the conversation, secondly, to determine any additional factors, which impacted on this interaction, and thirdly, to consider alternative approaches, if any, which could improve the interaction.

### **4.2 MEDICAL CONSULTATIONS AS INSTITUTIONAL INTERACTIONS**

With reference to the published literature on conversational analysis, the distinguishing characteristics of the data in this project suggest that the interaction in question was not a typical example of conversational analysis. A distinction could be made between ordinary conversation and the type of conversation taking place in the consultations. It is proposed that the interactions in this study be considered

'institutional interactions'. The characteristics of this type of interaction, which support this proposal, will be discussed below.

In their studies in conversational analysis, Drew and Heritage (1992a) have postulated that institutional talk has three essential features. Firstly, they suggest that institutional talk is goal oriented in institutionally relevant ways. This means that the interactions, which occur, occur for a specific purpose, or to achieve a specific goal. History taking, as discussed previously, is usually the first contact in the course of treatment a person may receive from a doctor. The purpose of history taking is to provide the doctor with information that he/she needs to make a diagnosis. In this study, the conversations analysed were history taking consultations. Previous studies of medical interactions report that history-taking interactions, by their very nature, lend themselves to a questioning procedure (Ten Have, 1999). The doctor in the interaction, through his/her position in the institution and the interaction, assumes the role of questioner and the patient has to answer. In the consultations, the interpreter and caregiver also remained goal oriented.

Findings from the analysis of sequence organisation, showed that even though the interpreter sometimes initiated her own questions independently of the doctor, she remained oriented to the purpose of the consultation and everything that she did was in line with achieving that goal. There was therefore a joint orientation to the goal of the interaction, which is accepted by all the participants as part of the 'culture' of the institution. Bolden (2000) has also shown that while the interpreter often preserves the format of the doctor's turn, the translation is often more constricting than the initial question. This was observed in the data in this study, where open-ended questions, which served to invite a more personalized description of the issue in question, were translated into closed questions, requiring a specific response. Where open-ended questions would cultivate a better rapport or feeling of equality for the patient in the consultation, the closed questions fit into a traditional biomedical model of working. This once again shows the orientation of the interpreter to achieving the goal of the interaction in the quickest, most effective way.

The structural organization, of the sequences in the data also supports the goal-oriented approach to the consultation. As discussed in the analysis section, the

consultation could be divided into three distinct sections or phases. These were the opening, body and closing phases of the interaction. Each phase was observed to serve a particular purpose or achieve a specific goal. The openings generally served to make introductions between the participants. The body of the interaction served to retrieve information from the caregiver. Within this general goal, sub-goals were observed, for example, retrieving information about pregnancy and birth history, retrieving information about developmental history. The final phase, which was the close of the history taking, served to inform the caregiver about what was going to happen next. Even though this may be true also for a 'normal' conversation, where there is usually a purpose to the interaction, the difference is that the goal in these phases or sections orientated to the primary goal of the interview and is therefore context specific.

The second characteristic that Drew and Heritage suggest as a feature is that institutional interaction involves special and particular constraints on allowable contributions to the business at hand. Ten Have (1999) suggests that the forms of interactions in institutions are more restricted in that one or more kinds of actions, forms or sequences are observed in conversations. In the study, participants were observed to perform a limited range of actions as discussed in section 3.1.4. In addition, certain participants were observed to carry out the same actions throughout the consultation. There were only two types of sequences observed in the data, which also suggests limitations to the range of sequence types, which can occur. The asymmetrical distribution of questions in the data also depicts the limitations present in the interaction. It is suggested by Ten Have that the interactions in institutions sometimes have a pre-allocated system of turn allocation. In the data a pre-allocation of questions and answers was observable, the former being to the doctor and the latter to the caregiver. The interpreter too, had a pre allocated turn. This was usually the turn, which followed the doctor or the caregiver. The difficulties with turn pre-allocation are that the questioner has a pre-given right to a questioning turn and as such can build a long turn until a question is produced. The questioner, however, should he/she do the same, runs the risk of being interrupted as soon as a minimally adequate "answering component" is uttered (Ten Have, 1999). This does not promote a positive interaction between the two and may in fact make the 'questioned' feel

like he/she does not have the equal right or opportunity to talk in the interaction. Overlaps in the data were indicative of this occurrence.

Furthermore, participants also used specific reference terms, descriptive terms and institutional euphemisms, which they would probably not have used in a 'normal' conversation. Reference terms used were formal and slightly impersonal, which again is deemed appropriate in this context. The interpreter and doctor also used medical terminology when conversing with one another. This was familiar to only the two participants, but once again indicates that this is not an ordinary conversation. The way of speaking too was constrained. The participants used directive speech most of the time, using close-ended questions, leaving no opportunity for additional talk or information. All the participants took the directive approach, once again suggesting that in this context this was accepted.

Another theme discussed by Drew and Heritage (1992) as a feature is that institutional interaction may be associated with inferential frameworks and procedures that are peculiar to a specific institutional context. This means that in a particular institutional environment, the people in the institution work within a specific framework relevant to the institutional context, and therefore also carry out procedures, which are specific to the institutional context. In this study, the history taking procedure in itself is a procedure specific to the medical context. The procedure of history taking is quite specific and is similar in all medical/health care settings. The operational frameworks in an institution, is also dictated partly by those in control of the institution and partly by the inherent operational frameworks present in the institution. In this study, the training undergone by both the interpreter and the doctor could also be suggested as an influential factor operating mechanisms of an institution. Training prepared them for the accepted procedures and protocols of this particular institution. When joining the institution, individuals are socialized to the inferential frameworks and procedures of an institution and are also made aware that conduct outside of these frameworks is not socially/professionally acceptable.

It is the researcher's premise that the interactions observed during the study contain the features of an institutional interaction as suggested by Drew and Heritage. This

does not suggest that this type of interaction is inappropriate or wrong, but merely specific for this interaction.

#### **4.3 INTERPRETER MODELS IN INTERACTIONS**

An additional dynamic in this study is that an interpreter was part of the interaction. Although, the interactions are considered to be institutional by nature, this aspect also needs to be taken into consideration. In contrast to the dyadic doctor-patient relationship with its single relationship, the triad doctor-interpreter-patient model involves three relationships. Wood (1993) suggests that within this structure, there are a number of possible ways for the interaction to be handled. Firstly, he states that an interpreter may function as an interviewer. In this model, the interpreter conducts the interview along specific guidelines set by the doctor, who has no direct interaction with the patient. Although the history taking procedure is usually quite structurally formatted, it is a significant part of the process toward formulating a diagnosis. This means that information arising out of one turn may lead to a different question that cannot be predicted. In order to function as an interviewer and provide the doctor with sufficient information to make a diagnosis, the interpreter would need to have a significant amount of medical knowledge, possibly equivalent to that of the doctor. In practical terms this would be very difficult to implement. This model of interaction was not present in this study. Secondly, the interpreter may function as a patient advocate. In this approach, the interpreter sees himself/herself as protecting the patient from excesses of the doctor or the medical context to which the doctor belongs. Wood (1993) indicates that it is unusual for the doctor to ask his/her interpreter to assume such a role. The data showed no evidence of the interpreter acting as a patient advocate. The interpreter did, however, see this as part of her role.

The third structure suggested by Wood (1993) is that the interpreter acts as 'cultural broker' between the doctor and the patient. In this study, a significant cultural barrier existed between the doctor and the caregiver. Much of the focus in the consultation was on overcoming the language differences, which may have diluted the significance of the cultural gaps. As the interpreter is more aware of the cultural differences he/she serves to bridge these gaps between the doctor and caregiver. In this study, both the caregiver and doctor seemed aware of their cultural differences, and therefore

appreciated the presence of the interpreter in helping each to understand the other. It is suggested that over identification on the part of the interpreter with either the doctor or patient, places pressure on the interpreter. This was not the case in this study, where the interpreter was observed to take a neutral stance in all the consultations. Although this is felt by many authors to be the appropriate way an interpreter should function, it is in conflict with the role of being a patient advocate.

Two models of interaction suggested by Wood (1993) were felt to be quite significant to this study. The 'Black Box model' of interpreting involves the interpreter acting as an instrument of the provider. In this interaction, the doctor remains in control of the interaction and requires the interpreter to make as direct a translation of his/her questions and the patient's responses as possible. The model, although popular, has been argued to be limiting in a medical setting. Historically this model has been prescribed as the appropriate way for an interpreter to function. The other model of significance is that of partnership between the interpreter and the doctor. In this model, it is acknowledged that the doctor and interpreter both have skills to offer the patient or caregiver, and that functioning, as a team will result in more effective patient care.

In the consultations, the interactions were observed to move between the two models of interaction. As mentioned previously, two particular patterns emerged in the analysis of turn taking organisation, which supported both these models of interaction. It appears that either model functions to a lesser or greater degree depending on the doctor with whom the interpreter is working at the time. In two of the consultations, the model of partnership was more obvious, whereas in the third consultation, the 'Black Box model' of interpreting took preference. It is suggested that the interpreter chose either approach, whether consciously or sub-consciously, depending on the doctor in the interaction. Bolden (2003) found similar results in her study of interpreted interviews of doctor-patient interactions, stating, as did Crawford (1994), that the black box approach was too simplistic and that interpreting should be understood more broadly as an activity in its own right. She attributed the presence of both models of interpreting as a manifestation of choice between several alternatives, which embody the interpreter's moment-by-moment decisions, about the most appropriate approach at the time in the particular interactional environment. In the

post-consultation interview in this study the interpreter acknowledged working with some of the doctors in the department on a regular basis and as such was familiar with the doctors. It is suggested that the interpreter adapts to each doctor's personal style and adapts to the approach she perceives the doctor wants her to take. Furthermore, the findings of the thematic analysis, indicate that these decisions are based on the doctor's turn design and approach to the interactions.

#### **4.4 CONGRUENCE BETWEEN CA AND INTERPRETER MODELS OF MEDICAL INTERACTIONS**

In conversational analysis studies of interaction between health care professionals and patients by Drew et al., it was concluded that the opportunities for and the character of patient participation in the interaction was largely bound, in systematic ways, to the way the doctor managed the interaction. The patient's participation in the interaction is therefore understood as at least partially the interactional product of the doctor's communicative practices and choices. Conversational analysis provides the opportunity to identify the kinds of choices doctors make in their turn at talk. Conversational analysis goes further to show how these choices or selections have consequences for what patients subsequently say and do. The interactions in this study have been shown to be typical examples of institutional interactions.

Similarly, Erasmus (1999) suggests that the Black Box model of interpreting, although extremely limiting, is the most widely used in institutions South African. In respect of this model, Crawford (1994) argues that doctors use the 'black box' model for the transformation of messages without appreciating the problems of cross-cultural boundaries where there is not necessary equivalence between cultural constructs and ways of perceiving the world. Bolden (2003) states that this model of interpreting is preferred because it complies with the traditional biomedical model of disease, where there is a preference for objective and decontextualized presentations of information instead of personalized descriptions. Although there has been a move toward a more patient-centred approach, most doctors are still trained in this model and this is true of the doctors participating in this study.. Consequently, doctors may feel that they are expected to be most efficient in diagnosing a medical problem presented in a traditional 'scientific' manner. The biomedical model in South Africa is inherent of

the apartheid of the apartheid era. Since 1994, the government has focussed on providing primary health care to all South Africans. This involved the mammoth task of changing a healthcare system, which was inequitable; fragmented, bureaucratic and inefficient; authoritative and undemocratic; and inappropriate for the majority of people. Since the biomedical approach is inherent in most medical institutions, change is a much slower process.

In summary therefore, it is suggested that the interactional strategies used and the interpreter models used in this particular institution, lends themselves to a biomedical approach toward interaction, although, there are indications that the doctors participating in the study are trying to move toward a patient-centred approach. Indirectly, they are trying to change the model of interpreting and interactional strategies. The issue is not whether the current approach to interaction is right or wrong, but whether it meets the goal of achieving a patient-centred approach. Furthermore, is it possible and necessary to identify and develop alternative ways in which this goal can be achieved.

## CHAPTER 5: CONCLUSIONS AND IMPLICATIONS FOR FUTURE RESEARCH

At the outset of this study, the researcher aimed to document and describe the interaction between the doctor, caregiver and interpreter in a case history interview within the field of medicine. More specifically, the researcher set out to determine the underlying interactional strategies used in the interactions and describe/interpret how this related to the interaction. The findings suggested that interactions taking place in this environment were essentially institutional interactions, both in terms of the interactional strategies and the interpreter models employed. The employment of qualitative, yet fairly objective analytical methods proved to be useful in describing the interactions without the threat of subjective influences.

The present study was not the first, which uses conversational analysis to study medical interaction, but it was to the best of the researcher's knowledge, the only one that has focussed on the interpreted medical interaction. Much of the research on interpreting originates in developed countries, which are experiencing an influx of people from less affluent countries, and are encountering new problems with communication relating to language and culture (Wood, 1993). Studies have been done in the social sciences on the use of interpreters with psychotherapists, but none have focussed on the doctor in particular. It is also the first to be carried out in a paediatric setting, a specific context in which the caregiver is the person participating in the interactions. The use of thematic analysis in collaboration with conversational analysis as a means for triangulation was also not been found in published studies.

A number of methodological issues also emerged out of the research. Firstly, at the outset of the study, it was the intention of the researcher to include a range of different health professionals in the study, including physiotherapists, occupational therapists and doctors. During the data collection this proved to be a difficult task. The occupational therapy department at the hospital, while willing to participate, made little use of the hospital's trained interpreter. This department employed two first language Xhosa speaking therapists and Xhosa speaking patients, would usually, be

treated by them. It was decided that including this department in the study would not give an accurate account of the interaction, which would occur in a 'normally' mediated interview, and this department was therefore, excluded from the study. The physiotherapy department had agreed to participate in the study, but no patients requiring an interpreter were seen in the clinic. Time constraints on the researcher did not allow for further attempts to be made, however, these settings should be included in further studies.

A second issue was that post-consultation interviews were only conducted following one consultation. Although, the interviews were solely for purposes of triangulation, it is not possible to comment on the generalizeability. Limitations with respect to time and the use of the research assistant may have impacted on the findings. The sample size of the research limited the possibility of statistical analysis, however, for conversational analysis, smaller samples are more appropriate due to the qualitative nature of the analysis.

Another factor, which may have impacted on the findings, is that the interviews were conducted in two clinics only, the medical outpatient clinic and developmental clinic. The developmental clinic specializes in assessment of children with special needs. It is possible that the doctors working in this setting, due to the nature of their work, may be more sensitive to subtleties of interaction. It is not possible to postulate from these findings the quality/type of mediated interactions, which might be observed in a more general outpatient clinic where time pressures and workloads are higher.

The researcher in this study was also not familiar with the language (Xhosa) and culture of some of the participants and therefore dependent on translators and interpreters to explain what was happening in the interaction. Fisch (2001) states that ethnomethodologists believe this to be a prerequisite for this type of research.

Detailed analysis of transcriptions and translations were, however, undertaken to ensure reliability of the data. The use of multiple raters to check transcriptions and translations in the study was felt to increase reliability. The final results are therefore indeed considered to be reliable and trustworthy.

In terms of conversational analysis and its purpose therefore, the research aim is not to judge whether the interactions which take place in a particular situation or right or wrong, but merely to describe what is happening and show how those findings have implications for the interaction. In keeping with this approach, the findings therefore suggest that the interactions described in the study are institutional interactions. The implications of this are that such interactions, although characteristic to the medical situation, are not really in keeping with a patient centred approach. Sefi (1988), in Jones (2003) reported similar findings in a study on health visitors' interactions with new mothers. Sefi concluded from the conversational analysis, that health visitors communicated from a pedagogical position as opposed a person-centred approach to communication. The significance of this is that there is a worldwide move towards adopting a patient-centred approach to health care. Many countries have already made it a central part of their health care system. In South Africa, the patient-centred approach is in keeping with constitutional and policy changes which have occurred over the past decade. Translating policy into practice at the interface between health care provider and client/patient level has been slow. Effecting changes in working procedures and systems is possibly easier than changing communication systems. This research does not suggest that the current approach is inappropriate or that a patient-centred health care system cannot be achieved this way, but that possible alternatives should be considered in the goal of patient centred care.

Change can take place at a number of levels. It may take place at the level of the institution, at the level of training or at a personal level. Proposing changes on an institutional or personal level is not in the remit of this study. Institutional changes need to be initiated and carried out by all stakeholders in an institution and requires recognition that there is a need for change. Change on a personal level requires an individual to initiate changes within him/herself and although outsiders may try to influence that individual, changing one's approach to an interaction, is a personal decision. The alternatives, which are suggested by this study, are that participants are made aware of the implications of the interactional strategies, which they employ. It is possible that doctors are unaware of how the communicative choices they make in an interaction influence the responses or participation from both the interpreter and caregiver. An example of this from the findings is demonstrated in the

inconsistencies in openings of interactions, where the significance of an introduction was perhaps not apparent to the doctor, but possibly influential in the interaction. The suggestion is therefore, that doctors are trained at a undergraduate and post-graduate level, to understand the consequences of certain actions. It is also important to provide them with alternative strategies, which would promote the participation in the interactions and enhance the relationship between the participants. Wood (1993) has included suggestions such as doctors using short, simple questions and rephrasing and repeating questions to check the quality of translations. Penn (2000) and Fisch (2001) have also suggested guidelines and aspects which could be included in training.

### **5.1 IMPLICATIONS FOR FUTURE RESEARCH**

The need for further research is indicated by the paucity of published research into medical interactions. Research into the use of mediated interpreting interaction by different health professionals as was initially intended for this study, is still an area which warrants further research. It could be useful to extend the analysis of interactions to include other types of medical interaction, for example, follow-up visits or diagnosis deliver, which would allow for the examination of different aspects which come into play in those situations. This could also have implications for educating doctors and other health professionals about the different interactional strategies, which they could use. Conversational analysis provides a sound basis for assessing the likely interactional and communicative consequences of adopting different approaches to an interaction. This is important in considering what to recommend that doctors should say in particular circumstances. Recommendations should be founded on the interactional consequences of adopting a given practice (Drew et al, 2001).

Research into whether educating doctors and other health professionals about interactional strategies and interpreting models, in fact makes a difference to the ensuing interactions in consultations enhance understanding of what is considered to be a vital component of health care – the health professional –client/patient relationship. The effect of this on the patient-centeredness of the interaction is a further research option. Research into the training and impact thereof, of interpreters is needed. The use of ad hoc interpreters is a current reality in the South African

health system, and in focussing on the interests of the patient, educating doctors and other health professionals would improve the use of the untrained persons, although this must be seen as a “less than optimum” option. It is currently rare to have personnel dedicated to interpreting in South Africa. If further research is able to demonstrate that the utilisation of trained interpreters by health professionals leads to improved patient care, this would be a strong motivation to include interpreters as a recognised members of the health care team. There are also implications for training for health care workers. Training can enhance awareness of interactional consequences when they select from various alternative practices available in certain situations and assist them in selecting courses of action, which are most likely to succeed in achieving certain aims (Drew et al, 2001).

Another aspect, which requires further investigation, is the potential impact of the relationship between the doctor and interpreter on the interaction. In this study, the doctor managed the interaction, or in certain instances allowed the interpreter to share in the management of the interaction.

Although there is a need for trained interpreters in health care institutions, it is also important that health professionals are able to use their skills optimally. Interpreter training aims to provide interpreters with a range of skills, which if used optimally, could impact positively on both medical interactions and the establishment of a patient-centred health care system. Efforts towards achieving both these goals should therefore also focus on health professional training in collaboration with promoting the use of trained interpreters.

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## APPENDIX I

### CONSENT FORM FOR HEALTH PROFESSIONALS

Hello, my name is .....

I am conducting a study on interpreting in South African Health Care. The purpose of the research is to document interpreted consultations within the fields of medicine, physiotherapy and occupational therapy, with a focus of the clinician in the interpreted interview. Hopefully the results of this research will contribute towards more effective interpreting services within health care in the future.

I would like to invite you to participate in this research. We would like to videotape an interpreted medical interview with a patient, a qualified/unqualified interpreter and yourself. Following this, with your permission, we would like to conduct an interview with you so as to find out how you experienced the interpreted medical interview. This interview will take approximately 45 minutes of your time.

All information including the videotaped material will remain confidential throughout the duration of the study. All videotapes will be destroyed at the end of the study. None of the participants in this study will be identified in any way, in any reports or publications resulting from this research.

There are no risks in this study, but it is acknowledged that some discomfort may be experienced as interviews will be recorded on tape. There are no direct benefits to participants. However, present and future health professionals may benefit from the information we collect, as it may influence future training of health professionals and thus might bring about change in practice that could be beneficial.

You have the right to decline to participate and the right to withdraw from the study at any time without providing reasons.

Thanking you,

-----

Contact person  
Dale Ogilvy  
Telephone number: 021 674-3284

I, \_\_\_\_\_ consent to participating in interpreted consultations, which will be recorded. I have read, understood and acknowledged the contents of this consent form. I agree that my response may be used in a report, but understand that there will be nothing to identify me personally.

**Signed:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

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

## APPENDIX II

### CONSENT FORM FOR INTERPRETERS

Hello, my name is .....

I am conducting a study on interpreting in South African Health Care. The purpose of the research is to document interpreted consultations within the fields of medicine, physiotherapy and occupational therapy, with a focus of the clinician in the interpreted interview. Hopefully the results of this research will contribute towards more effective interpreting services within health care in the future.

I would like to invite you to participate in this research. We would like to videotape an interpreted medical interview with a health professional, a patient and yourself. Following this, with your permission, we would like to conduct an interview with you so as to find out how you experienced the interpreted medical interview. This interview will take approximately 45 minutes of your time.

All information including the videotaped material will remain confidential throughout the duration of the study. All videotapes will be destroyed at the end of the study. None of the participants in this study will be identified in any way in any reports or publications resulting from this research.

There are no risks in this study, but it is acknowledged that some discomfort may be experienced as interviews will be recorded on tape. There are no direct benefits to participants. However, present and future health professionals may benefit from the information we collect, as it may influence future training of health professionals and thus might bring about change in practice that could be beneficial.

You have the right to decline to participate and withdraw from the study at any time without providing reasons.

Contact person  
Dale Ogilvy  
Telephone number: 021 674-3284

I, \_\_\_\_\_ consent to participating in interpreted consultations, which will be recorded. I have read, understood and acknowledged the contents of this consent form. I agree that my response may be used in a report, but understand that there will be nothing to identify me personally.

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

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

## APPENDIX III

### CONSENT FORM FOR CAREGIVERS OF PATIENTS / PATIENTS

Hello, my name is .....

I am conducting a study on interpreting in South African Health Care. The purpose of the research is to document interpreted consultations within the fields of medicine, physiotherapy and occupational therapy, with a focus of the clinician in the interpreted interview. Hopefully, the results of this research will contribute towards more effective interpreting services within health care in the future.

I would like to invite you to participate in this research. We would like to videotape your interpreted medical interview with the health professional and an interpreter. Following this, with your permission, we would like to conduct an interview with yourself so as to find out how you experienced the interpreted medical interview. This interview will take approximately 45 minutes of your time.

There are no risks in this study, but it is acknowledged that some discomfort may be experienced as interviews will be recorded on tape. There are no direct benefits to participants. However, present and future health professionals may benefit from the information we collect, as it may influence future training of health professionals and thus might bring about change in practice that could be beneficial.

All information including the videotaped material will remain confidential throughout the duration of the study. All videotapes will be destroyed at the end of the study. None of the participants in this study will be identified in any way in any reports or publications resulting from this research.

You have the right to decline to participate without giving any reasons and you have the right to withdraw from the study at any time without providing reasons.

Contact person  
Dale Ogilvy  
Telephone number: 021 674-3284

I, \_\_\_\_\_ consent to participating in interpreted consultations, which will be recorded. I have read, understood and acknowledged the contents of this consent form. I agree that my response may be used in a report, but understand that there will be nothing to identify me personally.

**Signed:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

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

## APPENDIX IV

### INTERVIEW QUESTIONS FOR TRAINED INTERPRETERS

#### BIOGRAPHICAL INFORMATION

##### Language History

What languages did you speak at home as a child?

What other languages do you speak and how would you describe your knowledge of your other languages?

How old were you when you acquired your second/third languages?

Where did you learn English?

What languages do you read and write?

Which language were you schooled in?

How would you rate your proficiency in English (not good/good/very good)?

When do you speak your other languages – work, home, social?

#### EDUCATION/TRAINING

What is your level of education?

Have you done training in any other field aside from interpreting?

Where did you undertake your interpreting training?

What was the name of the course?

How long was the course?

Are there any modules that you still need to complete?

Did you do the course on a full or part-time basis?

How long have you been interpreting?

How long have you been interpreting in healthcare?

Where else have you worked as an interpreter?

How long have you been staffed at Red Cross?

Do you think your training equipped you well enough for this job? In which way?

What type of work experience do you have other than interpreting?

#### WORK EXPERIENCE/INSTITUTIONAL HISTORY

How did you experience working here before you were staffed in full time posts?

Which clinics do you prefer working in? Why?

Are there certain clinics you work in more often than others?

Which clinics do you feel that perform better in?

Do you feel that you've gained any specific medical knowledge from your experience in the hospital? If yes, in which fields?

Do you find that if you work clinic a lot, that you find it easier to interpret there?

How often do you get booked?

What is the procedure for booking you?

How are you treated in the clinics?

Do you feel you are there for the doctor or the patient?

What do doctors expect from you when you are interpreting?

Do you feel you've gained any specific knowledge in any medical field from working as an interpreter?

How do you see your role?

Do you think there is a need for interpreters in this hospital?

How often have you interpreted for this doctor?

What are your work conditions like?

- What are your work hours?
- When are you allowed to take breaks and what is the length of each break?
- Do you have an office?
- How do you feel about your workload?
- In a hospital as big as this, how available are you?
- Do you find it frustrating to meet the needs of the hospital?

Are you happy with your work conditions, what would you like to change?

How would you describe your status in the hospital?

### ACCURACY

Do you think the patient understood everything you said?

Do you think the doctor understood everything you said?

Do you think the patient was happy with your interpreting?

Do you think the doctor was satisfied?

How do you feel the interview went?

How did you find the length of the doctor's utterances/ questions?

How did this affect your accuracy?

How did you find the doctor's rate of speech?

Do you feel that you were allowed enough time to interpret, or did you feel rushed by the doctor, or the patient or both?

How did the doctor help you when you didn't understand him?

Were there any words or concepts used by the doctor that you couldn't find a direct translation for?

How did you explain these words and concepts to the patient?

Were there any words or concepts used by the patient that you couldn't find a direct translation for?

How did you explain these words and concepts to the doctor?

Do you think the doctor used a lot of medical terms?

Did he explain these?

How did the doctor react when you were uncertain?

Did you meet with the doctor before or after the session to clarify any issues?

Was it easy for you to understand the doctor?

What do you think should change to improve the interpreting situation?

Do you think your training prepared you well for "the interpreting situation"?

Do you think the interview would have been different if you hadn't had the formal training you have had?

What aspects of your training were you able to use today / have helped you the most?

What areas or skills would you have liked to learn more about in your training to become an interpreter?

### INTERPERSONAL

In this particular interview, did you feel closer to the patient or the clinician?

Did this feeling change at any time during the interview?

Did you have to help the doctor more or the patient? In which way?

How important was your presence there today?

How did the doctor make you feel?

How do you feel about being in someone's private session with the doctor?

How do you feel about knowing their business?

What do you think is the primary role of an interpreter? Do you think you play any other roles?

What role do you think you played in this interview?

### SATISFACTION

Many of the patients attending this hospital are not English / Afrikaans first language speakers, yet the majority of doctors and therapists speak only English or Afrikaans.

What do you think about the quality of service that patients from language groups other than English / Afrikaans receive?

How can the quality of service to speakers from other language groups be improved?

How satisfied are you with the service you provide? In which way?

### CULTURAL

The doctor and the patient have different cultural backgrounds. Do you think the interview would have been different if the clinician had come from the same background as the patient?

What would have been different, had the clinician and the patient been from the same culture?

Do you feel that you have played any other roles today besides translating from one language to another?

How did you feel being the liaison between two culturally distinct groups?

Do you think the doctor understands the patient's problem, and what it is like to live with that problem in his/her community?

Please give reasons for your answer.

Do you think the doctor was culturally appropriate?

Please give some examples of his cultural appropriateness

Are there any examples where the doctor has not been culturally sensitive? Is there anything else you think I should be aware of?

## **APPENDIX V**

### **INTERVIEW QUESTIONS FOR HEALTH PROFESSIONALS**

#### **BIOGRAPHICAL INFORMATION**

##### **Language History**

What languages were spoken in your home?

What other languages do you speak?

What language did you receive your education in?

How would you rate proficiency your other languages?

What languages do you read and write- how would you rate yourself?

How old were you when you acquired your second/third languages?

In which contexts do you speak your other languages- work, socially, home?

#### **EDUCATION**

Where did you grow up?

How long have you been working in this clinic?

Where did you undertake your training?

When did you qualify?

How old are you?

What type of work experience do you have?

How old are you?

#### **INTERPRETING EXPERIENCE**

Have you ever read any articles or papers on interpreting?

Do you think there is a need for interpreters in this hospital?

Who do you normally use when you need an interpreter?

Have you ever taken any courses or attended any talks on interpreting or using interpreting services?

#### **WORK EXPERIENCE**

What do you think is the role of the interpreter in a consultation?

In your clinic, how many sessions on average need interpreting services?

What is the procedure to get an interpreter?

Do you use ad hoc interpreters? If yes, who do you normally use?

#### **ACCURACY**

How accurate do you think the interpreter was in interpreting what you said to the patient?

How accurate do you think the interpreter was in interpreting what the patient said to you?

What do you think the reasons were for these inaccuracies?

Do you think the interpreter understood what you wanted to tell the caregiver?

What difficulties does the inaccuracies pose to your consultation?

What do you think the impact of these inaccuracies are on the interview?

What impact does the presence of an interpreter have on your consultation?

Do you think the patient understood everything the interpreter said?

Do you think the interpreter explained everything you said to the caregiver? Was there anything you felt was left out?

Did you understand what the patient was saying through the interpreter?  
Did the caregiver's answers make sense?  
Did you ever feel uncomfortable during the session? If yes, why?  
What do you think should change to improve the interpreting situation?  
Do you think the interview would have been different if the interpreter had been untrained/trained?

### INTERPERSONAL

How would you describe the relationship between the patient and the interpreter?  
How would you describe your relationship with the patient?  
How did the interpreter and the caregiver make you feel?  
Do you think the interpreter was empathic/comforting?  
Were you happy with the way the interpreter gave you information? (i.e. interaction)  
What do you think is the primary role of the interpreter? Does she play any other roles?  
What roles do you think the interpreter you worked with played?  
What did you think of the seating arrangements?  
What do you think the role of the interpreter is in a clinical team?  
Have you worked with Pam before? If yes, how often?  
How important is it to have an interpreter in this clinic?  
In a hospital as big as this, what is the availability of the trained interpreters?  
What is the procedure for getting an interpreter?  
Do you find it frustrating to find an interpreter?  
If the trained interpreter is unavailable, who do you normally use?

### SATISFACTION

Many of the patients attending this hospital are not English / Afrikaans first language speakers, yet the majority of doctors and therapists speak only English or Afrikaans. What do you think about the quality of service that patients from language groups other than English / Afrikaans receive?  
How can the quality of service to speakers from other language groups be improved?  
How satisfied are you with the service you provide? In what way?  
Do you think the questioning protocol you used resulted in your getting all the information needed?

### CULTURAL

What is your knowledge of the Xhosa culture?  
Do you feel at a disadvantage in this interview because you don't speak Xhosa and are not from the same cultural background as the caregiver?  
Do you think you have a better understanding of the patient and his family?  
Do you think you have an understanding of the patient and his illness within his family and the community?  
If yes, how did the interview facilitate you gaining this understanding?  
If no, what prevented you from gaining this understanding?  
How successful was the interpreter in bridging the linguistic and cultural gap between the patient and yourself?  
Would you have changed anything about the interview session today?  
Do you have any questions?

## APPENDIX VI

### INTERVIEW QUESTIONS FOR CAREGIVER

#### BIOGRAPHICAL INFORMATION

##### Background

Where do you live?

Are you employed?

Where are you employed or what do you do?

How many people are living in your home?

Who works in the house?

What is your level of education?

What is your relationship to the child?

#### LANGUAGE HISTORY

What is your home language?

What other languages do you speak?

When did you learn these languages?

How would you describe your knowledge of your other languages-do you speak or understand it?

Could you find understand the doctor's language?

#### INTERPRETING HISTORY

Have you been to Red Cross before?

Have you had someone interpret for you before?

Who interpreted for you?

Who usually interprets for you?

#### ACCURACY

How did you think the interview went today?

Do you think the interpreter understood all that you wanted to say?

Did you understand what the interpreter told you from the doctor?

Do you think the interpreter explained everything to the clinician. If not what was left out?

Do you think the doctor really understood everything you were trying to say?

How easy was it to be understood?

Were you happy with your interpreter?

Do you feel that you have been able to say all that you needed to say?

Were all your concerns addressed adequately?

How have previous attempts been using interpreters?

How did the clinician make sure that you understood you?

#### INTERPERSONAL

Do you know the interpreter? (untrained)

Have you been to see this doctor before?

How did you feel about having the interpreter in the room with you?

How did you feel about her knowing all your business?

Do you think the interpreter was helping you or the doctor?

Do you think the interpreter and the clinician were com

How did you feel not being able to talk for yourself?

How did the doctor make you feel?

How did the interpreter make you feel?

How important was your presence of the interpreter there today?

What do you think the role of the interpreter is? Do you think she plays any other roles?

Do you think that you received better help because of the interpreter being there?

### SATISFACTION

How satisfied are you with the service you received here today? In what way?

### CULTURAL

Do you think that the doctor understood or tried to understand your culture? How?

How successful was the interpreter in helping you and the doctor to understand each other despite your differences?

## APPENDIX VII

### EXAMPLE OF TRANSCRIPT MEDICAL OUTPATIENTS DEPARTMENT

#### DOCTOR WORKING WITH A TRAINED INTERPRETER

##### Key to abbreviations:

D – Doctor	CG – Caregiver	TI – Trained Interpreter
<i>Italics - Translation</i>		

- 1 D : This is Ms Mati Zodwa neh,  
2 CG : [ewe (nods)  
*yes*  
3 D : [she is just going to ask you a few questions (1.0) alright can you ask  
4 her how old is the baby,  
5 TI : ugqirha uyabuza uba umntwana unangaphi=  
*The doctor is asking how old is the child*  
6 CG : =una 8 months.  
*He is 8 months old*  
7 TI : 8 months.  
8 D : [okay  
9 CG : [ewe  
*Yes*  
10 D : and: what was she concerned about why did she come to the  
hospital=  
11 TI : =uyabuza yintoni ede yakubangela uba amzise apha esibhedlele  
*She is asking what made you bring him here in the hospital*  
12 CG : okay (0.3)ndibona ngathi ugula yonto akakwazi ukuzihlalela(0.3)  
*Okay what I'm seeing is that he is sick because of he cannot sit on*  
*his own*  
13 TI : okay  
14 CG : ke ngoku unok – simane somnantsika ph'endlini simsekela unento  
15 Yokusoloko athi (shows head extension) ngathi apha ( pointing at  
16 the back of the neck) kubuhlungu.  
*and now he likes to we usually do the thing a majig there at home we*  
*support him with things he has this thing that he always does (shows*  
*head extension) and it seems as if it is sore here (pointing at the back*  
*of the neck)*  
17 TI : zezonto zombini?  
*Those two things*  
18 CG : ewe mama.  
*Yes mama*  
19 TI : first of all the child can't sit on her own his own and secondly the  
20 neck (moving her neck back and forth ) it's [not strong enough. [It's  
floppy

- 21 D : [okay [alright  
 22 (0.3)can she tell us about ehm when the baby was born how was  
 23 he delivered?  
 24 TI : okay (0.3) umntwana waye wawuzi wawuzibelekele ngokunokwakho  
*Okay was the child did you did you give birth on your own*  
 25 CG : e-e  
*Yes*  
 26 TI : okay (0.3)yah she delivered [on her own .....  
 27 D : [normally (0.3) okay was the baby 9  
 28 months, or was he born before time  
 29 TI : wawuzele ngenyaga zakhe zolithoba okanye phambi kwexashe  
*Did you give birth on his 9 months or was it before time*  
 30 CG : ha-a ngen 9 months  
*No in 9 months*  
 31 TI : [9 months  
 32 D : [okay (0.3) and where did you deliver?  
 33 TI : wawumbelekele phi  
*Where did you give birth to him*  
 34 CG : e-Mowbray.  
*At Mowbray*  
 35 TI : Mowbray [maternity  
 36 D : [okay (0.3) did you have any ehm were there problems  
 37 with the baby after the delivery.  
 38 TI : emveni kokuba umbelekele umntana ingaba zikhona iingxaki othe  
 39 Wazifumana  
*After you gave birth to the child were there any problems that you experienced*  
 40 CG : ha-a bandikhupha msinya naphaya esibhedlele.  
*No they even released me straight away there at the hospital*  
 41 TI : [no problems  
 43 TI : mingaphi iminyaka yakho.  
*How old are you*  
 44 CG : iyi 32  
*It's 32 years*  
 45 TI : 32years  
 46 D : Does she have any illnesses like high blood, (0.3) [sugar....  
 47 TI : [ingaba  
 48 akunasigulo unaso like iswekire, I-high blood, pressure zonke  
 49 ezozinto  
*Do you have any illnesses like sugar high blood all those things*  
 50 CG : hayi (0.3) umthetho wam okoko ndifikile apha eKapa  
 51 ndiyakhohlela nje ngathi ndinesifuba kodwa phaya e-Site B e-kliniki  
 52 (0.3) bandifaka kwi-x-ray isifuba sam sihle asinanto=  
*no what has been common with me is that since I came here in Cape Town I have been coughing all the time it seems as if I have a chest problem but there at the clinic in Site B they put me in for x-ray but they say my chest is clear there's nothing wrong with it*  
 53 TI : =but awunaswekile awuna high blood.  
*But you don't have sugar and you don't have high blood*  
 54 CG : ha-a

- 55 TI : no: there's only (0.3) when she came to Cape Town she started  
56 coughing (0.3) but at the clinic they put her on the x-rays but they  
57 didn't see anything.
- 58 D : okay (0.4)is she taking any medication  
59 TI : ingaba akhona amayeza owatyayo noba ngawantoni?  
*Are there any medication that you are taking what are they for*
- 60 CG : ha-a  
*No*
- 61 TI : no  
62 D : and eh (0.3) during the pregnancy, was she sick at all, or did she have  
63 a healthy pregnancy.
- 64 TI : ngokuya wasunzima wawusoloko ugula okanye wawurayiti nje wade  
65 Wayobeleka.  
*During your pregnancy were you always sick or were you just okay til  
you gave birth*
- 66 CG : ha-a andizange ndigule qha bendithanda ukuqhinelwa sisisu.  
*No I was never sick but I used to have stomach constipation*
- 67 TI : sithini  
*What was happening*
- 68 CG : [isisu esi sam asindikakasi  
My stomach made it difficult for me to go to the toilet
- 69 TI : [uthoyilethe nzima  
*Was it difficult to go to the toilet*
- 70 CG : um. (nods)  
*Yes (nods)*
- 71 TI : okay no, she was okay, but although she was having a problem when  
72 she was passing the stools she [was (using hands gesturing)
- 73 D : [oh get constipated  
74 TI : [yah
- 75 D : okay ehm (0.3) when the baby after he was born can she remember at  
76 what age was he when he first smiled.
- 77 TI : umntana uqale enangaphi uncuma  
*How old was the child when he started to smile*
- 78 CG : lona (pointing at the baby on her back)  
*This one (pointing at the baby on her back)*
- 79 TI : (nods)
- 80 CG : e-ena[....  
*He was..*
- 81 TI : [3 months neh?
- 82 CG : eh  
*Yes*
- 83 TI : 3 months
- 84 D : okay (0.3) and ehm and does she think that the baby can hear and  
85 see?
- 86 TI : xa usowucinga uyabona uyeva ?  
*Do you think he can see and he can hear*
- 87 CG : eh uyeva ngendlebe uyabona .  
*Yes he can hear with his ears and he can see*
- 88 TI : [yes.

- 89 CG : [yonke into [uyayenza  
*He is doing everything*
- 90 TI : [he can see
- 91 D : okay. (1.0) alright(0.3) can the baby sit by himself
- 92 TI : uyakwazi ukuzihlalela ngokunokwakhe ?  
*Is he able to sit on his own*
- 93 CG : ha-a (0.3)akakwazi ukuzihlalela uthi nje umzuzu (1.0) (trying to  
94 show how the Baby sits) uphinde ( trying to show how the baby is  
95 falling on his back) uyawa  
*no he cannot sit on his own he can do this for a little while (trying to  
show how the baby sits ) and again (trying to show how the baby  
falls on his back) he falls*
- 96 TI : no: just(0.3) just for a few minutes= (gestures)
- 97 D : =for a few minutes then he falls over?
- 98 TI : yes.
- 99 D : okay. (0.3) can he hold his own bottle with both hands?
- 100 TI : uyakwazi ikuzibanbela ibhotile  
*Is he able to hold his own bottle*
- 101 CG : uyakwazi ukuzibambela yonke into  
*He is able to hold everything*
- 102 TI : okay yes
- 103 D : he can.
- 104 TI : she can.
- 105 D : and if she puts him on the floor can he lift himself up onto his ehm  
106 onto the Hands?
- 107 TI : xa umbeke phantsi neh yaqondo mhlawumbi uba umbeke phantsi  
108 uyakwazi ukuziphakamela (shows lifting body up onto hands)  
109 ngezandla?  
*when you put him down neh do you understand perhaps you put him  
down can he get up on he lifts himself up ( shows lifting body up onto  
hands) on his hands*
- 110 CG : ha-a (shakes head) akakwazi.  
*No (shakes head) he can't*
- 111 TI : akakwazi  
*No, not yet*
- 112 D : okay (0.3) alright (0.3) were there any other symptoms like headache  
113 ag you know vomiting or fevers, or coughing
- 114 TI : khang 'akhohlele abenobushushu [abene  
*Has he not been coughing, feverish and have*
- 115 CG : [uyakhohlela  
*He is coughing*
- 116 TI : akanabushushu  
*Is he not feverish*
- 117 CG : uyakhohlela abenobushushu ndakha ndamsa apha ku doctor  
118 (unintell) Apha e-Site B wathi u-doctor ane Asthma  
*He is coughing and he is also feverish I once took him to the doctor  
(unintell) here in Site B and the doctor said he has Asthma*
- 119 TI : uyakhohlela ngoku.  
*Is he coughing now*
- 120 CG : no kodwa ungcono ngoku

- No but he is better now*
- 121 TI : He was, coughing and she was at the (0.3)private doctor she went to  
 122 the private doctor and the doctor says it the child has Asthma and  
 123 now [he is fine  
 124 D : [he  
 125 is fine okay good eh in in the father or even in her family is there  
 126 anyone with a big head.  
 127 TI : akukho mntu kwifemeli yakho okanye kwifemeli yakulotat'akhe  
 128 onetloko Enkulu?  
*is there anyone in the family or in the father's family who has a big head*
- 129 TI : utat'akhe intloko yakhe inkulu (laughs shyly)  
*His father's head is big (laughs shyly)*
- 130 TI : it's the father (laughs)  
 131 D : does she think the child's head is big  
 132 TI : xa usowucinga wena ingaba intloko yomntwana ingakanani  
*How much big do you think the child's head is*
- 133 CG : (starts to laugh) inkulu intloko yakhe (laughs again)  
*(starts to laugh) his head is big (starts to laugh)*
- 134 TI : yes  
 135 D : hmm?  
 136 TI : yes it's big  
 (all laughing)
- 137 D : okay. alright okay (0.3) does he ehm has he started to make sounds  
 138 already like a baby?

Interruption. Someone enters the room and speaks to the doctor

- 139 TI : ingaba seyazi seyenza laa ngxolo a uyancokola  
*Does he know does he make those baby noises is he playing with sounds*
- 140 CG : ewe uyathetha  
*Yes he can speak*
- 141 TI : yes he does make sounds  
 142 D : he does make [(0.3) okay alright ehm what does the baby eat?  
 143 TI : [sounds yah  
 144 utya ntoni sisi  
*What does he eat sisi*
- 145 CG : ndimtyisa I-verge ndimtyisa ne-Nestum, I-Cerelac nefruit  
*I give him vegetables I also give him Nestum, Cerelac and fruit*
- 146 TI : Fruits [(1.0) vegetables ( looks at the caregiver)  
 147 CG : [e-e Ne-Nestum  
*And nestum*
- 148 TI : Nestum[  
 149 CG : [Number 2  
 150 TI : number 2  
 151 D : okay and the baby is growing?  
 152 TI : uyakhula ke phofu umntwana  
*Is the child growing*
- 153 CG : uyakhula esikalini

- According to the scale he is growing*
- 154 TI : yes
- 155 D : did she bring the clinic card with?
- 156 TI : uliphethe ikhadi lakhe laseklinikhi  
*Did you bring his clinic card*
- 157 CG : e-e (nods)  
*Yes (nods)*
- 158 D : okay, it's fine

## APPENDIX VIII

### COPY OF ETHICS APPROVAL FROM PAEDIATRIC HOSPITAL

NAVRAE:  
ENQUIRES: Dr K Ramiah  
IMBUZO:

TELEFOON:  
TELEPHONE: 021 658 5805  
IFOWUM:

FAKS:  
FAX: (021) 685 3391  
IFAX:

VERWYSING:  
REFERENCE: CLINICAL  
ISALATHISO: RESEARCH

DATE: 25 OCTOBER 2002



PROVINCIAL ADMINISTRATION: WESTERN CAPE  
Department of Health

PROVINSIALE ADMINISTRASIE: WES-KAAP  
Departement van Gesondheid

ULAWULO LWEPHONDO: INTSHONA KOLONI  
Isebe Lezempilo

Dr Dale Ogilvy  
2 Kildare House  
Fedsure Oval  
Oakdale Road  
Claremont

Dear Dr Ogilvy

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL:  
A PRELIMINARY STUDY OF FOUR CONTEXTS IN LIGHT OF FUTURE RESEARCH IN THE FIELD OF INTERPRETING.**

Permission has been granted for Layla Shaffie and Taryn Schwartz to conduct their research here at Red Cross War Memorial Children's Hospital.

Dr Tony Westwood, Head of OPD, telephone number 658 5190 and Matron Rey Arendse, telephone number 658 5008, should be contacted before any research is done on the premises.

My best wishes accompany this letter and I am looking forward to the report from the two students, Layla and Taryn.

Yours sincerely

**Signed**

Dr K Ramiah  
Senior Medical Superintendent  
KRamiah Research Ogilvy 25 10 02

1) DR TONY WESTWOOD  
2) MRS REY ARENDSSE

## APPENDIX IX

### COPY OF ETHICS APPROVAL FROM UNIVERSITY OF CAPE TOWN



Research Ethics Committee  
Faculty of Health Science  
E46-26 Old Main Building, Groote  
Schoor Hospital, Observatory, 7925  
Queries : Xolile Fula  
Tel : (021) 406-6492 Fax: 406-6411  
E-mail : Xfula@curie.uct.ac.za

19 October 2002

REC REF: 273/2002

Dr D Ogilvy  
Communication & Disorders

Dear Dr Ogilvy

INTERPRETING AND THE CLINICIAN: A DOCUMENTATION AND ANALYSIS OF THE  
INTERPERSONAL AND COMMUNICATIVE DYNAMICS OF THE INTERPRETED  
INTERVIEW IN A PAEDIATRIC HOSPITAL WITH FOCUS ON THE CLINICIAN

Thank you for submitting your study to the Ethics Committee for review!

It is a pleasure to inform you that the Research Ethics Committee has **formally approved** the above-mentioned study with the proviso that the two minor changes in the consent form are attended to:

- 1) There needs to be an indication of the expected time commitment each subject is required to make if they agree to participate in the study.
- 2) Benefits and risks of the study need to be mentioned.

Please quote the above Rec. reference number in all correspondence

Yours sincerely

**Signed**

A/PROF CR SWANEPOEL  
CHAIRPERSON