

CHAPTER ONE

1 INTRODUCTION

1.1 Motivation for the Study

The problem of ineffective communication between health staff and their clients/patients is serious enough to warrant research. In most cases where health personnel and their patients interact, the health personnel use Medical Language (ML) while the patients/clients use Everyday Language (EL).

- **Medical Language** is the language used by the health personnel in the health institutions; and
- **Everyday Language** is the language used by the clients/patients outside the health institutions.

This is evident when the doctor uses the term “pulse” referring to the heartbeat (pulse is an ML and heartbeat is EL). The patient may not understand what the pulse rate is and respond inappropriately to the health personnel. Interpreters are used, but are often inadequate and do not know the technical medical terms. The interpreting of the information from the client/patient to the health staff is also prone to distortion by the interpreter/doctor because of the lack of proper understanding of the messages/ languages.

In addition, most of the written medical orders are abbreviated and a medical register is used. For example, in the case of a patient who is suffering from severe, acute diarrhoea, the instruction for taking the medicines may be written as :- “4 Tabs stat and 2 after every stool”, meaning that the patient has to take four tablets immediately and two tablets after every defecation. The different interpretations may be as follows:

- In the case of a Zulu woman from a rural area, taking her child who is suffering from acute Gastro Enteritis (GE = inflammation of the intestines), to a doctor in an

Outpatients' Department (OPD) of Durban hospital "A": The doctor will talk of "stools" and the interpreter who does not understand the medical convention may literally interpret the term to mean an object on which one sits, thereby distorting the entire message regarding how the medicine should be taken. The result of this could well be horrendous.

- Or, the instructions may be interpreted as doubling the dosage namely: 2 x 4 tablets after every defecation resulting in severe constipation, or even surgery, if followed for a long period.

The above example also illustrates common miscommunication that is serious enough to warrants urgent research and corrective measures.

1.2 Analysing the problem

The proposed study will focus on the identification of translation and interpreting difficulties in a hospital in KwaZulu-Natal, and suggest remedies and solutions for these linguistic problems. The majority of the clients/patients speak the local indigenous languages, namely Zulu, Xhosa and Swazi, and the English-speaking health staff do not understand these languages.

1.2.1 The possible reasons for the problem

The factors that cause or lead to this type of problem are multiple and diverse. The following may be mentioned:

1.2.1.1 Need for the National Language Policy in Health (LiHeP)

The Department of Health (DoH) has no LiHeP in place. Legislation and the Policy Framework directs organizations on how to implement the policies regarding the language issues. In the absence of a policy framework, there is no systematic direction. This means that the DoH has been and is still operating without direction as far as language related health issues are concerned. In the absence of the LiHeP, interpreters are not obliged to be qualified/trained health interpreters. They do not know the ML and are not knowledgeable. The implementation of the LiHeP will force hospitals to have trained, qualified, responsible health interpreters.

The process of formulating the NLPF was initiated in 1995 by LANGTAG. The consultative meetings and debates regarding the formulation of this policy took a very long time, funded by the South African taxpayers. Eventually the DAC minister, Dr Ben Ngubane, launched the South African NLPF in March 2003. This NLPF provided the framework for the formulation of an urgently needed SA LiHeP.

The absence of the LiHeP actually constitutes a danger. There were, and still are, no interim measures to provide a solution. Based on my observations, as far as language use in the health sector is concerned, there is a 'laissez-faire' approach. In other words, no one in authority really cares whether or not the health professionals understand what their clients are saying and vice versa. Language use in the South African public health sector is not monitored at all.

In addition to this break in communication due to language differences, there have been allegations made by members of the public that the use of abusive and ethically unacceptable language between patients and health professionals occurs regularly. This, however, is another facet of the topic and needs to be researched separately.

1.2.1.2 The inadequate knowledge of languages

In the target KwaZulu-Natal hospital, it was noted that the health staff have an inadequate knowledge of Zulu and the patients do not know English. The medical staff usually use the ML terminology, and the patients use the EL. The medical staff use ML in the context of a simple model of the VCP. This simple model of the VCP assumes that the 'signal' (message text) contains all the information.

The following discussions will illustrate why this inadequate knowledge of languages is a concern in multicultural and multilingual SA hospitals.

1.2.1.3 Cultural Factors

Language is a carrier or a vehicle of culture of society.

- **The cultural norms and values**

There is a link between the problem and values, and the cultural factors, norms and values can play a major role in causing and escalating the problem of ineffective communication between the health workers and the clients/patients. Language use in the health sector, therefore, needs to be observed closely. It is imperative for the health professionals to have some knowledge of the Indigenous Knowledge (IK) of the African people that they serve. This awareness of the community's IK will assist them to understand the implicit language behaviour of their clients/patients. For example, the Nguni people culturally do not make eye contact when communicating (*ukushalaza*), commonly displayed by women from the Nguni language group. This is a Nguni cultural sign of respect. A white health professional may interpret this as a sign of guilt, inattention or of not giving an appropriate medical history. Young Nguni females have often been insulted or abused by the white gynaecologists due to their misinterpretation of this Nguni cultural behaviour. The white doctors scold the patients and accuse the women of dishonesty, as a result of their conditioning in the European culture where lack of eye contact is regarded as a sign of guilt.

- **Traditional / Cultural Rituals**

Ngunis practice a ritual of man-made incisions (*ukugcaba*) on any part of the skin of the body. This ritual may be a sign of releasing 'bad' blood from the infant shortly after birth, depending on the clan. Sometimes, when one is sick and a traditional doctor is consulted, (s)he may perform these *izingcabo* as part of the treatment of the patient, including the topical administration of drugs.

In one reported incident, a Zulu woman brought her sick child to the paediatric ward of Durban hospital 'A'. The child was running a high fever. In addition, the child had visible *izingcabo* all over the body. The white doctor did not ask the mother why the child had *izingcabo*. Instead, he just commented on them by asking why the infant had the 'septic crude incisions' all over the body. This comment offended and disturbed the mother, and subsequently the client-doctor relationship became strained.

A caring health professional has to know about and understand the reasons for making these incisions and not refer to them as “crude septic incisions”. This type of comment violates the cultural norms and values of their patients/clients. Worse still, it will be taken as a sign of disrespect towards the cultural rights of the client/patient.

- ***Hlonipha Language***

The Nguni language group namely, Zulu, Xhosa, Ndebele and Swati have what is termed ‘*hlonipha language*’. The *hlonipha* language is the language of respect commonly used by young married females to show respect to their in-laws. The *hlonipha* language may cause communication problems between a white doctor and a patient if the health interpreter is not a first language speaker of the patient’s language. The following example can give greater clarity regarding the possible communication problems caused by the *hlonipha* language in multicultural and multilingual SA hospitals:

- If the name of the father-in-law is ‘*Manzi*’ meaning water, the daughter-in-laws will not pronounce/utter the word ‘*manzi*’ instead, they will use ‘*amakwete*’/‘*invoto*’, which is an equivalent.
- *Ubisi* meaning milk will be referred to as ‘*intusi*’. A health interpreter/doctor who does not know and understand the Nguni languages and culture will find this usage very confusing.

If a Zulu patient uses the ‘*Hlonipha language*’ and is not understood, there can be miscommunication during consultations and examinations. Culturally, Ngunis will not name the private parts of a person directly. Euphemisms are used when referring to the private parts, e.g. for a man, it is ‘*umuzi kaBaba*’ which literally means father’s home/house. So, in the case of a doctor examining a Zulu man for a sexually transmitted disease, the interpreter may misunderstand if the patient talks of ‘*umuzi*’ (home/house). Health practitioners may be confused if (s)he is not a first language speaker of Zulu or if not well conversant with local cultural issues. Health professionals should also be familiar with the IK of the local community that they serve.

The above indicate the need for the health professionals to know their clients/patients as people, including their languages and cultural characters.

The health professionals' attitudes have to shift from the perspective of looking at their clients/patients as objects of research or the illnesses/diseases/injuries they suffer, and instead focus their patients as valuable, dignified and unique human beings.

1.2.1.4 Dietary restrictions / taboos

Traditionally, the South African indigenous people have dietary restrictions that prohibit the consumption of certain food by certain people during certain periods of time.

For example, young Nguni women are not supposed to drink home produced milk and eggs (indigenous high protein products) when menstruating and for a certain period of time after giving birth. These Nguni women are also prohibited from moving amongst the cattle. It is believed that if these women break this taboo, the family cows will be affected and their milk will dry up. Young Nguni maidens are also barred from eating eggs.

The health staff working in these communities must have their linguistic knowledge, coupled with their cultural knowledge, up to date. This understanding becomes relevant when a doctor advises the patient on her dietary needs, especially after childbirth. The doctor has to know about the substitutions of the home produced indigenous high protein products. The interpreter has to explain clearly to the doctor so that the doctor can suggest alternatives to milk and eggs, etc. This information is of vital importance especially in the HIV/AIDS era. The health staff must understand the life styles of their clients/patients, and be able to recommend or prescribe the relevant alternatives for such foodstuffs. The solution is the understanding of the local language that carries or is a vehicle of the culture of the community.

This becomes vitally important in cases where counselling is necessary, as well as when designing criteria for discharging a patient. When a patient is being prepared for and advised on how to take care of him/herself after diagnosis or hospitalisation,

the doctor or nurse should be proficient in Zulu, know the taboos and be able to clearly explain and give alternatives that the patient will be allowed to eat. The knowledge and respect of the patients' cultural norms and values by the health team is of utmost importance since it shows respect for the patient as a whole, and this plays a vital role in disease management.

1.2.1.5 Technical terms / registers

All professional health staff, namely doctors, nurses, pharmacists, paramedics etc., use a register that is unique and peculiar to the health fraternity. The purpose of the register is precision. Technical terms are also used to protect the patient's privacy in cases of sensitive issues. The register should not exclude the patient. (S)He must understand the use of this register by the health professional for ethical reasons. For example, to ensure that the diagnosis of an individual is not divulged to the public, codes are used. The majority of clients/patients do not know about or understand the medical register.

In interpreting, the use of the health register can become problematic when the interpreters do not understand the codes used. This leads to a break in communication and can actually result in wrong information being conveyed to the doctor from the patient, or vice versa, leading to an incorrect diagnosis. For example, the patient may be diagnosed as having Chronic Asthma instead of a Chronic Cough. The treatment prescribed for this person will therefore be wrong and the patient's health may deteriorate and result in avoidable complications.

Or, in another scenario, the pharmacist does not understand the local indigenous languages and give the patient incorrect instructions on how to take the medicines. The dosage and frequency of taking the medicine may be wrongly conveyed and the patient may be subjected to the danger of over or under dosage. The abovementioned examples could result in fatalities and are, therefore, serious enough to warrant urgent research regarding the problem statement motivating this report.

1.2.2 *The Aim and Purpose of the study*

The aim of the study is to observe the communicative behavioural patterns of the KEH-CII health personnel and their clients.

The purpose is to describe and identify the translation and interpreting strategies used in the above communication process.

I shall describe the research questions that I will use in order to elicit the required information. The research will be restricted to Zulu and the white medical staff.

1.2.3 *Research Questions*

The following research questions will be discussed:

- What is the degree of knowledge of the white medical staff of Zulu?
- What is the doctors' proficiency level of Zulu?
- Does Zulu have the registered medical register (technical terms)?
- Is there cross-cultural miscommunication?
- What is the proficiency of the patients in English?
- Do the doctors have the necessary skills for cross-cultural communication?
- What is the role of the interpreter?
 - Are there any interpreters?
 - Are they properly trained?
 - Do they have any experience?
 - Do they know and understand the technical medical register?
 - Are they fluent in both Zulu and English?
- Is there a LiHeP in the hospital(s)?
 - If yes, does it cater for communication between the medical staff and the patients/clients?

1.3 Approaching the problem

1.3.1 *Research Methodology*

1.3.1.1 Selection of cases/respondents:

- Ten white doctors;
- Ten white nurses;
- Ten Zulu interpreters who know Zulu and English; and
- Ten Zulu patients.

1.3.1.2 Methods used to Investigate

I will have to decide whether the methods will be qualitative or quantitative.

- Observations
- Questionnaires and
- Interviews:
 - *Individual cultural interviews (ICI)*: The health professionals will be asked if they understand the paralinguistic behaviour of their clients, e.g. lack of eye contact, etc. Lack of eye contact according to the Nguni custom is a sign of respect whereas in the Western culture it may mean guilt or withholding information.
 - *Individual topical interviews (ITI)*: These interviews focus on an individual event. Interviews with translators/interpreters, patients and doctors will be regarding translation or interpreting events. The ITI will be aimed at gaining cross-cultural information from the conversational partners involved in the study of the DoH's T & I. The common questions that will be asked are: What happened? Did the person understand what was said?, If not, why not?, Where? etc.

Both cultural and topical interviews guide all the qualitative interviews.

- *The focus group interviews (FGI):* These interviews are used to assist in getting opinions on T & I or attitudes to languages at another level, for example: disagreement or consensus on health translation and interpreting. The FGIs will be used at the end of the interviews as a means of validating the information collected. Each group will consist of about seventeen (17) persons. All data captured will be integrated with and collated and made ready for analysis.

1.3.2 *The collection of information*

I will have to obtain the co-operation of patients and staff via the hospital authorities. The following will be used:

1.3.2.1 Observation and questioning

It is foreseen that one week will be used at the KEH-CII observing and issuing the structured list of questions to the health personnel and patients while consultations with and management of patients are in progress. This will assist in getting first hand experience and information about the problem in an appropriate scenario.

Documentation of the information will be captured electronically, namely, by the audio recording and video taping (for ethical reasons the informed consent of the participants will have to be obtained before capturing their images, etc.)

1.3.3 *Data Analysis (DA)*

- Data analysis will start when interviews are being conducted.
 - **Final DA (FDA):** This FDA will take place after the completion of the interviews. During FDA all information gathered is put together. The comparison of information is done within and across themes and categories. The variation in explanation within and across themes and categories are noted. The aim is to integrate the information into a theory that offers an accurate, detailed and subtle interpretation of the research.

In conclusion, the findings of my research will be used to develop policy proposals for a LiHeP that includes the theory and understanding of the everyday life in the health fraternity.

The mini-dissertation/research report will be organized as follows:

➤ **Chapter 2**

- 2.1 Literature review of verbal communication
- 2.2 Cross cultural communication
- 2.3 Survey of the literature on cross cultural communication in health

➤ **Chapter 3**

Research Methodology

➤ **Chapter 4**

Description and analysis of data

➤ **Chapter 5**

- 5.1 Consolidation of Data and findings
- 5.2 Summary
- 5.3 Recommendations and justifications
- 5.4 Future proposals

➤ **Bibliography**

➤ **Appendix A2:** Consent Form

➤ **Appendix A1:** Questionnaire on health translation and interpreting

CHAPTER TWO

LITERATURE REVIEW AND THE CONCEPTUAL FRAMEWORK

This chapter deals with a review of the literature on language as a problem in multilingual and multicultural (South African) hospitals, which will provide a background for this research. In addition to the review of the literature, this chapter will give an outline of the conceptual framework that will be used.

2.1 LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

It must be noted that to date research regarding translation and interpreting (T&I) in the health fraternity/discipline in South Africa has received scant attention. However, a few scholars internationally have investigated this issue. In this research, I will do a literature survey covering white doctors and non-white patients/clients internationally and nationally.

The conceptual framework (CF) I will use, deals with the definitions of concepts and principles that are relevant and appropriate to this study.

2.2 VERBAL COMMUNICATION PROCESS (VCP)

Most white doctors use the simple message model when communicating with the non-white patients.

2.2.1 What is the VCP?

According to Webb (2003:8), the VCP is an interactive, co-operative act involving the negotiation of meaning. This implies that in the cases under observation, the white doctor and the non-white patient/client should interact and co-operate in the process of negotiating meaning.

Fish (quoted in Webb, 2003:7), formulated the understanding of the VCP as follows: "The reader (receiver) of the text creates the text ". In other words, the message or

the text does not have one single “meaning” or “interpretation”, and can be interpreted differently when given different sets of contextual factors. The simple model of communication used by the white doctors assumes that the text contains:

- “ALL the information required by the hearer (reader) to understand the communicative intent of the speaker/writer.
- Ignores the essential role of the context in both the production and the interpretation of the text”. (Webb, 2003:7).

Both sender (S) and recipient (R) are involved in the VCP as S and R.

2.2.2 How the VCP works

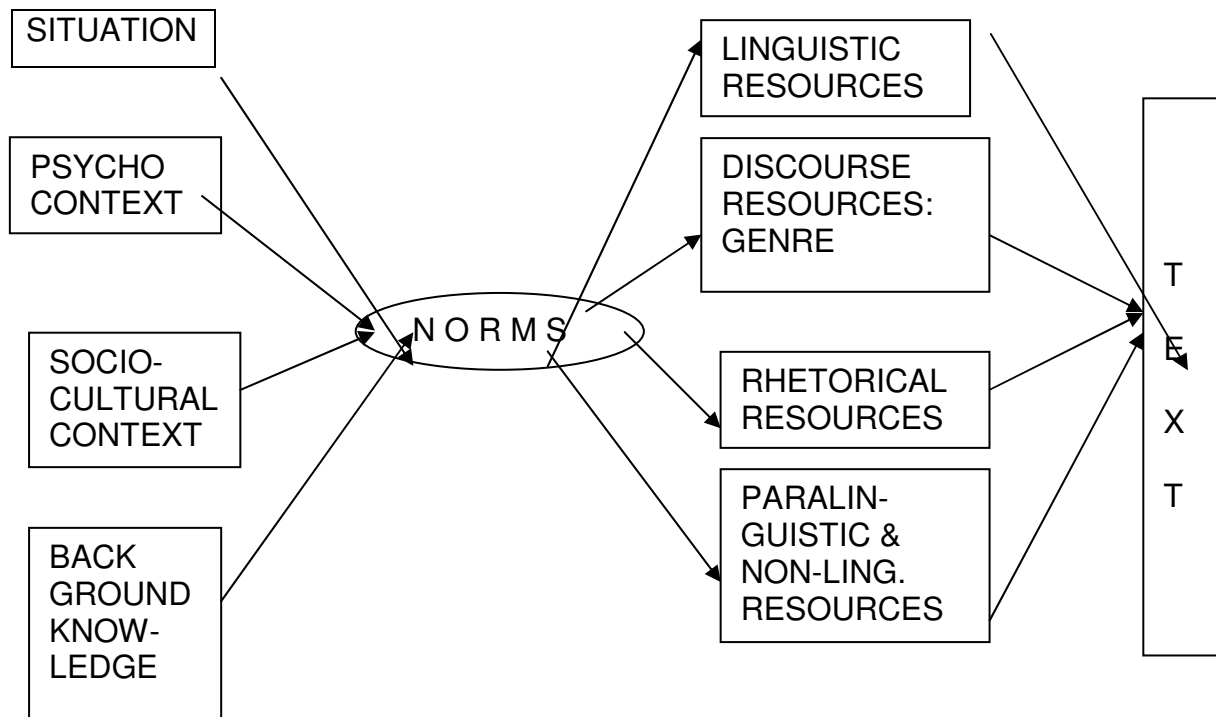
The VCP works in the following three ways:

- The doctor considers who the patient is, what s/he knows or does not know, believes in, etc.
- The patient considers the context within which the doctor produces the text including who s/he is, what his or her views and beliefs are and so on.
- The Zulu patient/client may ask the doctor what s/he meant and the doctor may ask whether the patient understood her or his text or not.

2.3 FACTORS WHICH CO-DETERMINE THE VCP

There are nine factors that perform a role in co-determining the text in the VCP. The following is an illustration for discussing the nine factors that co-determine the functioning of the VCP.

Figure 1: Framework for discussing the Verbal Communication Process (VCP)



(Illustration: Courtesy of Webb, V.N.; 2003:10)

Figure 1, above, only represents part of the VCP, that is, the text-production phase (TPP). To complete the VCP process, a text-interpretation phase (TIP) has to supplement the TPP. The factors in Figure 1 are organised in a non-arbitrary fashion. These factors are arranged in a hierarchical relationship. The framework also implies that the outcome of the VCP is non-predictable, since text interpretation is determined by several variables.

➤ **English Language Proficiency (ELP)**

In this study, some patients/clients have a degree of ELP. It is important to say that all medical personnel should have adequate Zulu Language Proficiency (ZLP). The question is:

➤ **When do we say that a white doctor has adequate ZLP?**

Zulu Language Proficiency can be at various levels. There is a level where one has knowledge of a language (Zulu) that enables her/him to do certain things but not

others. For example, having small vocabulary which enables her/him to greet the patients, but unable to hold a full meaningful conversation.

However, having proficiency in Zulu is not a solution to the problem as observed in the KZN multilingual and multicultural hospitals. Medical professionals need to have ZLP that includes vocabulary and terms that are appropriate to this health situation.

The above diagram's logic is that the contextual factors, namely: the situation, psycho context, socio-cultural context and the background knowledge co-determine the text. This means that contextual factors co-determine the context of communication that takes place between the white doctor and a Zulu patient. Each of these elements can play a big role in the miscommunication referred to in this study.

➤ **When do we say that there is adequate language proficiency (ALP)?**

It may be stated that ALP prevails when the communicative intent between the sender (S) and the recipient (R) has been achieved.

2.3.1 Contextual factors

➤ **Psycho-context:** This context plays a noticeable role in communication between the doctor and the patient. Studies (Capra, 1982 in NLP Report, 2001) have shown that effective communication between doctor and patient plays a big role on the patient's psyche and gives effective emotional support. It is claimed that patients on placebos with whom the doctor spent time communicating, did better when measured physiologically than patients who were medicated but were not given emotional attention. More dramatically still, babies whose mothers had been given extensive explanation and preparations for what to expect after their operations, developed fewer complications than babies whose mothers had not been similarly prepared.

The following behaviours which can be both from the patient/client and doctor may affect effective communication:

- Patient/client: S/he may be anxious about her/his illness. Ignorance about the disease, especially those such as HIV/AIDS or cancer, may cause a lot anxiety in the patient. This may impair effective communication.
 - Doctors, on the other hand, may be overworked and mentally exhausted, have attitudes about diseases of the affected. For example, believing that HIV/AIDS is the disease of the African people or of sex workers. These psycho-contextual factors may very well play a role in miscommunication. Lack of effective communication from the doctor's side may lead to the patient's deprivation of emotional support and thus delaying healing.
- **Socio-cultural context:** These factors refer to the ways of speaking. For example, loud, soft, accent, etc.
- Zulu young females often speak very softly, looking down, and this might well be misunderstood by the white doctor who is ignorant of the African culture. The white doctor may interpret this behaviour negatively and thus cause miscommunication.
 - A white doctor may have an accent that is difficult for a Zulu patient to follow, causing the patient to misconstrue the words, thus derailing the communication processes.
- **Background knowledge:** The white doctor may not know some of the things about the patient/client's culture. For example, that not to have children within a certain period (about two years) after marriage is a great concern and is regarded as misfortune in an African culture. It is important to note that family planning is not an African cultural concept, whereas in Western culture, it is an accepted and practiced behavioural concept. Differences in cultural behavioural norms may lead to miscommunication in the KwaZulu-Natal health institutions.

The white doctor's good understanding of the cultural norms and rules governing the use of Zulu language will in turn determine the doctor's choices from the available linguistic resources, namely:

- **Medical Language (ML);** that is the language used by the health professionals in health institutions or

- **Everyday Language (EL);** that is the language used by the patient/client outside the health institutions.

➤ **The Role of the medical terms or register during white doctor-black patient communication in KwaZulu-Natal health institutions**

The medical terms and register can be an obstacle during the communication between a black patient/client and the white doctor in the KwaZulu-Natal health institution. This can only be bridged by the use of a health interpreter using non-technical Zulu terms. This can also be viewed as a motivating factor towards compiling a glossary for the non-technical Zulu health terms.

- **An interpreter and his/her role**

An interpreter is a person who understands both the source and target languages and be able to explain adequately what is said by both the sender and the recipient parties in a dialogue. In this case, it would indicate an adequate level of proficiency both in Zulu and English by the staff members in health institutions.

- **How to identify an appropriate health interpreter**

This person has to be a trained person with minimal level of adequate health interpreting skills that qualify her/him to be an official registered health interpreter.

- **Why a need for a health interpreter?**

A health interpreter is needed in order to bridge a communication gap that may exist between a white doctor and the black patient. In KwaZulu-Natal health institutions, most of the Zulu patients/clients do not understand English. Even those who can speak English cannot express themselves confidently and ask questions freely. A health interpreter will then act as a common congruent cultural framework within which black patients/clients and white

doctors can understand each other. (S)He has to bear in mind that Crawford (1994:3 in Richard, Y.B. et al, 1989) is correct when she says that:

Doctors are not trained to explain the disease processes in a way that is intelligible and meaningful to a lay person and are not equipped to gauge sensitively the level at which such explanation could be pitched. They are not trained to elicit and value the patient's understanding of their illness as an indispensable guide to negotiating a realistic treatment which the patient will adhere to. Rather their gaze is directed to the patient as a decontextualised body system which can and does go wrong in certain predictable ways.

Looking at the above, the presence of the trained health interpreters can definitely bridge the absence of a common congruent cultural framework within which the black patients/clients and white doctors can understand each other.

2.4 THE CROSS CULTURAL COMMUNICATION (CCC)

Cross-cultural communication is communication between people who belong to different cultures. In the case of this study, the communication is between a white doctor, from a Western culture, and a patient from the Zulu/African cultural group.

According to Ndoleriire (in Webb Sure, 2000:275), “communication between people who differ culturally often breaks down, as their differences function as noise”.

This is exactly what happens to white doctors whose Western culture functions as ‘noise’ to the Zulu patient/client. The reverse naturally also holds true when the Zulu patient’s culture is unknown to the white doctor. Unfortunately, this remains a very common occurrence in a multilingual and multicultural South African hospital/health setting.

Their cultural differences simply manifest as ‘noise’. According to Ndilerire (in Webb & Sure, 2000:269); a “‘noise’ factor is any obstacle that might hinder the smooth transmission of messages.”

In the above scenario, the “noise” is twofold, namely:

- the lack of knowledge about the Zulu socio-cultural context; and
- the lack of the knowledge of the rules and norms governing the use of the Zulu language by the white doctor.

2.5 COMMUNICATIVE COMPETENCE (CC)

Communicative competence refers to the ability to communicate successfully and effectively in a particular language in a particular situation. For the purposes of this study, a white doctor in a multilingual and multicultural South African hospital has to have the ability to communicate competently in an indigenous African language, such as Zulu. In other words, a white doctor has to be proficient in Zulu and have a good understanding of the Zulu cultural background. Scholars like Kleinman (1988 in Richard, Y.B et al, 1989), who have observed the linguistic behaviour of the doctors, have the following to say about practising doctors:

In a very real way they were abstracted from the world of cultural expression at an extremely youthful and impressionable age and subjected to enormous academic pressure within the competitive milieu of medicine with a curriculum crammed to bursting. Upon release from their training ordeal some 5 years later they showed effects of segregation from the world of humanities. Their recourse for coping with the complex social reality they confront is to an atheoretical pragmatic common sense.

Viljoen (1992, in NLP Report, 2001), however, warns that common sense is notoriously unable to cross cultural barriers.

2.5.1 Role of Power Relations

Knowledge is often the precursor to power and in any health communicative encounter, the doctor is a more knowledgeable participant, and, therefore, the more powerful of the two interactants. This is often compounded by the use of medical terminology.

This situation automatically puts the patient at a disadvantage. Any medical discourse is generally characterized by a profound imbalance of power between the doctor and patient. Foucault (1973, in NLP Report, 2001), says that the patient is subjected to a medical gaze which establishes the patient as a body that can be probed and diagnosed, while the doctor occupies the powerful position of the one who sees and pronounces. He further says that what cannot be seen or measured in this way is discounted or relegated to the margins as irrelevant or irrational by the doctor.

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

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

In cases where a patient is resistant and attempts to establish a less passive and dependent position in the linguistic interchange, he is often headed off by a non-response or other indication of the doctor's displeasure at trespass on his/her field of expertise.

There are two questions that arise here and both are crucial and relevant to this study. These questions may be formulated as follows:

- Do the participants, namely; the white doctor and a Zulu patient have a sound discourse competence (DC) on how to conduct their conversation (that is; is their use of language appropriate, purposeful and coherent)?
- Do the participants have a sound linguistic competence (LC) in each others' languages, namely, Zulu and English (that is, are their phonological, lexical and grammatical abilities sound) for effective communicative encounter/conversation?

Effective discourse competence and linguistic competence give rise to effective Communicative Competence.

To illustrate the lack of communicative competence between a Zulu patient and a white doctor, the following discourse example, which took place at a Mission hospital “A” Outpatients’ Department (OPD) examination room in the KwaZulu-Natal Province, South Africa can be given:

Background:

A 50 year-old rural Zulu *Induna* (Zulu headman) from *Ndwedwe* (a rural village situated to the north of Durban), who had been drinking a type of home-made alcoholic drink from the age of 16, fell ill. His main complaint was the swelling of his whole body that was more pronounced around his abdominal region. He sought help from the neighbouring Durban mission hospital “A” about his illness.

The Durban mission hospital “A”, has mainly white missionary doctors from different European countries, who immediately after completing their internship, volunteered to come to Africa to do missionary work. Most of these missionary doctors have never been in direct contact with indigenous African people and their cultures.

In this case, the doctor was a 27 year-old European Christian man. He had been working in this hospital for six months and had learnt a few isolated Zulu words. After this brief exposure to Zulu, he felt ‘very confident’ and thought that he ‘knew’ Zulu and could communicate with a Zulu patient without the assistance of an interpreter. The communication/discourse went as follows:

Dr: *Sanibona Baba*
Good Day father
Pat.: *Yebo Dokotela*
Good Day doctor

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

Dr: *Mmm!, Baba kusugela nini ukhulelwe kagakha?*

Mmm!, Father, since when have you been so highly pregnant?.

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

Dr: *'Baba yisho, kusugela nini ukhulelwe kagakha? Ugamagali, iziguli bami bigibiza, igama lami, libizwa 'giguMajamela', iSangoma sikadokotela khobo!)*

Father, tell me, since when have you been so highly pregnant? Do not be surprised, my patients call me, my name, 'Just look at and diagnose doctor', a real *Sangoma* doctor!

The doctor proudly and confidently said this pointing at himself. There was no response from the *Induna*. After a further period of silence, the *Induna* responded with a trembling loud and forceful tone, saying:

Pat.: *Qha bo! angikhulelwe Dokotela, indoda ayikaze ikhulelwe, inhlamba leyo!*

No! doctor, I am not pregnant, a man never gets pregnant, that is an insult!

Dr: *Ukhulelwe, nasi isisu sakho makhulu kagakha!*

You are pregnant, your abdomen is very enlarged!

Pat.: *(Induna broke down sobbing and blew his nose) Dokotela, uyangithuka, abafazi ukuphela abakhulelwayo!*

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

The above scenario shows how an impoverished, monolingual, black man could be traumatised by an ethnocentric and largely monolingual (English dominant) South African health system. This also clearly illustrates the importance of the role of the socio-cultural factor discourse in a multilingual and multicultural hospital situation and in any other communicative encounter. The white doctor in the above scenario did not intend to insult the Zulu *Induna* by saying that he was pregnant. He intended to say that the Zulu *Induna* had an enlarged abdomen. It was his lack of discourse and linguistic competence in Zulu that made him use the word '*khulelwe*' instead of '*vuvukala*' (swelling).

Due to his minimal socio-cultural background knowledge, he further made the situation worse by claiming to equate himself with the Zulu traditional doctors, the ‘*Sangomas*’, who diagnose their patients without getting the relevant history from them. Culturally, Zulus value their *Sangomas* and associate them with their supernatural ancestors. For a young white doctor to equate himself with a *Sangoma*, was insulting to the Zulu *Induna*, a violation of the Zulu values as well as cultural norms and rules.

The norms of the white doctor completely clashed with those of the Zulu *Induna* and their communication was derailed, resulting to an unwanted and strained situation. The intended aims of their communication/discourse became null and void.

It is, therefore, not surprising that the American socio-linguist, Dell Hymes (quoted in Webb & Sure, 2000:247) stresses the need for effective communicative competence and he is concerned with appropriateness:

“We have then to account for the fact that a normal child acquires knowledge of sentence, not only as grammatical but also as appropriate. He or she acquires competence as to when to speak, when not, and as to what to talk about, with whom, when, where in what manner. (Hymes, 1972a:277)”.

Communicatively, white doctors working in multicultural and multilingual South African hospitals, have to know how to use language, appropriately. The following, pertinent question then arises:

‘What do the white doctors, speaking indigenous African languages in South African multilingual and multicultural hospitals, know about the African cultural context and the appropriate forms of language to express appropriate meanings?’

In answer to this question, I again consulted Hymes. He further talks of the frameworks for analysing the context. Central to his framework is the concept of the **speech event** defined as “activities, or speech activities, that are directly governed by the rules or norms for the use of speech” (Hymes, 1972b, quoted in Webb & Sure 2000:247).

Looking back at Figure 1, which illustrates the factors that determine the VCP, the **NORMS** are central. In other words, this study concurs with Dell Hymes and proposes that the white doctors working in the South African multilingual and multicultural hospitals, using indigenous African languages, have to know the rules and norms governing the use of indigenous African languages.

2.6 FACTORS THAT CONTRIBUTE TOWARDS CULTURAL MISCOMMUNICATION IN A MULTILINGUAL AND MULTICULTURAL SOUTH AFRICAN HOSPITAL

Cultural miscommunication is a breakdown in communication due to cultural differences that manifest themselves as noise. This manifestation is unfortunately common in the multicultural and multilingual hospitals.

There are three main factors responsible for this communication derailment, namely:

- Non-verbal factors;
- Paralinguistic factors; and
- Discourse conventions.

2.6.1 Non-Verbal Factors

The non-verbal factors are those that are not uttered by the communicating participants in a linguistic form. They usually consist of or refer to the cultural discourse conventions of a community. For example, it is common for the Nguni women not to look directly into the eyes of any male. In the case of a young Zulu maiden, it will be improper for her to look directly into the eyes of a man (doctor). These are referred to as the discourse conventions. However, to a white doctor, this behaviour of a young Zulu maiden may send a signal of not being trustworthy or of guilt. Thus, he may think that she is not giving a correct medical history. In other words, not looking directly into ones eyes signals respect in Zulu, whereas it signals non-trustworthiness in Western culture.

2.6.2 Paralinguistic Factors

Paralinguistic factors include volume, stress and spacing between words. For example, a high pitched tone, that in Zulu is consistent with shouting at or scolding, while in a Western culture it may mean interrogation. In the case of a white doctor, it may indicate a need for more information or clarification regarding the medical history.

This raising of the voice to a young female Zulu patient may cause miscommunication and the patient may become upset, resulting in a break-down in communication. Accordingly, in any hospital setting, the pitch of the voice has to be low. This signifies empathy from the health personnel towards their patients/clients. According to the Zulu culture, high pitch and fast speech is interpreted as lack of empathy as well as arrogance.

2.6.3 Discourse Conventions

In this study, the discussion of the discourse conventions will be limited to forms of addressing the medical, linguistic and cultural problems by Zulu patients.

In a Zulu culture, a feature of addressing any problem is to first recount the background history and to be indirect about the problem. This may be due to the Nguni (Zulu, Xhosa, Swati and Ndebele) *hlonipha* culture. For example, a Zulu man coming to the doctor for treatment of any sexually transmitted disease will not tell the doctor directly what is wrong with him. He may start by telling the doctor that it is customary for a Zulu man to have a lot of women, then go on to state that this behaviour exposes the Zulu man to a lot of unknown and unwanted diseases.

After the doctor has asked about the nature of these unwanted diseases, he may tell the doctor what is wrong with him.

It is important to note that choosing Zulu for this study does not exclude the other SA indigenous languages and cultures. This is just for a practical reason, i.e. to restrict the extent of the study. This study has to be seen as a pilot study. It is envisaged

that in future more SA indigenous languages' status in multicultural multilingual hospitals should be investigated.

2.7 CONCLUSION

In concluding the dissertation, the findings of the research will be discussed. Recommendations will then be made as suggested by the overall results. The study will also emphasise that it is not opposed to the use of English in multicultural and multilingual SA hospitals. This study is simply an attempt to highlight the reasons for the problems caused by the misunderstandings between white doctors and their patients.

CHAPTER 3

RESEARCH METHODOLOGY

In this chapter the research questions and research methodology will be discussed.

3.1 Research questions

To answer the following research questions, pertinent information regarding details will be collected.

The aim is to establish how effective the communication between health workers and patients is. The research questions are as follows:

- 3.1.1 What is the nature of communication between the health workers and patients?
- 3.1.2 What are the reasons for poor communication?
- 3.1.3 What can be done to resolve the problem, that is, to ensure effective communication between the health workers and the patients?

3.2 Possible reasons for the problem

The following are possible reasons for the problem of poor communication between the health workers and the patients:

3.2.1 Language Barrier

Black patients/clients not understanding English and white doctors not understanding Zulu properly. This results in the communication between the health workers and patients/clients being ineffective.

3.2.2 The Logic of the VCP

The logic of the VCP Framework (Fig. 1), that is, the contextual factors that co-determine the context of communication that takes place between the white doctor and the black patient. The following are the contextual factors:

3.2.2.1 Situation

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

A white doctor walking into a hospital ward and trying to initiate a formal dialogue with the black rural patient/client may be an unusual encounter for the client/patient. The relations of power may also affect their communication process. In other words, the black rural patient/client may perceive the white doctor as '*Basi/Mesisi*' and be intimidated, not able to express himself/herself accordingly, thus resulting to impaired or poor communication.

The communication between the two may further be difficult/strained due to having to discuss a topic that is taboo in the African culture, for example, sex (indirectly impacting on HIV/AIDS issues).

The effects of the situation on text construction, for example, a serious high pitched tone of the white doctor using the medical register may be interpreted as arrogance/scolding by a non-English speaking black rural patient. This negative interpretation may lead to misunderstandings between the two parties.

3.2.2.2 The psycho-context factors

The term "psycho-context" refers to the cognitive processes and affective issues.

- **Cognitive processes:** An example of this is when the patient is anxious because he/she lacks knowledge about his/her sickness. This anxiety usually manifests in cases of HV/AIDS and Post Traumatic Stress Disorders (PTSD), where clients have insufficient

information about their disease and perceive his/her illness only as fatal/irreversible. A marked degree of anxiety may result in impaired/poor communication.

- **Affective processes:** Generalizing naïve attitudes from a white doctor towards black patients/clients, for example, that diseases like TB and HIV/AIDS are the diseases of the poor black patients. The black patients/clients will perceive this naïve attitude negatively and this will lead to strained communication. Where there is a strained relationship, communication is bound to be poor and eventually breaking down.

3.2.2.3 Socio-cultural Context

The term culture refers to ways in which people do things, patterns of behaving, norms, values (respect, loyalty), beliefs (religion), and assumptions, attitudes (Webb, 2000:317).

- **Culture:** The black patients attended to at the multicultural multilingual hospitals constitute an African cultural community. On the other hand, white doctors attending to these patients/clients constitute a Western cultural community. Each patient/client and doctor has his/her cultural identity. Likewise, these cultural communities (and individuals) have their own socio-cultural identities. In order for the black patients and the white health staff to communicate effectively, there has to be common cultural grounds. This means that for communication to be effective, the white health staff member has to have a relative degree of the understanding of an African culture and its languages.
- **Class:** The social class of the white English-speaking doctors differs from that of the Zulu speaking patients, who do not understand English. The majority of white doctors belong to the upper middle class, whereas the non-white patients belong to

the working and peasant classes. Their operational worlds are far apart. This operational gap, that is also culturally based, has to be narrowed in order for them to communicate effectively. The use of the professional health interpreters as mediators should assist in closing the gap.

- **Language:** The linguistic behaviour also differs. The white doctors use mainly ML and the black patients use EL. The intervention of the professional health interpreters may also succeed in improving communication in this regard.

However, it is important to say that culture is not static or fixed, but changes over time. This implies that as the time goes by, the white doctors may acquire some of the African cultural identity, for example, have a good understanding of the African languages and the rules that govern their use. The reverse may also happen to the black patients.

During the last decade during which South Africa became a democratic and non-racial state, there have been a number of observable cross-cultural changes, for example, common education and marriages. It may come to pass that this social behaviour will eventually result in more sensible cross-cultural identities over time, when South Africans will show sincere tolerance for each others' cultures and languages. I have a vivid vision of a fully-fledged multilingual and multicultural South Africa after 20 years of democracy. This envisaged cross-pollination of the cultural identities may also give rise to an unselfish development and promotion of all eleven South African official languages as well as those that are not official. Hopefully, then the public services, especially the health services will not have cross-cultural derailments as a result of the following:

- **Unknown contextualisation**, for example, the use of ML only by white doctors to a black peasant social class patients/clients.
- **Conflicting conversational conventions**, for instance, how a young white doctor/psychologist (especially female) has to speak to an adult rural Zulu male patientsclients when referring to his private parts. Zulu language uses the *hlonipha* custom when referring to the human private parts and observes signals of cultural superiority when talking to older people.
- **Conflicting ethnolinguistic conventions**, for example, when a young Zulu maiden especially during the gynaecology, obstetrics and HIV/AIDS consultations looks down while talking to a white doctor/psychologist, it will not be interpreted as respect but mistakenly seen as not telling the truth/correct medical history.
- **Conflicting interpretative schemes**, for instance, the misinterpretation of the usage of high pitched tone as an expression of arrogance/aggression, instead of the expression of questioning or seeking for more/relevant information, etc.

The above socio-cultural contexts may derail the communication between health workers and patients, thus resulting to poor communication.

3.2.2.4 Background Knowledge

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

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

I fully concur with Webb, and further say that my simplistic view of the background knowledge of a person refers to:

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

I find that my simplistic view of the background knowledge is practical and applicable in a South African multi-lingual and multicultural society, where:

- The white doctor comes from an environment dominated by a Western cultural behaviour, such as an urban lifestyle and the black patient is from an African cultural environment with a rural lifestyle. Most South African urban dwellers believe in gender equality and the rural South African dwellers still maintain the cultural superiority of males. A young white female doctor/psychologist may ignore this cultural tradition while attending to an elderly rural Zulu male patient and thus derail their communication process.
- The white doctor has been exposed to a technologically orientated environment (hospital), that will include the use of equipment like stethoscopes, computers, etc. On the other hand, the Zulu patient is from a rural environment in which technology is often totally unknown. The use of this equipment by the doctor and the strangeness of the hospital environment to the rural Zulu patient may affect his/her cognitive functioning and thus strain and derail their communication.
- It is inappropriate for a white doctor to use ML only when speaking to a black patient, who does not understand English. Doing this, will show that the doctor is not context-sensitive in their communicative encounter. The world that the participants come from, plays a big role in their linguistic

behaviour. The world tends to mould the way people think, speak and the way they behave. The patient's (original) world contains a lot of taboo and is completely different from the doctors (scientific) world.

In order for the white doctor and black patient to effectively communicate in South African multi-lingual and multicultural hospitals, there has to be a relative degree of shared cultural and medical background knowledge. Both participants have to engage in a process of negotiating meaning effectively. The availability of trained health interpreters should assist in effecting an effective and meaningful process of negotiating meaning.

3.3 WHAT CAN BE DONE TO ENSURE EFFECTIVE COMMUNICATION BETWEEN HEALTH WORKERS AND PATIENTS IN SOUTH AFRICAN MULTI-LINGUAL AND MULTICULTURAL HOSPITALS

The following measures can be taken in order to ensure effective communication between health workers and patients:

3.3.1 Developing and designing a Zulu Language Programme (ZPL) for health workers

This program has to focus specifically on the non-Zulu speaking health workers, mainly the English-speaking doctors, psychologists, nurses and pharmacists. The aim and value of this project is to:

- Improve their Zulu language proficiency
- Equip them with the basic language skills in order to appropriately understand and interpret the information as well as the needs of their patients.

The following questions and their affirming answers are pertinent before one embarks on a program of this nature:

- Is it feasible to conduct such a study?
- Are the health workers available and are they willing to participate?
- How many are they?

- Who are they?
- What is their background knowledge?
- Are there adequate programs for teaching Zulu as a second language to the health workers?
- Will the development of Zulu as a second language be realistic?
- How long will the program take (time span)?
- Will it be practical to conduct such a program?
- What are the cost implications (budget)?
- Will the DoH be willing to fund the project?
- Who has to be involved in developing and designing the Health Department ZLP?

To answer the last question, I can only suggest that the development of this ZLP will have to be done by the DoH in close collaboration with other relevant stakeholders, namely, the Zulu-speaking community in and around Durban, PanSALB, DAC and the DoE. It is also recommended that some of the Zulu-speaking patients, who understand English, be included in the development and testing of this program.

3.3.2 Provision of adequate interpreting facilities/services

The adequate interpreting facilities/services will assist in bridging the language gap between the health workers and their patients.

The pertinent question, however, is:

- **Are there adequate health interpreting facilities/services in SA to cater for the huge interpreting need that presently exist in the multicultural multi-lingual South African hospitals?**

This question directly refers to:

➤ **Appropriate Interpreting programmes:**

In other words, are there appropriate programmes designed for interpreting provided by the tertiary institutions in SA? The tertiary institutions may have to design the programmes in close cooperation with the DoH, PanSALB, DAC HANSARD, the DoE, as well as the speech communities that they will serve.

If the answer is yes, the following questions arise:

- Are they fairly distributed across the country?
- To whom are they accessible? That is, what are the criteria for admission? In other words, do they only admit people with Matriculation exemption or not?

➤ **The appropriate human resource:**

Are there enough accredited/registered trainers in the tertiary institutions to train the health interpreters?

Between 1998 and 2001, PanSALB funded the National Language Project (NLP) of the Western Cape. One of the objectives of this project was to produce trained community health workers/interpreters. The primary aim was to have effective communication between the health care providers and patients leading to an improved, healthy, lifestyle. Projects of this nature need to be followed up, in order to check whether the intended outcome, namely, the production of trained and professional community health interpreters was achieved or not. If the intended outcome of the NLP was positive, the produced qualified professional health workers/interpreters can be used in transferring their acquired language skills to practitioners in other provinces, thus improving the translation systems in SA. The South African DoH in collaboration with PanSALB, DAC and the DoE, has to monitor the health interpreting services' practices. The use of unskilled health interpreters by any health institutions or any health practitioners has to be emphatically discouraged.

➤ **The availability of proper translating equipment**

SA has to improve and develop its Human Language Technology (HLT) systems, such as the proper translating microphones, speakers, booths, etc. The equipment used for interpreting has to have a stamp of approval by the South African Bureau of Standards (SABS) in close collaboration with the National Language Bodies (NLBs) of PanSALB. PanSALB has established an NLB for every official SA language. These NLBs are the custodians of all the South African official languages. One of their main functions is to authenticate or verify and approve the terminologies used by the different languages.

➤ **Funding**

The SA government has to give urgent and serious attention to the translating and interpreting services. The politicians must realize that effective communication is the key to negotiation of meaning even amongst themselves in Parliament. It has to be clear to them that the laws, policies, regulations etc., they enact are useless if not made accessible in all the official languages spoken by South Africans for whom they are intended. This then means that the SA government will have to allocate a substantial annual budget for the translating and interpreting services programmes. This will result in their parliamentary efforts being appreciated by all the South African citizens they serve and represent. Unfortunately, it currently appears as if the SA politicians are just talking to themselves and the minority elite who understand English. The RSA is not an English-only state but a multilingual and multicultural state, as enshrined in Section 6 of the RSA Constitution, Act 108 of 1996.

PanSALB and DAC also have to budget for translating and interpreting services, since Section 6 of the Constitution mandates them to create favourable conditions, develop and promote all the official SA. languages. PanSALB, in close consultation with the South African Qualifications Authority (SAQA) and HANSARD, has to monitor and provide quality assurance to all the services provided.

The private sector has to be educated about and encouraged to support the SA health interpreting and translating programmes financially. At present, the priority and emphasis has to be laid on the interpreting and translation of the health issues, such as the HIV/AIDS issues and documents.

SA has invested a lot of funding in the HIV/AIDS research and programmes. However, most of the relevant and vital information is “locked” in the documents written in English and cannot be accessed by the South Africans who do not know/understand English. If this vital information can be “unlocked” from the English documents into the SA indigenous languages, most of the SA citizens could access the information and learn more about this deadly pandemic. People will be empowered, be able to better manage their health with minimal assistance from the health institutions. The benefit will be seen in improved positive life styles leading to prolonged life.

3.3.3 Telephone Interpreting Service for South Africa (TISSA)

TISSA is a pivotal project as it aims at addressing the linguistic imbalances of the past. Through TISSA, SA citizens are able to reclaim their linguistic human rights as enshrined in the SA Constitution 1996. It is a project run by the Department of Arts, Culture, Science and Technology (DACST) and is jointly funded by DACST and PanSALB.

The then Minister of DACST, Dr Ben Ngubane launched TISSA on 15 March 2002 at the Kathlehong Police Station. It is important to note that the University of the Free State started the process of interpreting, by establishing the TISSA Call Centre on its campus, on 25 March 2002.

- TISSA Benefits:
 - Improved communication and service delivery to the customer
 - Equal access to services for everyone
 - Cost effective service
 - Easy to use system
 - Immediate access to interpreters across the country.

- TISSA functioning:

The following diagram illustrates how TISSA works:

Figure 2

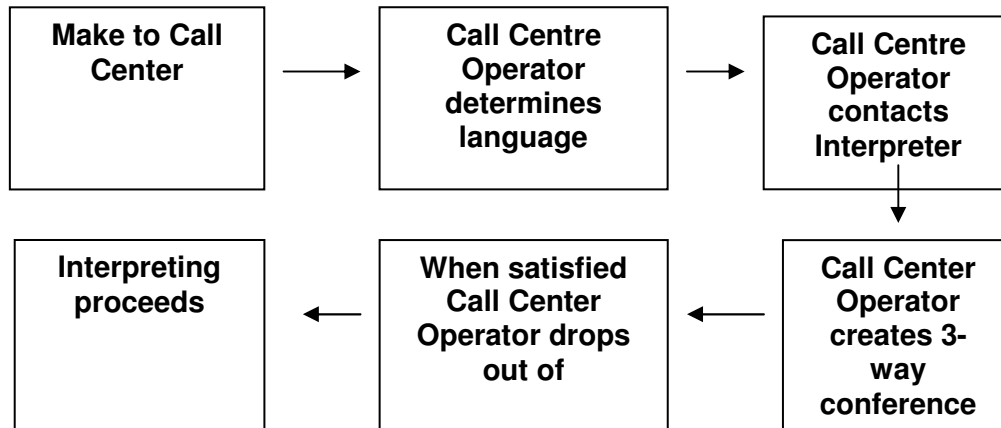


Illustration: Courtesy of TISSA; May 2002: Volume1, Issue 1)

TISSA has 60 centres, 40 of which have been allocated to the South African Police Services (SAPS) and the rest to Health and Land Affairs Departments.

It is envisaged that the TISSA software will enable its management to gather the statistical data in order to determine the needs frequency of use and to forecast the potential use. The findings of this statistical data will determine whether or not there is effective communication between the health workers and the patients.

3.4 Possible methods

The following two are possible methods for gathering data:

3.4.1 Qualitative method:

This method collects non-numerical data and it is richer in meaning. It is purely verbal, involving ambiguity that is unique to one's experiences.

3.4.2 Quantitative method:

This method is for collection of numerical data. The numbers have measure of quality and make our observations more explicit. However, the use of this method runs a risk of losing the richness of meaning.

3.5 Methods to be used

Both the qualitative and the quantitative methods are going to be used.

3.6 Justification:

My research is social research and both these methods are legitimate. There are situations, for example, in my observations, interviews, etc., where I will use the qualitative method since the richness of meaning is a priority.

On quantifying my data, I will use the quantifying method, for example, when compiling tables.

3.7 Analysing and interpreting methods

- **The social setting** is a formal one, namely the Clairwood KZN Provincial hospital in Durban.
- **The target group** consists of the Clairwood hospital health professionals, general hospital workers and patients. A population sample to be taken.
- **Analytical methods used to collect data**
 - Questionnaire
 - Interviews and
 - Observations.

CHAPTER 4

ANALYSIS OF THE DATA FROM THE MULTILINGUAL / MULTICULTURAL SOUTH AFRICAN HOSPITAL IN DURBAN, KWAZULU-NATAL

4.0 INTRODUCTION

This chapter deals with the analysis and interpretation of the data collected from the multilingual and multicultural South African hospital. The hospital investigated is the King Edward – Clairwood Provincial hospital (C11). All the government hospitals in KwaZulu-Natal have codes to identify them. This is an administrative identification tool that assists in controlling the assets and any other stock since the patients/clients are transferred frequently to other sister hospitals, namely; the Wentworth, the Addington, the King George and the RK Khan Hospitals for further management. The C11 hospital is situated about 20 kilometres north of the KwaZulu-Natal Airport and about 40 kilometres South of the centre of the City of Durban.

Direct communication between the health professionals and the patients/clients is problematic as indicated in the first chapter of this document. The pertinent question then is: How can this problem be managed?

- The use of the English only
Doctors and other health professionals use English language when communicating with the patients. The patients are SA indigenous languages mother tongue speakers, who do not understand English well. They cannot adequately express their problems in English to the doctors. Obviously, this is not a solution.
- The second option is the use of the patients' language.
The medical staff members do not communicate well with the patients/CLIENTS in this scenario either as their mastery of the indigenous languages is often not good enough. Therefore, the conclusion is that this is not a viable option.

- The use of the trained health interpreters is the only option that may work.

The following field research had to be conducted to verify the need for trained health interpreters in the multilingual and multicultural SA hospitals.

It was hypothesised that the population sample would react negatively towards the use of English in South African multilingual and multicultural hospitals. Responses will be presented by means of tables and only the percentages will be used.

The data to be analysed in this chapter emanates from the investigation of the problem of communication between the patients and the health professionals in the multilingual and multicultural SA hospitals. Logically, we know that the problem exists as indicated in the first chapter.

4.1 PROFILE OF THE HOSPITAL PATIENTS AND STAFF

The following is the general profile of the C11 hospital patients and employees. The different categories of staff will be presented separately.

4.1.1 The bed statistics of this hospital:

Table (i): C11 Hospital Bed Statistics

WARDS	FEMALE ADULTS	MALE ADULTS	CHILDREN	TOTAL
Female medical	6.7%			6.7%
Male Medical		6.6%		6.6%
Female Surgical				
(i) Plastic Burns Units	11.1%			11.1%
(ii) Surgical Operation Wards	15.6%			15.6%
(iii) Ophthalmic Wards	1%			1 %
(iv) Uro-surgical Wards	1.2%			1.2%
Male Surgical Wards				
(i) Plastic Burns Units		10%		10%
(ii) Surgical Operation Wards		10%		10%
(iii) Ophthalmic Wards		1%		1%
(iv) Uro-surgical Wards		2.2%		2.2%
Obstetrics Wards				
(i) Normal Delivery Wards	5.6%			5.6%
(ii) Ceasarian Section Wards	6.7%			6.7%
Paediatric Wards			13.4%	13.4%
Female Fever Wards	4.5%			4.5%
Male Fever Wards		4.4%		4.4%
TOTAL	52.4%	34.4%	13.4%	100%

Table (i) shows the different types of patients admitted and treated at C11 hospital.

In addition to these in-patients, C11 hospital also has an Out Patients' Department (OPD). At the OPD, as the name indicates, patients/clients consult with the health staff, receive treatment and return home. This is also a section of the hospital that is

highly problematic with regard to miscommunication between the health professionals and their clients. People from neighbouring African states also make use of the OPD, thus making the communication problem more complex.

Compounding this problem is the absence of the South African Sign Language (SASL) health interpreters to cater for the hard of hearing patients/clients at the OPD. The confidentiality ethic is severely compromised by this.

4.1.2 The socio-linguistic profile of the C11 hospital Staff:

The main languages used in C11 hospital are Zulu and English. This socio-linguistic profile is composed of the languages of all the employees of C11, namely, the nursing and medical management staff/sisters, the auxiliary nursing staff, the doctors, the hospital general workers, the paramedics, the pharmacy staff, the psychologist, the administrative (clerical) staff and the patients/clients. The socio-linguistic profile of the employees of the C11 hospital is as follows:

4.1.2.1 The Nursing staff language profile

Table (ii)(a) The C11 Nursing staff language distribution

Zulu speakers	English speakers	Total
99%	1%	100%

Table (ii)(b) The C11 hospital Nurses academic status profile

University Graduates	Nursing College Graduates with Matric Exemption	Nursing College graduates without Matric Exemption	Total
20%	50%	30%	100%

Table (ii)(c) The C11 hospital Nursing staff chronological profile

20 – 35 years	35 – 50 years	50 – 65 years	Total
20%	50%	30%	100%

The majority of the nursing management staff/sisters use Zulu when speaking to each other and the patients. They also use English to accommodate the mostly English-speaking medical doctors and other nursing staff members, the Coloureds and those of Asiatic origin. It is interesting to point out that most KwaZulu-Natal Coloured people, speak English, unlike most of the Western Cape Coloured people who speak Afrikaans. The KZN Coloured people are descended from English speaking missionaries and settlers, for example, the Dunns, the Fynns, etc.

The auxiliary nursing staff use Zulu when speaking to each other. They do speak English when addressing those who do not understand Zulu. They also try to use the SASL and interpret for the SASL users, although they reported experiencing great difficulties when trying to use the SASL. The 'SASL health interpreters' indicated that derailed communication is common when they use the SASL. This happens because they do not have an in-depth knowledge of the SASL, and do not know the signs for formal health and medical register words. They learn by trial and error, and this endangers their hard of hearing patients/clients..

4.1.2.2 The C11 hospital Medical doctors language profile

They mainly use English. This includes those who use English at work only, but use their mother tongue languages at home. They communicate with their indigenous language-speaking patients/clients through the assistance of a 'health interpreter', as they do not speak or understand Zulu. Even those who know a few Zulu words and phrases, do not comprehend it appropriately.

Table (iii) The C11 hospital doctors' language distribution profile

Heritage language and or English speakers	Indigenous language speakers	Total
98%	2%	100%

The chronological profile of the doctors cannot be compiled as they did not reveal their ages.

Academically, all the doctors are in possession of their basic first degrees, namely the Medical Bachelor and the Bachelor in Chemistry (MBBCH). This does not mean that the doctors do not have post-graduate qualifications, it is only that they did not declare them.

These English-speaking doctors cannot effectively treat patients without the assistance of a health interpreter, due to their lack of indigenous linguistic skills and knowledge. For a doctor to diagnose a patient/client, s/he has to elicit the medical history from the patient/client. This history will assist the doctor, by suggesting a direction when doing an examination and a diagnosis. It is surprising, therefore, that the Medical Schools/Universities overlook this and do not include courses in local languages in the medical students' curriculum. At this stage the following pertinent questions arise:

- Do the Medical Schools/University authorities not consider that the prospective doctors will interact with the multilingual and multicultural patients during their working lives?
- Do the Medical School/Universities authorities view the patients/clients of the prospective doctors as objects to conform and comply with the “authority figures” language of choice?

The knowledge that the student doctors acquire at medical schools is meaningless without the ability to communicate in the language of the patients/clients. It will always be ‘locked’ in the doctors’ ‘superior’ language.

The DoH, DoE, PanSALB, DAC and all stakeholders involved in designing the curriculum of the medical, nursing and paramedic students, etc., are urged to incorporate indigenous language courses as a matter of urgency. Their decisions and policies have to be based on and focussed at the realization of the following Sections of the Constitution of the Republic of SA, Act 108 of 1996: 6(3)(a); 10; 14(d); 27(1)-(2) and 30.

Viewing the health scenarios in the SA multilingual and multicultural institutions critically, one wonders who is really being cared for. Some of the doctors impose

their scanty knowledge of the local languages upon the indigenous language speakers and this often results in degrading and humiliating the patients.

For example: An English-speaking doctor insisted on calling an elderly Nguni man *Mfana*. *Mfana* is a Nguni noun referring to a young male, who has not reached puberty stage/manhood.

In SA, *Mfana* is also widely used by White and Asiatic domestic employers when referring to adult men working for them at their homes. This usage diminishes the status of a mature man to that of a young boy, implying that this person is dependent on the employer for survival. This is highly derogatory in the African culture. The young, mostly English-speaking doctors, who grew up with indigenous language-speaking adult men working in their family homes, tend to refer to the adult indigenous language speaking male patients/clients as *Mfana* (boy), and thus unwittingly insulting their patients. They simply do not understand where, when and to whom this term may correctly be used. The use of this term also results in an imbalance in the use of power relations, and clashes with the African culture.

However, it was very encouraging to see that the senior management and all the staff that participated in this field research are very keen to have their language issues dealt with in a proper manner.

4.1.2.3 The paramedics use both Zulu (50%) and English (50%)

The pharmacy staff use English mainly, but when speaking to the non-English speaking patients/clients, the Zulu-speaking pharmacy staff assist with the interpreting on rotational basis.

Table (iv)(a) The pharmacy staff language distribution profile (this includes the heritage language speakers who use English in public spheres)

English speaking staff	Zulu speaking staff	Total
97%	3%	100%

Table (iv)(b) The C11 pharmacy staff academic profile

University Graduates	Technikon Graduates	High School Graduates with Matric Exemption	Total
15%	40%	45%	100%

The pharmacy staff chronological profile: Their ages range between 25 to 53 years.

The mean age is 31 years.

4.1.2.4 The psychologist only speaks English.

When counselling or talking to the patients/clients, a nursing staff member is used to interpret. In this case, confidentiality ethics may be bridged since these 'health interpreters' are not bound by a code of ethics. They are not professionally sworn health interpreters. These 'health interpreters' personified the pronounced cultural gap between the patients/clients and the psychologist.

4.1.2.5 The administrative (clerical) staff language profile

They mainly use English. This is because the clerical staff at the C11 hospital is also dominated by the speakers of the heritage languages, such as Gujarati, Hindi, Tamil, etc. Due to their close contact with the people of indigenous languages origin, they do have an understanding of Zulu, although they mutilate it when they speak.

Table (v)(a) The C11 Hospital administrative staff language distribution profile

English speakers	Zulu speakers	Total
98%	2%	100%

Table (v)(b) The C11 administrative staff academic profile

University Graduates	Technikon Graduates	High School Graduates with Matric Exemption	Employees without Matric Exemption	Total
None	15%	65%	20%	100%

4.1.2.6 The C11 Hospital general workers' language profile

Table (vi) The C11 General Workers language distribution profile

Zulu speakers	English speakers	Total
97%	3%	100%

The majority of the general workers are indigenous language speakers, usually Zulu-speakers. The few who make up the 3% (English speakers) do 'special reserved' work, such as the making of the tea for the management staff, sewing of the hospital garments and packing surgical instruments. They speak English in these hospital sections. These job allocations go to prove that speaking English is still a means to better jobs, when comparing what they do with collecting hospital litter, cleaning the floors and sluice rooms, working at an incinerator, mortuaries, etc, which is what the majority of indigenous language speakers do. This practice raises the following pertinent question:

- Are the SA indigenous languages still used to discriminate against the people that speak them in the multilingual and multicultural SA hospitals?

I believe that placing English-speaking general workers in the 'better jobs' is done primarily to make life easier for the English-speaking management staff members when communicating with the workers. However, this elevates the status of the English-speaking general workers compared to that of the indigenous language speakers, without attention to the ability or potential of the worker him/herself.

It is interesting to note, however, that when the English-speaking management or medical staff member is desperate for a 'health interpreter', they often temporarily remove the indigenous language speaking general workers from the sluice rooms, floor cleaning, etc., to interpret for them.

The above discussion shows that there is an urgent need for 'health interpreters' in the multilingual and multicultural SA hospitals. If linguistic transformation has genuinely taken place in SA, why is the above a general practice in the SA

multilingual and multicultural hospitals when it comes to job allocation and descriptions? The onus lies on the DoH management to take appropriate action, possibly starting with the SA DoH and the hospitals' management to revisit the hospitals' organograms and recruitment policies. They have to achieve visible transformation of the language use patterns and behaviours in the multilingual and multicultural SA hospitals.

I personally consider that freedom of choice in language is also freedom of mind, since one can then communicate freely. At the moment, however, the SA health fraternity is not linguistically free, and will not be free until they have sound, functional health interpreting systems in place.

4.1.2.7 The C11 Hospital patients' language profile

The majority of the patients speak Zulu and a few speak English. The C11 patients'/clients' language use distribution is as follows:

Table (vii) The C11 Hospital patients' language use distribution profile

Zulu speakers	English speakers (including heritage language speakers)	Total
96%	4%	100%

Table (vii) illustrates that the C11 patients are predominantly Zulu-speaking and they often do not understand English properly. Even those who understand a few words of English cannot express themselves in English well when communicating with the doctors. This means that they are not in a position to discuss their problems effectively with English-speaking doctors, without the assistance of a professional health interpreter.

Looking at tables (iii) and (vii), one can see the imbalanced language knowledge distribution between the doctors, who are predominantly English-speaking, and the patients, who are predominantly Zulu speakers and cannot communicate well in English.





4.2 OBSERVATIONS MADE AND QUESTIONS RAISED DURING THE FIELD RESEARCH

The primary issues that were scrutinised included the following:

- Are there any health interpreters? If the answer is 'yes', -- are they good / properly trained?
- The issue of the cultural gap between the patients/clients who are mainly African and the English-speaking health professionals with a Western background. For example, the only psychologist in this institution, who functions with the use of untrained 'health interpreters';
- The question of confidentiality, especially when counselling the HIV/AIDS affected and infected clients;
- The absence of the medical terminology in Zulu; and
- The proficiency of the medical staff in Zulu.

The following information was collected:

4.2.1 Data from the Questionnaire

The questions were structured and the information will be presented in terms of the questions asked.

4.2.1.1 Question 2.1 was posed to establish how many of the hospital employees were used as 'health interpreters'.

NB. The percentage of responses for the following tables indicates percentages based on the entire staff complement.

Table (viii) responses to question 2.1

Category	Yes	No	No response	Total Employees
Nurses	73%	4%	0%	77%
Doctors	0%	8%	0%	8%
Pharmacy staff	2%	3%	0%	5%
Psychologist	0%	0%	1%	1%
General workers	9%	0%	0%	9%
Total	84%	15%	1%	100%

The responses reflected in Table (viii) clearly show that there is an urgent need for trained health interpreters. This is indicated by 84% out of the whole staff component, who said that they are being used as 'health interpreters', 75% of whom are nursing, 2% of the pharmacy staff and the other 9% are general workers with no medical background.

It is apparent from the high percentage among these categories, that they are being misused. Using unskilled people as interpreters from English to the local indigenous languages, in this case, Zulu, constitutes a danger to the patients.

There are no doctors being used as interpreters, simply because they are the people who need interpreters as they do not understand the local indigenous languages.

The psychologist declined to participate in this exercise. I found this inexplicable, since she is one of the English-speaking staff members who cannot function without the assistance of an indigenous language speaker as a 'health interpreter' to bridge the communication chasm and cultural gap. This reflects a pattern of behaviour or attitude that suggests further separate investigation. Granted, research is a voluntary exercise, however, cooperation of all those involved and affected assists in validating the hypothesis and suggesting effective solutions.

4.2.1.2 Question 2.6 was posed to establish who the respondents would prefer to become their health interpreters.

Various options were given. The only two options chosen were trained/professional health interpreters or nurses.

Table (ix) Response to question 2.6

Category	Trained health interpreters	Nurses	No response	Total Employees
Nurses	77%	0%	0%	77%
Doctors	1%	7%	0%	8%
Pharmacy staff	5%	0%	0%	5%
Psychologist	0%	0%	1%	1%
General cleaners	9%	0%	0%	9%
Total	92%	7%	1%	100%

The above table gives the impression that 7% of the medical doctors cannot delimit the scope of a trained nurse to that of a trained health interpreter. Only 1% of the doctors saw the need for trained health interpreters. This is an indication that a great deal of education regarding interpreting skills is needed in the health sector.

The staff that is inappropriately used as ‘health interpreters’, namely, the nurses and general assistants know exactly how difficult it is to be an unskilled health interpreter and the figures, (77% and 9% on table (ix)) are a testimony to that.

4.2.1.3 Response to question 2.11

This question wanted to test the attitudes of the C11 staff with regard to the introduction of a short course for the health interpreters in their institution. Programmes recommended were: a certificate, diploma or degree.

Table (x) Responses to question 2.11

Category	Yes	No	No response	Program chosen	Total Employees
Nurses	76%	1%	0%	Certificate	77%
Doctors	8%	%	0%	Certificate	8%
Pharmacy staff	5%	0%	0%	3% = diploma + 2% = degree	5%
Psychologist	0%	0%	1%	-	1%
General cleaners	9%	0%	0%	6% = degree + 3% = certificate	9%
Total	98%	1%	1%		100%

The respondents who said ‘yes’ in table (x) = 98* indicate the eagerness of the C11 staff towards transformation of the health sector with special reference to language use matters. Their firsthand experience in the interpreting issues and the difficulties experienced are some of the motivating factors. The programmes chosen indicate who the people are and the way they think. See the categories pharmacy staff and general cleaners. This is an indication that they revere education and are in favour of improving one’s status academically, as well as one’s linguistic skills.

The 1% of the nurses who said ‘no’ to this question indicated that they believe that nurses are capable of fulfilling their roles and being ‘health interpreters’ at the same time. What I found interesting here is that this response came from some of the senior nursing managers. This shows how differently and uniquely people can interpret and give meaning to the same information.

4.2.1.4 Responses to question 2.14

This question was posed to establish the attitudes of all the C11 staff towards the introduction of a Zulu Language Program (ZLP) for all the English-speaking health workers in their institution.

Table (xi): Responses to question 2.14

Category	Yes	No	No response	Total Employees
Nurses	77%	0%-	0%	77%
Doctors	8%	%	0%	8%
Pharmacy staff	5%	0%	0%	5%
Psychologist	0%	0%	1%	1%
General cleaners	9%	0%	0%	9%
Total	99%	%	1%	100%

Question 2.14 was also aimed at assessing the possibility of the future plans for health interpreting at the institution. The responses to this question would give an idea on which direction to take regarding the future planning for this programme. To be specific, the Deputy Medical Manager of the C11 Hospital indicated during the interview that he wants to be part of the first proposed Zulu Language Project (ZLP) group for the English-speaking health professionals in KwaZulu-Natal. He further enquired about the existence of the national language conferences and workshops that can assist in introducing these critical language issues into the health fraternity.

The attitude of the C11 staff towards the use of the local indigenous languages in the KZN multilingual and multicultural hospitals is generally positive.

It is clear from the responses to question 2.14 that the ZLP is an urgent need for the C11 English-speaking staff.

This work is aimed at eventually having an implementable and functional LiHeP. The LiHeP should result in all the multilingual and multicultural SA hospitals having their own unique Language Policies, Language Mission Statements and Visions. For the sake of this study, it is important to say that at the time of writing, the C11 Hospital did not have any of the above mentioned documents in place.

4.2.2 Interview data

4.2.2.1 Interviewing the health professionals

The health professionals, namely, the English-speaking doctors, indigenous language speaking nurses, English-speaking and black pharmacy staff as well as the general workers were interviewed regarding interpretation tasks.

The indigenous language speaking staff indicated the following:

- They were used as interpreters, often more than five times a day.
- Sometimes they get frustrated because they do not have appropriate equivalents of the medical register in Zulu.
- The cultural gap needs to be closed between the English-speaking health workers and the patients/clients speaking SA indigenous languages.
- The English-speaking health workers sometimes query the long African language phrases used by the 'health interpreters'. To the 'interpreters', these queries show lack of the vote of confidence leading to strained relationships between the English-speaking health workers and the 'health interpreters'. This emphasises the need for the standardisation of the terminology used for the medical technical terms in Zulu.
- Regarding the SASL interpreting, especially in the OPD for the HIV/AIDS affected and infected patients/clients, it was stressed that
 - Very few people at the institution have any idea regarding the SASL.
 - Even those who understand it slightly are not trained to interpret it properly. This results to the frustration of both parties.
 - The English-speaking health workers take it for granted that if the SASL user is black, all black people can understand him/her. This is not the case. The colour of a person has got nothing to do with the specific language being spoken.
 - English speaking health workers do not seem to understand that SASL interpreting is a skill that has to be learnt formally.
 - The HIV/AIDS counsellors expressed a great need for SASL professional health interpreters to be utilised when counselling the

people living with and affected by HIV/AIDS. They emphasized the need for the recognition of confidentiality.

4.2.2.2 The psychological services

One Nursing Manager working in the medical wards of this hospital expressed great concern regarding an English-speaking psychologist who is counselling the non-English speaking patients/clients. Her concerns were as follows:

- Confidentiality and its ethical issues are not recognized.
- The psychologist's lack of knowledge of the African culture.
- The psychologist's lack of the knowledge of the indigenous African languages and the rules that govern their use.
- The patients/clients lack of knowledge of the psychologist's Western culture.
- The conflicting of the cultures in both parties that lead to pronounced break in communication.

This manager pointed out that counselling is governed by the confidentiality clause that works well if counselling is done on one to one basis. The presence of the third person ('the health interpreter') compromises this confidentiality.

She further expressed her concern about the misunderstanding and the discomfort that takes place when these two parties try to communicate through the assistance of a 'health interpreter'. The reason for this is as follows:

The English-speaking psychologist does not understand that a single English word may have to be interpreted as a phrase in the indigenous African languages. A classical example of this is when a client suffering from sexually transmitted diseases (STDs) is advised to practice safe sex by using a condom.

When an African language interpreter says this in Zulu, the term 'condom' will be translated as *ijazi lomkhenyana/likababa*, where *ijazi* refers to a coat, *Lomkhenyana* refers to the son-in-law's property, and *Likababa* refers to that which belongs to Father.

A 'vigilant' English-speaking psychologist may query the length of the phrase and may sometimes even think that the 'health interpreter' has added or changed the original message. This may strain the relationship between the English-speaking psychologist and the African language speaking 'health interpreter'.

However, a quick fix solution can be achieved by using the word 'condom' as a borrowed word, *ikhondomu*.

The speakers of a language, such as Zulu, have to accept and standardise the word through its standardising authority body, the MZUKAZWE (isiZulu NLB in this case). The MZUKAZWE will give the stamp of approval for using this borrowed word.

These quick fix solutions are often used to accommodate the speakers of the 'dominant' language. This is a good thing in a way, since it enriches the recipient language with newly invented words. The more the speakers of a certain language come into contact with the speakers of other languages, the more new words are coined. After all, language is dynamic and changes over time.

Borrowing from English is not a new phenomenon in Zulu. For example, the English word 'spoon' is used in Zulu as *isipuni*. This does not mean that there is not a correct Zulu word for spoon, which is *ukhezo*, but some Zulus prefer to use the word *isipuni* and this is understood by other Zulu language speakers.

A male African pharmacist working at the dispensing section also expressed his concern regarding the presence of a psychologist who does not understand the African languages and the rules that govern their use.

He specifically indicated that an English-speaking psychologist who has no background of any African culture is not able to communicate the use of any medicine appropriately to his/her clients/patients.

He further said that the English-speaking psychologist does not have any knowledge of the African language of respect (*hlonipha* language), commonly used by young married women when referring to their elderly in-laws. He reported that this

particular psychologist insists that some of these young married Zulu women use words like *amanzi* instead of *amakwete* (the later is *hlonipha* language) for water, something that they are culturally not supposed to say. Not recognising the *hlonipha* language taboos violates the African cultural norms and rules and embarrasses the patients.

He also indicated that this English-speaking psychologist sometimes uses vulgar language unintentionally due to the lack of her African language expertise.

The 'health interpreters' also expressed their concerns at being exploited by the English-speaking psychologist, as they do not get any financial reward for the work they do for her. They claim that they have been doing this interpreting work for decades and have great experience. They see themselves as 'semi skilled health interpreters', something that the English-speaking psychologist does not want to acknowledge.

4.2.3 Interviewing the Patients

The following were some of the questions discussed:

- How do they communicate with the English-speaking health workers?
- Which languages do they prefer to use when communicating with the health workers?

The response to the first question was:

- They communicate with difficulty because of the English language used by most of the doctors/paramedics and nurses. There are a lot of language barriers such as the medical terms. This is alleviated on occasion by the use of the 'health interpreters'.

The response to the second question was:

- All the indigenous language speaking patients/clients preferred using indigenous languages, such as Zulu, Xhosa and any of the other African indigenous languages from the Sotho group.

The following are extracts from some of the conversations and comments from the patients interviewed:

- A 45 year old Zulu male patient admitted in a male medical ward, when requested to comment about the languages used in the hospital, he said that:
 - English is used by the doctors, paramedics and other non-African language speakers. He added that they use abstract Medical Language (ML).
 - Zulu is used mainly by nurses and some paramedics. In other words, they use Everyday Language (EL).

When asked about his language preferences, he opted for Zulu. He also indicated that Tswana was his next language choice as he understood it.

He was also asked to comment on the use of Zulu by the English-speaking health professionals and the following were his comments:

- He said that the English-speaking doctors carry small pocket English/Zulu dictionaries that they refer to, if they talk to a patient without the assistance of a 'health interpreter' or Zulu-speaking nurses.

This is an indication that a small pocket simple English/Zulu medical dictionary is one of the urgent needs.

- He further added that when using these pocket dictionaries, if there are synonyms for a word, they do not consider the context in which the synonym is used. They just take any of the words and use it. Although

they are making an effort, these doctors are not linguistically conscious or trained communicators and can inadvertently insult their patients.

For example, the English verb 'to vomit' can be translated in Zulu as -*hlanza*; -*phalaza* or -*buyisa*. These Zulu synonyms are used in different contexts.

-*Hlanza* and -*buyisa* are used in voluntary vomiting.

-*Hlanza* is commonly used when referring to non-rational animals and -*buyisa* is used for the human beings. This means that if -*hlanza* is used when referring to a human being, it is derogatory and the Zulu person will be insulted.

-*Phalaza* is used in cases of induced vomiting by human beings.

-*Phalaza* is always associated with the Nguni cultural cleansing ritual commonly performed by young adults in order to be sexually attractive. A Nguni traditional herb, called *ubulawu*, is used as an emetic. It is believed that using *ubulawu* to *phalaza* removes all the *isichitho* (bad luck) and people of the opposite sex fall in love with you.

This patient expressed his disgust at the English-speaking health professionals who ask him: *Wena hlanzile ngakhi futhi?* Meaning 'How many times have you vomited again?' but actually implying that he is an animal. He stressed the point of using appropriate Nguni words in their correct context. Otherwise people are humiliated and insulted.

- He finally recommended that it be compulsory that all the English-speaking health professionals be taught an African language used in the area in which they are going to work, such as Zulu in KwaZulu-Natal, before they leave their training schools.
- A 13 year-old boy currently in Grade 7 at *Inanda* Secondary school and admitted to a surgical ward said that he prefers to speak Zulu all the time with the health workers. When asked why he preferred Zulu, he responded by saying that Zulu is the only language in which he can fully express himself and understands well.

He did admit that he knows English and Afrikaans since these are two of the languages taught in his school.

To support his choice of Zulu, he shared some of his experiences regarding the use of languages in a multilingual and multicultural hospital in SA. He related that he once consulted a dental surgeon (he was eleven at the time) because he had toothache. His mouth was examined and the dental surgeon advised that the tooth had to be extracted. He was given a local anaesthetic injection in preparation for the extraction. When it had taken effect, the English-speaking dental surgeon said, “*Hlala lapha ngihlakaze umhlathi wakho.*” This when translated into English means: “Sit down here and let me break your jaw.”

The surgeon obviously did not intend to harm the boy, it was only the use of an inappropriate Zulu verb *-hlakaza* and the noun *umhlathi* in the wrong context. However, this scared the boy and his family and they lost all the trust in the dentist, notwithstanding the proper explanation given by a Zulu-speaking dental assistant later. The boy and his family left without having the tooth extracted.

This type of scenario shows the power of the use of language and the urgent need for providing training for the SA indigenous languages in the SA multilingual and multicultural hospitals.

- An old lady aged 71 years, in a female surgical ward expressed her discomfort in talking directly to the English-speaking health workers. She indicated that she only feels comfortable and trusts the interaction if there is an interpreter who knows her language (Zulu) when talking to the English-speaking health professionals.

When asked about her fears, she said that the doctors sometimes use Zulu words that have meanings that do not express what they want to say. She recounted that she had once witnessed an incident where the doctor was explaining a surgical procedure to a lady (who had been diagnosed with a septic gangrenous left foot). The doctor used the Zulu word *-sika*, which means ‘to cut’ or ‘to incise’ instead of *-nquma*, which means ‘to amputate’. The patient signed the operation consent form under the impression that her painful foot was going to be incised

in the operating theatre. After the operation, however, she was shocked to discover that she was now crippled.

The above testimonies or life world incidences confirm the following:

- That the English-speaking health workers are not proficient in SA indigenous languages, in this case, Zulu;
- That the Zulu-speaking nurses are proficient in English and Afrikaans; and
- That the patients/clients are not proficient in English and Afrikaans.

4.3 Conclusion

It may therefore be concluded that there is an urgent need to train the English-speaking health workers in the local indigenous languages and customs, as well as a need for the visible use of the SA indigenous languages in all the multicultural and multilingual hospitals.

4.4 Proposals for Chapter Five

In the following chapter the need for a Zulu Language Program for English/Afrikaans speaking health professionals will be discussed, together with related issues.

CHAPTER FIVE

CONSOLIDATION OF DATA AND RESEARCH FINDINGS

This chapter deals with the consolidation of all the data of the field research work conducted at the C11 Hospital, Durban-KZN, the findings and the suggested solutions, both the immediate recommendations and future proposals.

5.1 PART ONE

5.1.1 The problem

The major problem is the ineffective communication between the English speaking health professionals and their African language speaking patients/clients.

5.1.2 Research questions

The research questions were formulated as follows:

- What is the nature of communication between the health workers and the patients?
- What are the reasons for poor communication?
- What can be done to resolve the problem, that is; to ensure effective communication between the health workers and the patients?

5.1.3 How to get answers

Both qualitative and quantitative methods were used. The research field was defined and a population sample was selected. The field research work was conducted at the C11 Hospital, Durban, in the province of KwaZulu-Natal.

The research instruments used were:

- a structured questionnaire,
- interviews and
- observations.

Collected information was documented and analysed.

5.1.4 Chapter Outline

In this dissertation, the chapters are organised as follows:

5.1.4.1 Chapter One -- The problem is outlined and analysed. Possible reasons for the problem are also highlighted and they are diverse and include:

- Lack of the LiHeP that is fundamental in regulating cross-cultural communication in any multilingual and multicultural SA hospital.
- Inadequate basic knowledge of the official South African languages, both by the health professionals and patients.
- Conflicting African and Western cultures (norms and values), thus resulting to strained doctor-patient relationships and derailed communication.
- The absence of the medical technical terms in African languages, with specific reference to the Zulu medical technical terms.

The aim and purpose of the study is defined as the study of the language behavioural patterns of the C11 hospital health professional staff and their patients/clients. The research methodology is outlined and discussed.

5.1.4.2 Chapter Two

- A literature review is given. The Conceptual Framework is outlined and discussed.
- The VCP is defined. The exposition of how it works is given as well as the factors that co-determine it are illustrated and discussed.
- Cross Cultural Communication and the factors responsible for it are outlined and discussed.
- Communicative Competence is discussed at length.

5.1.4.3 Chapter Three

The research methodology is discussed under the following headings:

- Research questions

- Possible measures to be taken or answers/remedies to the perceived problem
- Possible research methods used to gather/collect data
- Research methods used are the qualitative and quantitative field research methods
- Justification of methods used and
- Analytical and interpretative methods, procedures etc.

5.1.4..4 Chapter Four

This chapter deals with the documentation and interpretation of the data collected during the field research work at the C11 multicultural and multilingual hospital in Durban, KZN.

Responses from the participants of the structured research questionnaire exercise are presented by the means of tables and percentages only.

The socio-linguistic profile and other variables, such as age, are also presented. Different employee categories are presented separately in order to give clarity regarding which participant said what and the reasons for their responses. When reading these findings, it must be born in mind that as far back as 1996, 79.8 % of the KwaZulu-Natal population reported that their home language was Zulu, English accounted for 1.6% and Afrikaans = 15.8% (Stats in Brief, 2000:15). This is against the background of the entire SA population who reported that 22.9% of them were Zulu first language speakers, English first language speakers totalled 8.6% and Afrikaans, 14.4% (2000:16).

The data collected were documented and interpreted.

5.2 PART TWO

5.2.1 The Summary of the Findings

The percentages in these findings represent part of the total population of each employee category:

- 99% of the nursing staff are Zulu speakers. They do, however, understand English and Afrikaans.
- 98% of the doctors are English speakers. They are not proficient in the SA indigenous languages, specifically Zulu in this case.
- 97% of the pharmacy staff speak English. They are not proficient in Zulu.
- 98% of the administrative staff speak English and are not proficient in Zulu.
- The psychologist is an English speaker who is not willing to participate in the pertinent language issues affecting the C11 multilingual and multicultural hospital. The psychologist only communicates with the clients through the use of the untrained 'health interpreters' who are not bound by confidentiality accords.
- 96% of the patients are Zulu speakers and are not proficient in English. They cannot discuss their problems in English with the English-speaking doctors.
- A few staff members have a vague idea of what SASL is.
- The SASL users are offered trial and error sub-standard language services.
- A pronounced cultural gap between the English-speaking health workers and the indigenous African language-speaking patients exists.
- English-speaking health workers, especially the senior medical management are very keen to learn the African indigenous languages.
- The language imbalances shown by tables (iii) and (vii) clearly spell out the urgent need for the trained health interpreters in the multilingual and multicultural SA hospitals.

5.3 PART THREE

5.3.1 The recommendations

Based on the above findings, the following are the recommendations of this dissertation:

- ❖ A Zulu Language Programme must be designed and developed firstly for all the multilingual and multicultural KZN hospitals for the English/Afrikaans speaking health professionals (a pilot project for the African indigenous languages in the multilingual and multicultural SA hospitals). This should also cover all aspects of cultural character.
- ❖ Medical terminology (glossary) – term creation and standardisation thereof is imperative.
- ❖ Production of pocket dictionaries for (simple English/Zulu) medical contexts.
- ❖ Designing and implementing the courses for the trained medical interpreters; and finally
- ❖ The development of the code of conduct for the trained medical interpreters – they need to be legally accountable with regard to patient confidentiality issues, among others.

The responses of the structured questionnaire data and the interviews data justify the abovementioned recommendations.

5.4 PART FOUR

5.4.1 The future Plans/Proposals

Following the recognition and implementation of these recommendations, the long-term solution will include:

- ❖ Reviewing the curriculum of all the SA health students and ensuring that it includes courses in the basic local indigenous languages. Ideally, sign language should also be included.

- ❖ Translation of the English/Zulu medical pocket dictionary into other eight official SA indigenous languages.
- ❖ A COMPULSORY local SA indigenous languages' in-service course for all the English/Afrikaans current practising health staff. This includes the ENTRANCE SA OFFICIAL LANGUAGES' COURSE for all the health practitioners from outside the RSA..
- ❖ The URGENT formulation of the SOUTH AFRICAN LANGUAGE IN HEALTH POLICY and its IMPLEMENTATION PLAN.
- ❖ The expansion of the TISSA Project to cover the whole of SA.
- ❖ All the Departments concerned must be willing to support the recommendations and proposals. This includes making provision for the projects in their annual budgets to ensure the success of the projects.

5.5 Conclusion

South Africa is currently undergoing a process of nation integration and building after the apartheid period of 1948 to 1994. SA is a multilingual and a multicultural democratic state.

One of the SA advantages is its multilingual and multicultural diversity. It is therefore the responsibility of all the SA citizens to value and protect this multilingual and multicultural diversity.

The SA government and all its citizens have to make a genuine effort to know and accept each others' languages and cultures. By doing this, the South Africans will be working towards the effective management of the cross-cultural communication. For cross-cultural communication to be successful in the SA multilingual and multicultural hospitals, English/Afrikaans speaking health professionals have to make a genuine effort to effectively understand the cultures and customs, as well as be proficient in the languages spoken by their patients. These languages directly translate to the health professionals' ultimate proficiency and effectiveness.

My view is that DAC, PANSALB, the DoE, the Medical Schools, the Nursing Universities/Colleges and all the other relevant stakeholders have to collaborate effectively and form a sound partnership, thereby finding viable strategies to

manage cross-cultural communication in the SA health fraternity. One of the necessary outcomes for that collaboration will be the birth of a sound, implementable and sustainable SA LiHeP. This proposal has to be treated as a matter of urgency since it forms part of the nation building and the moral regeneration of our democracy.

It is important to realize that ineffective communication in the SA multilingual and multicultural hospitals is a major factor that contributes to racial tensions, medico-legal hazards and even the unnecessary demise of patients, citizens of our nation.

***KHULUMA DOKOTELA, BUA NGAKA, SPEAK DOCTOR,
KHAVHA AMBE VHODOKOTELA etc. !!!!***

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