COMMUNICATION STRATEGIES OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS IN THE LIMPOPO PROVINCE

by

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DECLARATION

I declare that the thesis titled **COMMUNICATION STRATEGIES OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS IN THE LIMPOPO PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

Adebola Abosede Fawole Date: …….

[redacted]
Student number

DEDICATION

This thesis is dedicated to God who has made this possible.

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ABSTRACT

The study focuses on communication during consultations between English-speaking foreign medical doctors, patients and nurses as interpreters in the Limpopo province. It aims to identify and describe the communication strategies, politeness strategies, influence of gender on the communication process as well as a review of the policy on language practice in the hospitals with a view to suggesting amendments.

Through a field work carried out in 10 public health facilities in Limpopo province, the study adopts an eclectic research method of semi-structured interviews, audio recording, and observation in the collection of data. Thirty-five patients, thirteen nurses and nineteen medical doctors are involved in the study. All the interviews and audio recordings were transcribed and translated wherever needed. Collected data was analysed using the Statistical Package for Social Sciences (SPSS) and Nvivo softwares.

Results showed that many foreign doctors were frustrated that they could not communicate directly with patients because they could not speak the indigenous language and the assumption that most patients could communicate in English often turned out to be erroneous. The hospitals are ill equipped to deal with the language problems. The linguistic barrier made it difficult to give equal medical care to all patients and doctors resorted to avoidance strategies in selecting patients.

Five consultations types based on the turn-taking were identified. These are clarification, continuation, convergence, knowledge and avoidance strategies. The study also reveals that the doctors use more positive politeness strategies when communicating with the patients and nurses. Gender was found to influence the choice of communication strategies by the foreign doctors. The inadequacies of the National Department of Health Language Practice Policy are highlighted and suggestions are made towards its amendment.

KEY CONCEPTS

English-speaking foreign medical doctors, communication strategies, politeness strategies, gender, language policy, interpreters.

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LIST OF ACRONYMS

1	SPSS	Statistical Package for Social Sciences
2	CA	Conversation Analysis
3	BSAE	Black South African English
4	HPCSA	Health Professional Council of South Africa
5	TCU	Turn Construction Unit
6	ULWASA	University of Limpopo Women's Academic Solidarity Association

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Translating one's thoughts into words can be difficult, especially when it is not into the mother tongue. Baker (2013) quoting Culler (1976) stresses the fact that languages are different and are not mere nomencletures but articulations of realities of the speakers. Thus, when people from different cultural and linguistic background interact, the problem encountered in communication becomes complex.This is often the situation during consultations between foreign medical doctors and indigenous patients in South Africa when they have to communicate in English language which is usually a second language to both. It is for this reason that this study would like to investigate and establish the strategies used by the foreign medical doctors when communicating with their patients who may speak little or no English.

This introductory chapter presents the background and the research problem identified in the study. The study is placed in context by giving a brief discussion of the theoretical and conceptual framework on which it rests. The research questions, significance, aim, objectives of the study and an outline of the methodology are presented. Finally, an outline of the chapters is presented.

1.2 KEY CONCEPT

An English-speaking foreign medical doctor is defined for the purpose of this study as a non-South African medical doctor who did not receive his medical training in South Africa, or one who does not speak English as a first language and does not speak any indigenous black South African languages.

1.3 RESEARCH PROBLEM

Communication forms the bedrock of all social interactions, including doctor-patient interactions. Failure or problems in communication may lead to unforeseen or sub-optimal medical consultation outcomes. On the one hand, good doctor-patient communication often results in better emotional and physical health, higher symptom resolutions and better control of chronic diseases (Wong & Lee, 2006). On the other hand, Meryn (1998) noted that breakdown in communication between doctors and patients often leads to patient dissatisfaction, subsequent upon which they may opt for alternative medicine.

Due to a shortage of medical doctors in South Africa, the government employs medical doctors from other countries to fill vacancies in rural areas. As the foreign doctors cannot speak the indigenous languages, most communication in the medical consultation process is often in the English language. This situation is referred to as the use of the “third power” language by Allwood (1985:20). This happens when people from different linguistic and cultural backgrounds decide to speak a common second or foreign language during their interactions. English is usually the language common to both the citizens and foreigners in South Africa.

However, English itself is a second language to both citizens and most foreign doctors. T**he knowledge and construct of English as the second language is influenced** by -among other factors - the culture and mother tongue of the speaker leading to a situation where there are many varieties of English based on the speaker.

The use of English as the language of communication in medical consultation may prove problematic due to the influence of culture and mother tongue leading to differences in pronunciation, use of vocabulary and semantics. The use of culture bound words like metaphors, euphemisms, idioms, local names of different symptoms in

relation to the health belief system and other cultural beliefs is also a problem as these cannot be easily translated into the English language or understood by a stranger in the community.

Summarizing the possible problems arising from the use of a second language, Allwood (1985:20) noted:

> Through the difficulty of attempting to master a third culture's way of thinking and speaking that is foreign to them both, they are forced to add to the difficulties in understanding that might already exist between them because of differences between their respective background cultures. That which is said must now be interpreted not only with consideration to the background of the speaker but also with consideration to the values and norms of the third, imported culture.

A situation described by Milubi (1998:18) helps to illustrate the use of proverbs, metaphors and euphemisms and the attendant problems:

> …a woman who enters the surgery and when the doctor asks her what the problem is, says: 'My snake does not catch.' The doctor fails to understand how and why a snake should catch. (*I cannot conceive*)
> Another case is that of a woman who tells the doctor that when she 'sees the moon', she experiences many pains. (*I experience pains during my menstrual flow)*

The extract below illustrates effect of culture on the consultation process as documented by Mandla (2009) in the Eastern Cape:

> Doctor: Take off this rope; I can't examine you with it around your neck. Don't you see that rash is caused by your allergy to this animal's hair?
>
> Patient: This is not a rope. It is my medicine. It has nothing to do with this rash.

When the patient is unable to communicate in the English language due to low proficiency, the need for an interpreter arises, creating other problems in the communication process. These may include omission or editorialization of information by the interpreter who in most cases are nurses who are often second language users

of English. Mandla (2009) recorded a typical example. An extract of interaction between a nurse acting as an interpreter and a patient is presented below.

Patient: Umxelele yonke le nto bendryrthetha ugqirha?
Did you tell the doctor all what I've just said?

Nurse: Ewe, Kutheni undibuza loo nto nje? Ukuba akundithembi zithethele.
Yes, I did, why do you ask? If you don't trust me, then speak for yourself.

Patient: Ndibona indlela le okhawuleze ngayo ukumxelela. Mna ndithathe ixesha elide ukuchaza isiqalo sale ngulo, wena uthethe nje imizuuwana. Nokuba anidisazi isiLungu akuthethaga le nto bendiyiththa nasoloko Ningxamile ukuthetha, kodwa nitharha, ithuba ukusibhalisa.

Your speech was too short. I took a long time trying to explain how this sickness started, and you only took seconds to report. Even if I don't understand English, what you said is not what I told you. You are always in hurry when telling doctors our sickness, but you take your time registering us.''

The examples given above are indicative of problems arising from the influence of culture and language on the intercultural interactions. The doctors in a bid to have successful consultations often use diverse methods in communicating with their patients during consultations. The researcher refers to the methods that the English-speaking foreign medical doctors use in an intercultural medical consultation as communication strategies. At this juncture, the questions to ask are what communication strategies are used and how successful are these strategies are as judged by the patients?

However, the success of the strategies cannot be judged successful or otherwise until they are first identified. This thesis therefore seeks to identify the communication strategies employed by the doctors during the consultation with patients with or without the use of interpreters.

1.4 THEORETICAL AND CONCEPTUAL FRAMEWORK

Communication in intercultural health consultations is complex, requiring the study of language and the cultural dynamics involved in the process. For this reason, the study will employ two theories and a model to explain the conceptual framework

The fact that culture affects health care is no longer news and there is need for effective intercultural communication between doctors, patients and other health workers. One way of achieving this is for health workers to learn about and be sensitive to the culture of their patients (Ulrey & Amason 2001). However, there are still problems in the communication process due to noise from the use of language and culture.

Miscommunications do occur in the use of language in intercultural interactions due to the influence of the cultures and the mother tongues of the people involved. This is true in a situation where both speakers speak a common second language or there is a need for interpretation. Lê (2006) cautions that it should not be assumed that 'fluent translation' will lead to perfect understanding. In this case we have problems on linguistic and cultural levels. The linguistic relativity theory commonly referred to as a hypothesis proposed by Sapir and Whorf helps to explain why miscommunications occur in cases where a second language is used.

The Sapir-Whorf hypothesis of linguistic relativity holds that language influences the way we think about reality (Lucy, 1997).The hypothesis has two versions. The strong version states that language determines the way an individual interprets the world while the weak version states that language only influences thoughts about the real world. It also holds that no two languages can represent the same social reality. This implies that interpretation cannot be accurate when translating from one language to another.

Littlejohn (2002) in agreement with this, states that language habits predispose people to certain ways of thinking. This suggests that people speak and act based on their cultures and that words do not always have the meaning that is available in the dictionary. The same word may have different meanings to different people based on their cultures. For example, 'wedding ceremony' may have different meanings to a man from the USA and a man from Nigeria. To the former, it may be a simple ceremony in the registry but a ceremony involving the entire village that is held over many days to the latter. When these two interact, there are bound to be misunderstandings although they have spoken the same language; the differential here is the culture.

Communication cannot be said to have occurred until the receiver has been able to decode the message as encoded by the sender. Because the speakers have different linguistic and cultural backgrounds, each speaker, thinking in his/her first language, translates what needs to be said into the English language.

The hypothesis has been criticized over the years and some researchers have investigated it. Some of these include Ji, Zhang, and Nisbett (2004); Davis, Sowden, Jerrett and Corbett (1998); Cook, Bassetti, Sasaki and Takashashi (2006) and Tse and Altarriba (2008). Findings from the researches are non-conclusive with some in support of the hypothesis and others against it. From findings in the medical field on doctor – patient communication across cultures, it is clear that culture is an important factor in determining the success or otherwise of the interaction.

Given the fact that South Africa is a multicultural society (with 11 official languages) and using this hypothesis as a foundation, we can suggest that the interactions between patients, nurses and English-speaking foreign medical doctors will have communication problems even though they communicate in a shared second language (English). These

problems will inevitably affect health care interpretations, decisions, outcomes and the health system in general.

The Communication Accommodation Theory (CAT) initially known as the Speech Accommodation Theory (SAT) was presented by Howard Giles in 1970 (Orbe & Harris, 2008). SAT explains how speakers from different cultures adjust their speech styles to accommodate others during interactions. CAT goes beyond what is said to include all aspects of communication in intercultural interactions which may involve 'accent, rate, loudness, vocabulary, grammar and gestures' (Orbe & Harris, 2008:126). The theory proposes that speakers make adjustments in two ways, namely: convergence and divergence. Convergence involves ways a speaker makes adjustment to become more like the other speaker while divergence involves ways employed to highlight differences between speakers.

Another way to explain the communication strategies in intercultural medical communication is the model of third culture building. When people from two different cultures interact, it is possible that a new culture distinct from the two original ones is created. Parry (2004) observed that in communication, people from different cultures are on equal footing when they compromise by temporarily adjusting their behaviour and pattern of communication. In the case of the intercultural health communication between foreign English-speaking doctors and patients, a third language is employed for communication. However, the compromise may extend beyond language to other aspects of the culture.

The number of studies conducted on doctor-patient communication underscores its importance in good clinical practice. Walker, Arnold, Miller and Webb x (2001) cited authors who confirm that many malpractice litigations actually boil down to poor communication skills of doctors and patients alike rather than the issue of clinical acumen, accuracy or skills of the medical doctors.

The problem is further compounded when the interaction takes place across cultural and linguistic divides. Eunson (2008:511) noted that ‘perhaps at no time in history has there been more contact between people of different cultures, ranging from refugees to asylum seekers…business people to professional diasporas---’. In discussing communication across cultures, he highlighted five models of intercultural communication. These are the Bennet’s developmental mode of intercultural sensitivity, Deardorff’s model of intercultural competence, Hofstede’s model of culture, House’s GLOBE model of cultures and Hall’s Context model. All these models provide invaluable insight into the intrinsic world of communication across cultures. These include, among others, acculturation, sensitivity to other cultures, the different dimensions of how one culture views another and understanding cultural communication in terms of the context in which it occurs.

In Hall’s Context Model, Africans as well as Asians, Arabs and Latin Americans are categorized as having high context culture that view time in multiple time frames and allow events to proceed at their own pace. However, this may be seen as a broad generalization as there are many and varied cultures and subcultures within the continents. With many opportunities for travelling for leisure and professional reasons, cultures may cease to follow this categorization. In other words, some high context cultures may become low context cultures due to exposure to the media and people from other cultures.

Problems may occur in intercultural communication due to different sets of communication rules in different cultures. According to Clyne (1985), each culture has a set of communication rules, which he lists as speech act rules, honorific rules, discourse rules, channel/medium rules, and linguistic creativity rules.

He further stated that problems in communication are likely to occur due to “culture-bound” differences in rule variants or overzealous attempts of one speaker to accommodate the other speaker’s variants of rules. In the light of this, one could expect problems of communication between doctors and patients in spite of the fact that many of these foreign doctors are also from Africa, (i.e. from the same high context culture). Of the five sets of rules discussed by Clyne (1985) only the first three will be considered in this study as the written communication and language play are not relevant.

Researchers consider gender and other demographic variables as non-significant in effective communication. However, Gabbard-Alley (1995) observed that many conclusions from studies on the role of gender in health communication were suspect due to faulty research designs. Differences based on gender reported by Gabbard-Alley (1995) include the following:

1. Women are more likely to report mild symptoms as they have more sick-role behaviours than men.
2. Women give more information in health communication encounters than men.
3. Health workers engage in more verbal interactions with women
4. Women receive shorter, less technical answers from doctors and their concerns are usually taken less seriously.
5. Women give and receive more nonverbal cues than men do.

All these may be linked to traditional stereotyped expectations of women in Africa that are acted on even when they are not true. For example, even though women are reported to be more knowledgeable health-wise, they are still considered less able to understand medical terms (Gabbard-Alley, 1995).

Larson and Smalley (1972:39) defined culture as a ‘blueprint’ that guides the behaviour of people in a community and is incubated in family life. Culture governs our behaviour in groups, makes us sensitive to matters of status, and helps us know what others

expect of us and what will happen if we do not live up to their expectations. Finally, culture helps us know how far we can go as individuals and what our responsibility is to the group.

It may be argued that language is a part of culture and culture is part of a language and that the two cannot be separated (Brown, 1994). However, it is also a fact that one may learn a language without necessarily learning the intricacies of the culture. Hsieh (2006) pointed out that language is not synonymous with culture.

The use of nonverbal communication goes a long way in determining the success or otherwise of a communicative interaction. These are bound in culture and do vary from one to another. The doctor ought to have a good understanding of the non-verbal cues of his patients to effectively diagnose and manage his patients. People usually do not like to talk about illness and disease. When it becomes necessary to do so, it often makes them anxious and defensive creating a fertile ground for communication breakdown (Robin & Wolf, 1988). To circumvent such breakdown, the use of politeness strategies becomes necessary. Politeness involves speech acts to reduce the risk of miscommunication and show intimacy between speakers.

Brown and Levinson (1987) proposed that politeness strategies are universally applied in all languages. However, it is a known fact that rules do differ from culture to culture and this affects politeness strategies as well create problems in intercultural communications. In the doctor-patient interactions there is need to ‘negotiate’ diagnosis and treatment, but sometimes in the process, patients may interpret the doctor’s information as threatening and seek to save face.

If doctors are to have effective communication with patients, they need to be culturally sensitive Brislin (1993) cited in Ulrey and Amason (2001). This requires the willingness of the doctor to consider and utilize cultural knowledge when discussing with patients, diagnosing and making recommendations for treatment. There is also the need for the doctor to have the time to actively learn the culture of his would-be patients. At present, such training does not seem to be available for foreign medical practitioners in South Africa.

Interwoven with this are religious beliefs. Patients visit the doctor, engage in communicative interactions and respond based on their cultural and religious beliefs. Are the doctors able to negotiate and speak above the noise created by these beliefs?

In the South African situation, culture and religion are not the only areas where miscommunication occurs. The linguistic aspect is also problematic. Most of the foreign medical doctors are posted to the rural areas where many indigenes speak little or no English. The need therefore arises for interpreters in the doctor-patient interactions.

Hsieh (2006) divided medical interpreters into five categories. These are untrained interpreters, chance interpreters, bilingual health care providers, on-site interpreters and telephone interpreters. Research into the use of medical interpreters has yielded conflicting results. On the one hand, studies like Baker, Parker, Williams, Coates, & Pitkin (1996), Carrasquillo, Orav, Brennan and Burstin (1999) reported that the use of interpreters improved services to the patients leading to greater satisfaction. On the other hand, studies like Rivadeneyra, Elderken-Thompson, Silver and Waitzkin (2000) and Baker and Hayes (1997) reported the opposite.

1.5 PURPOSE OF THE STUDY

1.5.1 Aim of the study

The aim of the study is to investigate verbal and nonverbal communication strategies of English-speaking foreign medical doctors, patients and interpreters when English is the common second language during consultations in the linguistic and culturally diverse Limpopo province of South Africa.

1.5.2 Objectives of the study

In order to achieve the above-stated aim, the specific objectives are:

- To examine communication between doctors, patients and interpreters who are all L2 speakers of English in relation to culture and language
- To examine politeness strategies employed by the doctors, patients and interpreters,

- To investigate the influence of gender on the use of language by doctors, patients and interpreters
- To outline policy implication for improving the communication strategies of doctors, patients and interpreters when a second language is used.

1.6 RESEARCH QUESTIONS

The study focuses on providing answers to the following questions:

1. What are the communication strategies employed by the English-speaking foreign medical doctors when communicating with patients and interpreters?

2. What are the politeness strategies used in medical interactions between English-speaking foreign medical doctors, patients and interpreters?

3. How does gender influence the use of communication strategies in medical interactions between English-speaking foreign medical doctors, patients and interpreters?

4. How can the language policy on Health be improved to facilitate the use of appropriate communication strategies by English-speaking foreign medical doctors and interpreters?

1.7 METHODOLOGY

1.7.1 Research design

Research methodology refers to ‘a general approach to studying research topics’ (Silverman 2000:88). A researcher chooses a method of research that will facilitate the gathering of necessary data and the analysis to provide answers to the research questions. In line with this, the study employed the qualitative method of research which Denzin and Lincoln (1998:3) described as “multidimensional in focus”. It studies things in their natural setting with the aim of understanding and explaining the findings.

The study focused on the communication between English-speaking foreign medical doctors, their patients and interpreters making it germane to understand what transpires in the consultation rooms when such intercultural and interlinguistic interactions take place. To achieve this, the study was designed as a descriptive study which used Conversation Analysis (CA) both as a data gathering and data analysing tool. The use of CA in the study of communication between health care workers and patients is useful because according to Drew, Chatwin and Collins, (2001), it helps to identify behaviour patterns that health workers need to consider when consulting with patients. The nature of CA demands that talk-in-interaction be recorded; translated if need be, transcribed and analysed. Thus consultations between the doctors and patients were audio recorded, transcribed and analysed using the CA conventions.

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In order to gain a better understanding of the dynamics of the communication during consultations, the methods of observation and post-consultation interview were also used. According to Wimmer and Dominick (1983:116), qualitative research uses a flexible questioning approach. Although a basic set of questions is designed to start the project, the researcher can change questions or ask follow-up questions at any time. Thus, questions were self-developed by the researcher and the sequence reorganised as the situation demanded. The interviews were transcribed and analysed to identify themes to further strengthen findings from the CA.

1.7.2 Sampling

Since it was not feasible or practicable to include all English-speaking foreign medical doctors, nurses and patients in the study, it became necessary to draw a sample from the poll of available population and draw conclusions based on data collected from them. The purposive sampling method was used in the selection of the hospitals to be used in the study. The inclusion criteria were the availability of English-speaking foreign medical doctors in the hospital and the location of the hospital in a rural or urban area. Effort was made to include two hospitals from each of the five districts of the province with equal number of hospitals in rural and urban areas. Consequently, ten hospitals were selected.

1.7.3 Data analysis

Data from the interviews with the participants were analysed using the Statistical Package for Social Sciences (SPSS) software for the background information. The Nvivo 10 software was used for the coding of participants' responses during interviews and the recordings of the consultations. CA was used to analyse data collected through audio recordings of interviews and doctor- patient interactions. CA is posited as offering new insights into medical interaction and communication to identify patterns of behaviour and interactional strategies and subsequent effect on the patient satisfaction (Drew, Chatwin & Collins 2001). Hutchby and Wooffitt (2008:11) defined CA as "the systematic analysis of talk produced in everyday situations of human interaction: 'talk-in-interaction.' Real and not arranged interactions are recorded for analysis." The analysis involved the transcribing of collected data, identification of phenomena and determining variations (Perakyla 2004). The CA notation developed by Gail Jefferson was used in transcribing the data.

1.7.4 Reliability, validity and objectivity

Reliability is described as the extent to which research findings are repeatable while validity in research refers to the accuracy or soundness of research findings Van der Riet and Durrheim (2006). To ensure the above criteria, the interviews were subjected to a pilot study to validate that they are relevant, easily understood and unambiguous. All transcriptions and translation were checked by another transcriber to uphold the tenets of truthfulness and trustworthiness. To ensure validity, data were collected using different tools i.e. participant observation, audio–recordings and interviews. Research assistants were also involved in interviewing patients to ensure that they understood the questions.

1.7.5 Bias

Answers from the respondents during the data collection process may introduce bias in the study if they give inaccurate answers or those they believe will project a good self-image to the researcher. To guard against this, many tools were used to collect the data. Thus, the study will not rely solely on the verbal answers from the respondents but also on information gathered through observation and audio-recordings.

During the analysis of the data, the researcher was neutral, not allowing personal opinion or sentiments affect the data collection process.

1.7.6 Scope of the study

The study investigated the communication strategies of English-speaking foreign medical doctors, patients and interpreters whose first language is not English. Data were collected in only the ten hospitals selected for the study. Only English-speaking foreign medical doctors who speak English as a second language and are employed by the government hospitals were used for the study. In answering the research question on gender, the study was limited to the use of language by doctors, patients and interpreters during medical consultations.

Of the forty-nine (49) hospitals (which includes the district, regional, specialised and tertiary hospitals) in the province, ten (10) were chosen as sites for the study. All categories of hospitals except the specialised hospitals for ethical reasons were included in the sample. Effort was made to include two hospitals from each of the five districts of the province with equal number of hospitals in rural and urban areas. The two hospitals in the Capricorn district are located in the rural area as the district is largely urban and also to provide opportunity to collect data from a tertiary institution. Doctors are sampled from all districts of the province to cater for the different language groups within the province.

The hospitals are as follows:

Table 1.1: Names of selected hospitals

	Name of hospital	District	Location
1	C.N. Phatudi	Mopani	Rural
2	Van Velden	Mopani	Urban
3	Ellisras	Waterberg	Rural
4	Mokopane	Waterberg	Urban
5	Seshego	Capricorn	Urban
6	Polokwane	Capricorn	Urban
7	Louis Trichardt	Vhembe	Urban
8	Elim	Vhembe	Rural
9	Jane Furse	Sekhukhune	Rural
10	Mecklenburg	Sekhukhune	Rural

1.8 ETHICAL CONSIDERATIONS

1.8.1 Protecting the rights of the participants

In order to protect the right of individuals, participants were informed of the purpose of the study and made aware of their rights not to answer questions they consider personal. They were also informed that their participation in the study was voluntary and that they could withdraw at any point without explanation. The participants were assured that confidentiality and anonymity will be maintained at all times and that their answers could not be traced to them.

1.8.2 Protecting the rights of the institution

A clearance certificate was obtained from the Turfloop Research Ethics Committee (TREC) before the commencement of data collection for the study. Permission was also

granted by the Limpopo Department of Health to conduct research in the selected hospitals.

1.9 SIGNIFICANCE OF PROPOSED RESEARCH

With the National Health Insurance (NHI) scheme scheduled to take off soon, it is evident that South Africa will still have to rely heavily on the services of foreign medical doctors for some time to come due to shortage of qualified medical personnel. In view of this, it is envisaged that the findings of the study will be beneficial in helping the Department of Health and Health Professions Council of South Africa in formulating programs that will help integrate foreign medical doctors into medical practice in both rural and urban areas.

It will assist medical personnel here in South Africa as well as other countries with foreign medical personnel in dealing with intercultural communication when attending to their patients as a means of improving the quality of health care delivery.The study will also be of value to patients, as it should shed light on appropriate communication strategies to employ when visiting doctors. The findings of the study will be published in academic journals.

It is envisaged that the present study will generate insight on doctor-patient communication in an intercultural setting where neither the language of the doctor or patient is spoken but a common second language is the means of communication in a high context society like Limpopo Province, South Africa.

1.10 LAYOUT OF THESIS

Chapter 1- The chapter presents a background of the problem, the purpose of the study, research questions and summary.

Chapter 2- The chapter discusses issues germane to the study. It includes among others, literature review on culture and health, English in South Africa, the second

language user of English language, medical consultations, politeness strategies, gender and the theoretical framework of the study.

Chapter 3- The research design and methodology is presented in this chapter with a view to explaining the tools and techniques for the collection of data.

Chapter 4 – The findings from the interviews are discussed in this chapter.

Chapter 5—The Chapter presents the findings from the analysis of the recorded consultations and observation.

Chapter 6-- The chapter discusses the findings of the study, make relevant recommendations and present a conclusion to the study.

1.11 CONCLUSION

This chapter presented the introduction, identified research problem, and a theoretical and conceptual framework. It also listed the research questions and highlights the significance, aim and objectives of the study. The methodology used in the study was also discussed. Finally, an outline of the chapters was presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter seeks to establish the existing national and international research in the area of communication between doctors and patients as a means of highlighting the gap in literature that this study seeks to fill. With reference to the objectives and research questions in Chapter One, this chapter discusses the concepts germane to the study. The theories that inform the study as well as the derived conceptual framework will also be discussed. Finally, a review of the use of Conversation Analysis in the research of medical communication will also be presented.

To this end, the rest of the chapter is divided into the following sections:

2.2. Previous studies on doctor-patient communication
2.3. Communication
2.4. Communication strategies
2.5. Politeness strategies
2.6. Gender and doctor-patient communication
2.7. The language policy in health in South Africa
2.8. Interpreters in healthcare
2.9. English language in South Africa
2.10. Theoretical background and conceptual framework
2.11. Conclusion

2.2 PREVIOUS STUDIES ON DOCTOR-PATIENT COMMUNICATION

Various researchers have studied the communication between doctors and patients with or without the use of interpreters within an intercultural setting from diverse viewpoints. This review of literature focuses on this type of communication in relation to the use of communication strategies, the issue of gender and politeness strategies. It will be

arranged in themes in line with germane issues in the study. The previous studies in South Africa are presented separately.

2.2.1 Communication Strategies

Identifying the communication strategies used by the foreign doctors to overcome language and cultural barriers in a hospital in Midwestern Ohio, United States of America was the focus of the research by Jain and Krieger (2011). They were of the opinion that understanding the communication strategies that the foreign trained medical doctors used in interactions with patients would help in drawing up a programme for the training of future foreign doctors. From the analysis of in-depth interviews with twelve foreign trained doctors in the residency programme in the hospital, it was found that the foreign trained doctors used multiple convergence strategies which included the repetition of information to patients, changing their speaking styles and using non-verbal communication.

In Canada, Rosenberg, Kirmayer, Xenocostas, Dao and Loignoo (2007) the strategies used by general practitioners in consultation with patients from cultures different from their own were examined. Using semi-structured interviews as the data collection tool, they found that the doctors used three main strategies during consultations. These are insisting on the patient's adaptation to local beliefs and behavior, the doctor conforming to what he/she thinks the patient wants and negotiation between the doctor and patient concerning a plan mutually acceptable to both parties. The use of these strategies differs depending on the doctor and topic being discussed. The researchers noted that the doctors had no framework for addressing cultural differences between them and the patients. Understanding the choice of communication behaviour of doctors with patients in relation to disability insurance claims in Netherlands was the focus of van Rijssen, Schellart, Anema and Van Der Beek (2011). They asserted that identifying the factors responsible for the choice of a communication strategy may enrich the understanding of face to face communication as well as give insights into the training needs of doctors.

Analysis of responses from questionnaires posted to respondents indicated that the attitude of the doctors was a major determinant of communication with patients.

In Sweden, communication between non-Swedish doctors, their patients and colleagues was examined in Lindström (2008). The study focused on the effect of cultural differences, the use of Swedish language by foreign doctors, the issues of gender and power in intercultural communication in the Swedish medical setting. A combination of audio recording of medical consultations, observation, questionnaires and interviews were used as data collection methods. Conversation analysis was used in the analysis of the audio recordings of medical consultations. Other data were analysed both quantitatively and qualitatively. The study noted differences in communication styles, power distance and hierarchy of non-Swedish doctors, their patients and colleagues.

The research by Claramita, Van Dalen and Van Der Vleuten (2011) investigated the relationship between the communication styles of doctors and the educational background of the patients in a South east Asian Hospital. The Roter Interaction Analysis System was used to analyse the 245 audio taped consultations of 30 internal medicine residents with patients. The residents were found to use unidirectional, paternalistic communication styles during consultations regardless of the educational level of the patients. This finding contradicts an earlier study they conducted in which doctors claimed that consultations with people of high educational level were less difficult. The doctors used predominately biomedical utterances and they paid little attention paid to the patient's concerns. The study however did not identify the factors responsible for the choice of communication style by the doctors.

Communication strategies adopted by medical doctors was noted to affect patients' perception and understanding of their illness as well as prescribed drugs and access to therapy was explored in Labhardt, Schiess, Manga and Langewitz (2009). The study

was conducted in a rural health district in Cameroon where 130 consultations were audio recorded and analysed using the Roter Interaction Analysis System. They found that the ability of the patient to recall diagnosis was related to the extent of clarity of the doctor during consultation. They also noted that the doctors voiced disapprovals to their patients. It was advocated that doctors be non-judgmental and give more explanations to the patients

2.2.2 Politeness strategies in medical communication

In Norway, the involvement of medical doctors with their patients during consultation was the focus of the study by Agledahl, Gulbransen, Forde and Wifstad (2011). They found that despite the medical doctors' courteous attitude towards their patients, they did not give them the opportunity to talk about their problems outside the medical diagnosis. Thus, the doctors maintained their professional position at all times by displaying a polite and friendly attitude towards the patients without treating them as fellow human beings but rather viewed purely from a scientific and professional stance. They concluded that the doctor's problem was not a lack of courteous behavior but the moral offence of covering their indifference and lack of curiosity in non-medical issues raised by the patients.

Iragiliati (2006) noted that the use of politeness strategies that reflected the cultural values of the patients was crucial to the success of consultations. In a study of interactions between of medical doctors, seventh and eighth semester medical students and patients in Indonesia, the use of communicative codes and politeness strategies was described. It was noted that the positive face was achieved by the use of personalization and social identity markers while the negative face was achieved by using impersonal forms of address.

2.2.3 Gender and medical communication

Bylund and Makoul (2002) described the development and validation of the Empathic Communication Coding System (ECCS), a system they developed to measure empathic communication. They used the system to measure the extent to which the use of empathic communication varies with physician and patient's gender. One hundred video recorded consultations between doctors and patients were analysed using the ECCS. The results revealed that male and female patients created comparable opportunities for empathy though those created by the females were more emotionally intense. The female physician communicated more empathically than the males.

Bischoff, Hudelson and Bovier (2008) suggested that doctor-patient communication patterns and patient's satisfaction are influenced by gender. The study explored the effect of doctor–patient gender concordance on the satisfaction of foreign language-speaking patients in consultation with or without an interpreter. The doctors were found to prefer and give more attention to male patients .The female patients received more explanation but asked fewer questions. The female patients were found to be more comfortable with the female doctors and gave them more information. Patients, regardless of their gender, interrupted the female doctors more.

The effect of gender on the referral of patient for joint arthroplasty was the focus of Borkhoff, Hawker and Wright (2011). Through a systematic review they found that doctors referred more female patients signifying that gender was an important factor in the issuance of referrals to patients. They are of the opinion that doctors need to be aware of and accept the unconscious bias that may influence their decisions to refer patients. The influence of patient and doctor gender and gender concordance on the provision of a patient–centered care was examined by Bertakis and Azari (2012). They found no difference between male and female patients. The female doctors were however found to provide more patient–centered care than their male colleagues and more to the female-female doctor–patient dyad.

Thus, literature confirms the relevance of the issue of gender as a factor to be considered in the doctor-patient interactions as it affects the medical consultation. However, what remains unclear is if these findings are consistent with intercultural medical consultation where the patient needs to speak in a second language.

2.2.4 Use of interpreters

Rosenberg, Leanza and Seller (2007) examined how doctors perceived the influence of professional and family interpreters on their performance as doctors during consultations in Canada. The authors used the methods of stimulated recall, video recording of consultations and semi-structured interviews. The doctors expected both the professional and family interpreters to perform the duty of interpreting the same way but they treated them differently. They followed the communication rules when working with professional interpreters but when the interpreter was a family member, they were treated as a caregiver as well as an interpreter. They also reported that the doctors preferred working with professional interpreters as they had a knowledge of medical terms and the medical system, were more certain to interpret what the doctor and patient say more accurately and ensure confidentiality. Doctors would, however, prefer direct communication as it was difficult to build a relationship with the patients when an interpreter is present and who constitutes a third party. This may truncate the doctor's thought process during history taking.

2.2.5 Foreign doctors

Diaz and Hjörleifsson (2011) explored whether and how foreign doctors in two Norwegian cities perceived the effect of the cultural background on their work. From data collected from seven foreign doctors in a focus group discussion, the study found

that the doctors though keenly aware of cultural differences, did not make a big issue of it and they described a gradual process of becoming bicultural. They also believed that being foreign and being culturally aware helped them to give better services to immigrant patients.

The acceptance and awareness of the cultural differences could be the explanation for the finding of a recent study by Sandvik, Hunskaar and Diaz (2012) who found minimal evidence of differences in the practice patterns of foreign and native doctors in Norway. The observational study aimed to evaluate if there were differences in the practice patterns of foreign and native Norwegian doctors. McGrath, Henderson, Tamargo and Holewa (2012) argued in favour for the International Medical Graduates (IMGs) need to be educated in the culture of their host communities, as culture invariably affects the consultation with patients. The authors conducted the research in a hospital in Queensland, Australia and based the study on data collected using telephonic interative, open-ended, in-depth interviews from thirty IMGs who were selected using the stratified purposive sampling method. The study focused on the impact that the IMGs' perception of cultural issues of their host communities have on their communication with patients. The interviewed IMGs indicated that the medical culture in Australia was different from what they were used to in their countries of origin. The Australian culture emphasized the patient-centered communication in contrast to the paternalistic method practiced in the countries of origin. They added that they had to learn and adjust to these differences on the job as they did not receive any formal training. For some it took only a few months for them to acquire a working knowledge of the culture while others acquired it after working for many years. The study underscores the importance of the foreign doctors' need to be aware of and educated about the culture of the host community as a means of improving their communication with patients.

2.2.6 Use of English during consultation

On the use of English in consultation, Wilson, Chen, Grumbeck, Wang and Fernandez (2005) examined the effects of limited English proficiency and doctor's language on patients' comprehension of medical discussions. A telephonic survey conducted in California, USA revealed that patients with low English proficiency were more likely to report problems with understanding medical situations and labels, hence low English proficiency is a barrier to comprehension and consequently increases the risk of adverse reaction to medication.

Roberts, Moss. Wass, Sarangi and Jones (2005) conducted research on the use of English as the language of communication between a general practitioner and patients with low English proficiency in London. They found culturally different styles of presentation a major source of misunderstanding between doctors and patients. Other factors are pronunciation, word stress, speech delivery, grammar, vocabulary and lack of contextual information.

2.2.7 Policy

Language barrier is not only a problem for the individual doctor and patient involved but also affects the health care cost of the nation. The link between language barriers and cost implications for asylum seekers in Switzerland was examined in Bischoff and Denhaerynck (2010). Using results from data gathered through the use of a cross-sectional survey, they found that health care cost was higher for patients who used interpreters in communicating with health care workers than those who did not. They suggested the training and use of interpreters in health care consultation in Switzerland arguing that though the initial cost may be high, it will prove cheaper on the long run.

2.2.8 Medical communication in South Africa

“Medical treatment without communication” is how a health worker described health care in South Africa (Deumert, 2010). The study explored the problems of communication between the largely isiXhosa speaking patients and their English and Afrikaans speaking health care workers in Cape Town and the barriers to care experienced by the patients. Using an eclectic selection of the research methods of in-depth, semi-structured interviews for staff and patients, questionnaires for staff, observation and recording of consultations, the researcher found that many health care workers were frustrated and dismayed that they could not communicate with patients because they could not speak the patient’s language and that the assumption that most patients could communicate in English often turns out to be erroneous. Also, it was noted that the hospitals were ill equipped to deal with the language problems and a lot of staff believe that the linguistic barrier did not afford them the opportunity to give equal medical treatment to the patients. The linguistic challenge also led to the inability of health workers to accord patients the respect they deserve according to their culture (e.g. failure to call Black South Africans their African names). This is often offensive especially to the elderly ones and reminds them of the apartheid era. However, it was noted that they are called by their English names because of health workers’ inability to pronounce the local names. The anxiety of health workers about the problem of communication often removes their focus from the well-being of the patient to negotiating the language issue immediately the patient enters the consulting room.

Mandla (2009) explored the problems encountered by doctors who are not proficient in isiXhosa when communicating with Xhosa patients as well as the communication strategies they use in such consultations. The study used the qualitative methods of interviews, questionnaires and observation to collect data for analysis. The study found that the doctors tried to learn the language of the patients and often referred to isiXhosa/English pocket dictionary in communicating with the patients but that this often proved counter-productive as patients were offended by words used out of contexts and the doctors were considered rude. Another strategy identified is the use of interpreters who often were staff or family members. This strategy was considered ineffective as

there were a lot of distortions leading to miscommunication. Another research, Nibe (2000) examined the communication between health workers and isiZulu speaking female patients in a Pietermaritzburg hospital, KwaZulu Natal using the tools of semi-structured interviews and questionnaires. The study explored the tangible and intangible verbal and nonverbal communication problems that occur during consultation.

2.3 COMMUNICATION

Gudykunst (1998) asserted that communication involves the exchange of messages and the creation of meanings. It is also a process that is on-going, ever-changing and continuous (Neuliep, 2009). People are constantly exchanging messages and interpreting them either consciously or unconsciously. Neuliep (2009:10-13) proposed seven more properties of communication. These are:

(a) Communication is dynamic signifying that is active and forceful making it impossible to capture its essence in a written or graphic form.
(b) Communication is interactive and transactive requiring the participation of at least two people.
(c) Communication is symbolic. A symbol is an arbitrarily selected and learned stimulus that represents something else. These may be verbal or nonverbal and are the means of sending thoughts and ideas as messages to other people. The symbols are meaningful to people who attach a meaning to them.
(d) Communication is intentional. This happens when people consciously engage in interaction. Gudykunst (1998) was of the opinion that messages may be sent and interpreted unconsciously or unintentionally due to cultural differences. A person may not intend to send a message but a message may be received by the other person. For example, an Arab may be offended by an American who sits with his shoes pointed to the Arab. For the American, it is a comfortable sitting position and sends no message, but it is interpreted as an insult by an Arab.

(e) Communication is dependent on the context in which it occurs making it contextual. A context is defined as the cultural, physical, relational and perpetual environment in which communication takes place.
(f) Communication is ubiquitous; is engaged in by everyone at all times.
(g) Communication is cultural, giving rise to different styles of communication even when the same language is spoken. Nonverbal communication is greatly impacted on by culture and is a fertile ground for misunderstanding.

Reviewing all the properties of communication, Neuliep (2009:13) summarised thus:

> Communication, then, is the dynamic process of encoding and decoding verbal and nonverbal message within a defined cultural, physiological, sociorelational, and perceptual environment. Although, many of our messages are sent intentionally, many others, perhaps our nonverbal messages can unintentionally influence others.

Attributing meanings to messages involves encoding and decoding based on the terms of reference of the speaker and hearer respectively. The way a person transmits and interprets a message is dependent on the person's unique life experiences. As we experience things differently so also the interpretation of messages differs from person to person. This is more so when people from different cultures communicate. Gudykunst (2003:256) defined intercultural communication as…"the exchange of cultural information between two groups of people with significantly different cultures." Misunderstandings occur due to the effect of culture on the encoding and decoding of message. Since culture is the main factor that affects communication in intercultural interactions, it is important to understand what culture is and its effects on communication.

Defining culture has proved problematic as different researchers define it in line with their field of study. Two of the definitions that are relevant to this study are from Jandt (2010: G-4) and Allwood (1985). Jandt (2010) defined it as the "sum total of ways of living, including behavioral norms, linguistic expression, styles of communication,

patterns of thinking, and beliefs and values of a group large enough to be self-sustaining transmitted over the course of generations." Allwood (1985) defined it as "all the characteristics common to a particular group of people that are learned and not given by nature." From both definitions, it becomes clear that culture is what defines a group of people who have a learned common way of living, beliefs, language and values. All these act as a unifying factor for the group.

According to Allwood (1985) there are four dimensions of culture. These are the pattern of thought referring to the common beliefs, values, norms and emotional attitudes, patterns of behavior which refers to the ways of speaking, commerce and industry, patterns of artifacts which is the common ways manufacturing and using materials and imprints in nature comprising of the groups' lasting imprint on the environment. The study is concerned with the first two dimensions as they are the ones often reflected in communication with other people. These dimensions are potential sources of misunderstanding in intercultural communication.

Gudykunst (1998) suggested that sources of misunderstanding in intercultural communication may arise from the following factors:

(a) The message is transmitted in a way that is unclear to the listener; this may be due to issues of pronunciations and accents.
(b) The rules of communication are different from one culture to the other and may be misunderstood by other people.
(c) The speaker or hearer may not be proficient in the language being used for communication.
(d) The listener may not know how to interpret an utterance within the context it was used.

Different scholars have presented different ways of categorizing cultures. The two common ones are Hofstede's five dimensions of culture and Hall's cultural contexts.

Hofstede (1980) gave five dimensions that can be used to note differences and rate different cultures. These are individualism-collectivism, uncertainty avoidance, power distance; masculinity–femininity and long-term and short-term orientation.The dimension of Individualism–collectivism shows how different cultures define personal relationships with other people. An individualistic culture emphasizes the individual above a group, independence rather than dependence, personal achievement and the uniqueness of individuals. Hence, individualistic cultures places a high value on the achievement of individuals requiring the setting of and accomplishment of personal goals if need be at the expense of others. Individuals often strive to prove that they are better than others. Individualistic cultures places values on direct speaking; saying exactly what they mean in their interactions

Collectivist cultures, on the other hand, emphasize the group above the individual. An individual's identity is drawn from belonging to a group. The notion of "duty" is important in collectivist culture and it takes pre-eminence over personal comforts or needs. People from this type of culture often focus on cooperation to achieve success than competing against each other. People from collectivist cultures often use indirect style expecting that people are able to infer the meaning.

Uncertainty avoidance refers to circumstances in which people in a culture are made nervous by situations they think are unstructured or unpredictable. Cultures can be categorized as having high or low uncertainty avoidance. High uncertainty avoidance cultures observe strict rules and schedules while the low uncertainty cultures are less strict with rules and more likely to take risks (Dainton & Zelley, 2005). Hofstede (1980) refered to power distance as how people consider inequity acceptable and as a norm in the society. Similar to uncertainty avoidance, cultures are divided into high or low power distance categories. High power distance cultures are of the opinion that power is a scarce commodity and accept that some people are superior by placing a high value on status and position in the society. On the converse, low power distance cultures are less

accepting of power divides believing that anyone can attain a place of power through hard work and dedication.

Cultures may also be considered along into patriarchal or matrilineal divide. Masculine cultures have distinct roles for men and women with the men expected to be assertive, ambitious, and competitive and the women supportive, nurturing and deferent (Dainton & Zelley, 2005). Men and women are considered equal in feminine cultures without strict rules or expectations based on the sex of individuals. The final dimension is the long-term and short-term divide in culture. Long-term cultures are willing to deny self and immediate gratification for an expected achievement, while the short-term cultures want immediate gratifications. There is evidence suggesting that Hofstede's dimension of culture is not absolute. For example, Jandt (2010), citing Woodring's study, reported that Japanese students were more individualistic than group orientated. This is in contrast to Hofstede's classification where Japan was categorized as a collectivist culture.

Another classification relevant to the study is Hall's classification of high and low context cultures which focuses on cultural differences in the process of communication (Hall, 1976). The classification is based on the fact that the environmental, sociorelational and perceptual contexts in which communication takes place are important (Neuliep, 2009). In a high-context message, most of the information is either in the physical context or internalized in the person, while very little is in the coded, explicit, transmitted part of the message (Hall, 1976:79). The low-context message on the other hand, has most of the message in the explicit code (Hall, 1976).

People in low-context cultures are likely to send clear, direct, simple and explicit messages, emphasise verbal rather than nonverbal communication. High context cultures are likely to encode indirect, implicit or ambiguous messages using metaphors

and expect people to infer or read between lines and use a lot of nonverbal communication (Gudykunst, 1998; Neuliep, 2009; Jandt, 2010). Understanding in intercultural communication requires that each participant is mindful during the communication process. This according to Gudykunst (1998) implies that individuals will become aware of how they communicate and intentionally execute plans to correct their tendencies to misinterpret other people's behavior. Thus, interlocutors need to be open to new ideas and be aware that there is more than one perspective to an issue.

2.4 COMMUNICATION STRATEGIES

When people interact using a second language there is always the possibility that both interlocutors may struggle to clearly express themselves verbally and nonverbally so as to be understood by the other person. Thus, they use different methods to achieve their desired objectives. These methods are referred to as "communication strategies", a term coined by Selinker (1972). Scholars are unable to agree on a single definition of communication strategies and there may be as many as there are scholars in the field of second language acquisition and teaching. Some definitions given by scholars as cited by Bialystok (1990:3) are presented here. Faerch and Kasper (1983:36) defined communication strategies as potentially conscious plans for solving what to an individual presents itself as a problem in reaching a particular communicative goal. Corder (1977) stated that it is a systematic technique employed by a speaker to express his ideas when faced with some difficulty. Tarone (1980) defines it as a mutual attempt of two interlocutors to agree on a meaning in situations where requisite meaning structures are not shared. Stern (1983) refers to the strategies as techniques of coping with difficulties in communicating in an imperfectly known second language. Furthermore, Rubin (1987) defines communication strategies as strategies used by learners to provide or continue communication with others rather than abandon the interaction. Brown (2000) saw communication strategies as pertaining to the employment of verbal or nonverbal mechanisms used in communication. Following a discussion of what communication strategies are, Ellis (1985:182) concluded that communication strategies are "psycholinguistic plans which exist as part of the

language user's communicative competence. They are potentially conscious and serve as substitutes for production plans which the learner of a new language or second language user is unable to implement."

The definitions above may be divided into two schools of thought. Faerch and Kasper (1983), Brown (2000) and Croder (1977) dwelt on the fact that the strategies are carefully thought out actions that are involved in using communication strategies while Tarone (1980) and Rubin (1987) focused on the interaction between interlocutors as the driving force for the use of communication strategies. Ellis (1985) attempted to synthesise the two schools of thought. Taken as a whole, the definitions suggest that careful thought is given to the choice of communication strategy used by an individual when interacting with others as a means of achieving understanding.

The study of communication strategies has largely been in the field of second language acquisition hence the use of the word "learner" when discussing communication strategies. It also focuses on the communication between native speakers and second language learners with a view to identifying errors or the angle of foreigner talk and repairs involving second language learners and native speakers (Tarone, 1983). However, communication strategies are different from learning or production strategies and transcend the learning stage to the stage of usage where there is a need to select strategies to use in order to communicate effectively as well as save face when necessary, in interactions with others.

Ellis (1985) noted that communication strategies are used by native speakers as well as second language learners. The emphasis is on the need to negotiate meaning with another person to ensure mutual understanding irrespective of whether the speaker is a beginning learner or a proficient second language user or a native speaker of a language. When communication strategies are seen as a joint negotiation of meaning

by interlocutors, it becomes that communication strategies are not only employed in communication between learners of a second language and native speakers alone but in different categories of interlocutors as a means of negotiating meaning (Tarone, 1983). This thesis focuses on the use of communication strategies by second language users of English in interaction with other second language users with a view of identifying and describing how they negotiate meaning when they interact. Different typologies have been created for the study of communication strategies. Four of these are ascribed to Lantolf and Frawley's (1985), Tarone's (1981), Faerch and Kasper's (1984) and Dornyei's (1995). These typologies show the development of the creation of the typologies from one level to another.

Lantolf and Frawley (1985) studied communication strategies from the viewpoint of gaining control. They created a typology of communication strategies namely object-regulatory, other-regulatory, and self-regulatory strategies. The object-regulatory stage is when a second language learner is controlled by the language. At the second stage, the other-regulated stage, the learner depends on others for help to communicate in the second language. By the time the learner attains the self- regulated stage, he/she is able to communicate independently in the second language. The authors note that the speaker may, however, slip back into the earlier stages depending on the circumstances e.g. the difficulty or complexity of the issues at hand. Based on the typology of Lantolf and Frawley, the use of communication strategies may be seen as a continuum with low proficient speakers, on the one end and the proficient ones on the other. This study will focus on the use of communication strategies as it examines communication between doctors and patients with or without the use of interpreters.

The need for communication strategies arises when a speaker desires to communicate a message to the listener and believes that he/she does not have the required linguistic and sociolinguistic structure to convey the message and he/she therefore needs to choose to avoid or not attempt to communicate or finds alternative ways of conveying

the message (Tarone, 1981). To achieve the desired communication, Tarone (1981) presented a typology of strategies that may be used by the speaker. She divided the strategies into five categories namely paraphrase, transfer, avoidance, appeal for assistance and mime. The first three categories have sub-divisions. Under paraphrase are the subdivisions of approximation, word coinage and circumlocution. Approximation is used when a speaker uses an incorrect word or structure because it shares semantic features with what the speaker intended to say. This is done even though he/she is aware the word or structure is incorrect but desires to continue the interaction in spite of the difficulty experienced. Using word coinage, the speaker makes up a new word to continue the interaction instead of giving it up. With circumlocution the speaker, instead of using appropriate word, describes the characteristics of the object or action. Transfer involves the transference of the mothertongue to the second language. The sub-divisions under it are literal translation, when the speaker makes a word for word translation from the mother tongue and language switch where the speaker uses a word from the mother tongue without translating it. Another strategy mentioned by Tarone is the appeal for assistance by the speaker by asking for the correct word or structure. The use of nonverbal communication instead of words is referred to by Tarone as “mime.” The last strategy is avoidance with topic avoidance and message abandonment as sub-divisions. When a speaker avoids a topic of discussion because he/she lacks the words to continue the conversation, the strategy of topic avoidance is being used. Message abandonment occurs when a speaker stops talking about an issue because of lack of appropriate words to continue the conversation.

Faerch and Kasper (1983) presented a similar typology but divided it into two broad categories of reduction and achievement strategies. The formal reduction strategies are used when the speaker avoids the rules of the second language he/she is not sure of what they should be. When the speaker avoids, replaces or abandons some types of discussions, the functional reduction strategy is used. The achievement strategies are further divided into two categories of compensatory and retrieval strategies. The compensatory strategies used may be non-cooperative or cooperative strategies. Using

the non-cooperative strategy, the speaker makes use of L1/L3 based strategies of code switching, foreignizing and literal translation and L2 based strategies of substitution, paraphrase, word coinage, and restructuring as well as non- linguistic strategies like mime.

The retrieval strategies are used when the speaker encounters a problem in communicating but decides not to use any of the compensatory strategies but rather perseveres by either waiting until he/she remembers the word or structure he/she wants to use. The speaker may also mentally identify the semantic field he/she needs and run through them until the needed word or structure is located. Finally, the speaker may think of an item in another language and translate it into the second language. With the third strategy which is meaning replacement, the speaker tries to preserve their intended meanings and topics of discussion by generating general expressions similar to their original topics and meanings when faced with a problem caused by their linguistic limitation. This often leads to a substantial amount of vagueness as what is said may not be as accurate as the original intended one (Faerch and Kasper 1983). The first achievement strategies which is code switching is similar to the language switch in Tarone's typology. Interlingual transfer is also similar to literal translation with the addition of foreignized forms of words. The interlingual/intralingual transfer involves the transfer of the structure of the first language to the second language. The interlanguage – based strategies include strategies like paraphrasing, word coinage, and restructuring. Cooperative strategies involve a positive attitude and asking questions. Nonverbal strategies include the use of mime, gesture and sound imitation.

The typology by Doryeni (1995), as cited in Brown (2000), follows a similar structure with the Faerch and Kasper typology. It is also divided into the categories of avoidance and compensatory strategies. The avoidance strategies comprise message abandonment and topic/phonological/ syntactic avoidance. There are eleven compensatory strategies namely circumlocution, approximation, use of all-purpose words, word coinage, prefabricated pattern, non-linguistic signals, literal translation, foreignizing, code switching, appeal for help and stalling/time-gaining strategies.

The typology of Lantolf and Frawley (1985) is different from the other three discussed as it does not focus on the process of interaction but on the level of proficiency the speaker has attained. It also suggests that the communication strategies used by an individual will depend on the level of his/her proficiency and confidence in the language of communication.

The other three typologies acknowledge the two broad divisions of communication strategies which are, on the one hand to continue an interaction in spite of problems encountered and to discontinue the interaction, on the other hand, even though Tarone does not make this distinction clear in her typology. The three typologies agree on the strategies used by the speaker to discontinue an interaction; topic avoidance and message abandonment. Differences, however, exist in the strategies for the continuation of interactions.

A major deficiency in the typologies is the lack of emphasis on the nonverbal strategies. The scholars referred to them as mime or nonlinguistic strategies. The nonverbal strategies are very important in intercultural interactions as they differ from one culture to another and may lead to miscommunication. In medical consultation, the importance of nonverbal strategies cannot be overemphasized as patients often observe and pick up many nonverbal cues from their doctors and take them as cues on how they should be feeling or behaving during consultation (Marcinowicz, Konstantynowinc & Godlewski, 2010; Pendleton & Hasler, 1983). Pendleton and Hasler (1983) argues that nonverbal expressions of patients may be more accurate than verbal descriptions of their symptoms as nonverbal expression are without the awkwardness or embarrassment which accompanies the verbal expression of some ailments. Nonverbal strategies may include facial expression, the tone of voice used, touch, direction of gaze, body position, as well as seating position. Ruusuvuori (2001) asserts that the doctor's body position at the beginning of a consultation affects the patient's fluency. He advocates the teaching

of the basics of nonverbal communication to undergraduate and postgraduate medical students.

Medical consultations are considered intergroup communication where interlocutors are from different groups (in this case doctors and patients) and each participant is aware of the norms guiding such interaction (Watson & Gallois 1998). Thus, each party seeks to use communication strategies which ensure the success of the interaction. In any medical consultation, doctors are advised to adopt seven key communication tasks (Makoul 2001). The key tasks rest on the building of a cordial relationship between the doctor and the patient which is thus the first task the doctor has to accomplish. A patient-centered approach is advocated for in consultation with the focus on the patient's illness. The doctor-patient relationship is to be seen as a partnership which should be extended to the patient's family and other support networks. The remaining six tasks when accomplished strengthen the relationship established between the doctor and patient. They are ordered sequentially as they occur in consultation. First, the doctor commences the discussions and gives the patient the opportunity to clearly state the health concerns. Secondly, the doctor is to gather information from the patient using open-ended questions, active use of non-verbal techniques to encourage the patient to give all necessary information. Thirdly, the doctor needs to understand the patient's perspective by acknowledging the patient's ideas and beliefs about the illness as well as exploring issues relating to family, gender and spirituality. Fourthly, after listening to the patient, the doctor needs to share information with the patient in the language that the patient understands, check that the information is well understood and offer clarifications when needed. Fifthly, both patient and doctor need to agree on a treatment plan. Lastly, the doctor needs to provide closure for the patient by inquiring about other concerns the patient may have, summarizing the treatment plan and discussing follow-up where needed. The medical doctor needs to adopt appropriate communication strategies. When this is done, there may be an expectation of patients' satisfaction, adherence to treatment suggestions and subsequent return for later appointments.

The development of effective communication strategies becomes more important in intercultural communication. Foreign medical doctors experience difficulties in the area of language used during consultations, how to provide emotional support for patients and understanding their cultural norms (Jain and Krieger 2011; Fiscella, Roman-Diaz, Lue, Botelho and Frankel 1997). In the area of language, the doctors may have the problem of understanding due to differences in pronunciation, use of colloquialism, idioms, accents and body language among other factors. Foreign doctors are often confused about the right and acceptable ways to comfort patients in the host culture. Eid and Diener (2001) noted that emotions are experienced differently in collectivist and individualistic societies. To combat these difficulties, the doctors need to develop coping strategies. For the international medical graduates in the United States of America, these strategies include learning to pronounce words the American way, learning meanings of slangs, repeating sentences, speaking slowly and verifying if patients understood what had been said. To compensate for the linguistic inadequacies, most doctors use body language like maintaining eye contact when speaking with patients.

The communication strategies of foreign medical doctors in South Africa have not been studied. It is important to note that intercultural communication in South Africa is not necessarily between foreigners and South African citizen alone but also between South Africans themselves due to the multicultural and multilingual landscape of the country. Some of the strategies used include the learning of the local language, repetition and verifying that message is understood and the use of interpreters (Ellis 2004). The success rates of these strategies are not verified and the strategies that have proved successful elsewhere may be unsuccessful in South Africa due to cultural differences. For example, Ellis (2004) noticed that although patients often answer in the affirmative when he asked them if they understood the instructions, they later asked the nurses for better explanation. An understanding of the communication strategies used in consultation will help in developing appropriate integration programs for foreign trained medical doctors.

2.5 POLITENESS STRATEGIES IN MEDICAL COMMUNICATION

Mills (2002) described politeness as a set of strategies or verbal habits which is determined as a norm by oneself or others and are socially acceptable within a given community. Foley, (1997), defined it as a battery of social skills designed to make sure everyone is affirmed in a social interaction. According to Holmes, (1995), politeness is an expression of concern for others. Blum-Kulka (1997) referred to politeness as the intentional strategic behaviour exhibited by people when they wish to save face in threatening situations. Thus, a person is judged polite or impolite based on the appropriateness of the behaviour towards other people in relation to the set of community-approved rules. It may also be seen as a gift that benefits both the giver and receiver as polite people are judged more likeable by others and the interlocutor is also saved from an embarrassing situation (Holmes, 1995).

Brown and Levinson (1987) building on the work of Goffman (1955) developed the politeness model which has been used in the study of various interactions and it offers a framework for the explanation of people's behaviour in face-threatening situations. The Theory according to Blum- Kulka (1997), also offers insights into the contextual and cultural differences that may be observed in interactions.

The Politeness Theory has three main notions, namely: face, face threatening acts (FTA) and politeness strategies (Ji, 2000). Face is the public self-image a person wants to claim for himself. The face consists of two kinds of wants; negative face wants which is the desire for one's actions not to be unimpeded, and the positive face wants which is the desire to be approved of and appreciated by others (Brown & Levinson, 1987). FTA refers to actions which militate against the face while the politeness strategies are ways of negotiating these threats (Kwon & Ha, 2004). They further suggest that politeness has two main functions which are to reduce the risk of threat to the face and to show intimacy between interlocutors. Thus, the concepts of face and FTA necessitate the use of politeness strategies in interactions.

Politeness strategies are tools used to create messages based on the desire of the speaker. Brown and Levinson (1987) presented two types of politeness strategies; the positive and the negative. Positive politeness refers to strategies that take into cognizance the need to satisfy the hearer's face; communicating to the hearer that they are similar and that their wants are desirable. They also consist of familiar and joking behaviours. The negative politeness strategies, on the other hand, are used to minimize impositions that occur with FTA by paying attention to the hearer's negative face.

The proposal of Brown and Levinson (1987) is summarised in Table 2.1

Table 2.1: Strategies for politeness

Strategies for positive politeness (Claim common ground)	**Strategies for negative politeness (Be direct)**
1. Notice, attend to interest, wants, needs, goods of the other person	Be conventionally indirect
2. Exaggerate (interest, approval, sympathy with the other person)	Questions, hedges
3. Intensify interest to other person	Be pessimistic
4. Use in-group identity markers	Minimize the imposition
5. Seek agreement	Give deference
6. Avoid disagreement	Apologize
7. Presuppose/raise/assert common ground	Impersonalize the other person
8. Joke	State the FTAs as a general rule
9. Assert or presuppose knowledge of and concern for wants of other person	Nominalize
10. Offer, promise something	Go on record as incurring a debt, or as not indebting the other person

11. Be optimistic	
12. Include both S and H in the activity	
13. Give or ask for reasons	
14. Assume or assert reciprocity	
15. Give gifts e.g. goods, sympathy, understanding, cooperation	

TABLE 2.1 (Adapted from Brown and Levinson, 1987)

The main way a speaker shows positive politeness according to Brown and Levinson (1987), is to claim a common ground with the other person. This may be achieved by making reference to similarities between the interlocutors. For example, that they have the same values and attitude or have a common background. Thus, there is the use of inclusive terms like “we” and “us” to express the notion of cooperation between the two speakers. Thirteen other examples of positive politeness were given by the authors and they focus on finding a common ground between speakers or pleasing the hearer. They also listed ten different ways by which a speaker may use negative politeness. The negative politeness focuses on saying what needs to be said directly without paying attention to the face wants of the hearer.

On the use of politeness strategies by second language users of the English language, Brown and Levinson (1987) identified three strands of study. First, is the study of transfer of politeness strategy from the mothertongue to the second language. They note that non-native speakers are more aware of politeness distinctions than the native speakers, suggesting an over-sensitive consciousness of the grammatical form in different request forms. The second is the research on how speakers from different cultural backgrounds communicate. The third strand is the study of the strategies used by speakers to facilitate mutual understanding between native and nonnative speakers. This study focuses on the second strand of study as it explores how foreign medical

doctors who speak English as a second language communicate with patients and nurses who are also second language users of English during consultation.

The authors argued that minor differences in interpretative strategies of speakers from the first language to the second may lead to misunderstandings in communication. However, it is not clear if second language users of a language only transfer politeness strategies from the mother tongue to the L2 or engage in convergence by using politeness strategies from the L2 when conversing with someone who is also a L2 speaker of the language.

According to Brown and Levinson (1987), the politeness theory is a universal concept present in all cultures. The study of Kwon and Ha (2004) challenged this concept in a comparative study of Koreans and Americans politeness and concluded that while politeness is indeed universal as all cultures engage in it, overall tokens were different. This suggests that different cultures have different ways of conveying politeness even though the aim of use is the same. In Africa, politeness may be ensured through the use of idioms and euphemisms. Milubi (1998) argued that idioms are used to ward off feelings of embarrassment that may have otherwise prevented the patient from giving valuable information to the doctor. This presents an interesting scenario for the foreign doctor who has to consult in the English language with patients from different linguistic and cultural backgrounds. How are these idioms and euphemisms translated to convey the correct meaning to a person who does not understand the culture and health belief models behind the sayings?

In the doctor-patient communication, politeness strategies shed light on problems inherent in the communication process, how to avoid them, and provide a template for the training of health workers (Yin, Hsu, Kuo & Huang, 2011; Robins & Wolf 1988). As opposed to the practice in the western world where consultation is increasingly being seen as a partnership between the doctor and the patient, the consultation style in developing and underdeveloped countries remains largely paternalistic. The doctors in

the developing world are accorded a lot of respect due to the high status placed on their educational achievements. This view often leads to an asymmetric relationship in the doctor-patient communication often requiring the use of politeness when the face is threatened. Calarmita, Nugraheni, Van Dalen and Van der Vleuten (2013) note that patients often did not voice their dissatisfaction with the doctors and when they did it was done in an indirect hesitant manner**.**

Often in consultation, the doctor and patient have a common goal of diagnosis and treatment and make efforts to achieve this goal by using different strategies. Bagheri, Ibrahim and Habil (2012), noted that professionals use language based on several factors which include politeness rules. However, as noted earlier, politeness tokens differ from culture to culture and this may constitute a problem during consultation in multilingual and multicultural settings. Calarmita, Nugraheni, Van Dalen and Van der Vleuten (2013) noted that the doctor- patient relationship follows unspoken rules of behaviour which places emphasis on politeness and which strives to maintain a positive image.

It is not uncommon for doctors using the paternalistic method of consultation to appear rude and hurried in their interactions with patients. However, this can also be noted even when the doctor appears polite and friendly. Agledahl, Gulbrandsen, Forde and Wifstad (2011) view politeness as a cover up by the medical doctor for their lack of concern for patients' underlying existential needs. They believe that the polite and friendly demeanour of the doctors is used to ensure control of the consultation and maintain focus on medical scientific issues raised without paying attention to what the patient has to say or feel. This is plausible when one considers that some speech acts are face-threatening and people may use different strategies to minimize the threat (Brown and Levinson, 1987). In this case, the need to attend to a large number of patients within a short time frame creates a conflicting situation between the wants of the doctor and patients. This is akin to the distinction made by Misher, (1984:6) between the "voice of medicine" and the "voice of the life-world." With the voice of medicine, the doctor takes charge of the interaction while in the voice of the life-world, the patient is of

primary importance and the doctor pays attention and gives the patient opportunity to voice concerns outside the medical issues. The voice adopted by the medical doctor will determine the type of strategies used in interaction with the patient. In a same culture consultation, it may be easy for the doctor to make a decision about the strategy to use depending on the circumstances. It may, however, be more difficult for a foreign doctor when the tokens of politeness are different.

Addressing in interactions is part of cultural awareness that indicates the level of politeness, the type of relationship that exists between the interlocutors and the attitude of the speaker towards the addressed person as well as creates the framework for the conversation (Trudgill, 1983; Alder, 1978; Quirk, Geenbaum, Leech & Startvik, 1985). In other words, the way a speaker addresses the hearer is very important as it occurs at the beginning of the interaction and may determine the development of the conversation.

Quirk et al (1985) categorised address forms into:

Names - first name, last name, full name with or without title or a nickname

Standard appellatives - family relations, titles of respect e.g. sir, ma'am, and markers of status

Occupational terms like "doctor", "nurse"

Epithets - nouns or adjective phrases expressing an evaluation either favourably or unfavourably e.g. dear, honey, beautiful etc.

General nouns often used in more specialized senses e.g. girls, ladies etc.

The personal pronoun 'you'

In the doctor- patient interactions, Iragiliati (2006) opined the form of address used by medical doctors is pertinent to the success of consultations. She concluded from analysis of data that positive or negative politeness strategies are reflected through the forms of address used by both doctors and patients. The forms of address are culture based and when not used at all or used in the right context, the consultation and

subsequent medication is adversely affected. This underscores the need for doctors foreign to the culture where they practice to learn and use appropriate forms of address. Considering the importance of the correct form of address in interactions, the way the English-speaking foreign medical doctors address their patients will be examined in the analysis of the consultation.

Interactions in institutional settings which involve power and distance are negotiable according to Aronsson and Rundsrtom (1989), and as such some strategies which may have otherwise been viewed as negative may actually be positive. Hence, superficial rudeness may produce a feeling of solidarity when the interlocutor understands that the opposite of what is said is meant (Grainger, 2004). It underscores the fact that the interlocutors must have a shared understanding of the choice of words and circumstances.

A germane question to ask is how speakers decide on the politeness strategies to use in any given situation. Holtgraves (2002) identified two competing motives; the motive to manage face and the motive to communicate efficiently and he then reasoned that the choice of a strategy depends on the motive most important to the speaker. Brown and Levinson (1987) also thought along the same line with an additional option. They believe that speakers will weigh the options of communicating the content of the FTA, the want to be efficient and the want to ensure that the hearer's face is maintained. Hence, the speaker needs to make a decision to satisfy himself/herself or the hearer. Both authors also agree that the decision also depend on sociological variables like social distance, power, and knowledge of cultural tokens of politeness. In a multicultural and multilingual interaction, the choice is also dependent on knowledge of the hearer's cultural token of politeness as the different presentation of face in different cultures affects communication patterns (Chen & Starosta, 1998).

2.6 GENDER AND DOCTOR-PATIENT COMMUNICATION

The word gender refers to the learned behaviours that are associated with femininity and masculinity and is a social and symbolic creation by the society (Jandt 2010; Neuliep 2009). It is different from sex which is a biological description. It is a social label which stipulates roles prescribed by culture and although these roles are merging, gender remains an important yardstick by which people are measured (Dielissen 2012).

Lakoff‘s (1975) research highlighted the fact that men and women communicate in different ways. She identified various differences in their communicating styles. According to her, women’s language style is characterized by the use of elements like hedges, tentativeness and tag questions. She concludes that these characteristics indicate indirectness, mitigation, diffidence and hesitation. This is in contrast to the male communication style which is characterized by direct unmitigated statements and interruption indicating that the male is direct, forceful and confident.

Lakoff (1975) may be taken as a generalization of communication differences between men and women as there may be cultural differences which will affect these differences. For example, the communication style considered feminine in America is considered masculine in the East. Gender communication may also be determined by the context in which it takes place. A woman in a position of authority may assume a traditionally masculine communication style and the opposite may happen when the man is in a subordinate position. Roter, Hall and Aoki (2002) from a Meta analytical review of research on doctor-patient communication between 1962 and 2001 gave an overview of how gender may affect communication during consultation. They reported that the female doctors were more likely to use psycho-social discussion, more lengthy positive and emotionally focused talk than the male doctors. They, however, found no significant difference in the amount of biomedical information discussed, quality of information given, or social conversation exchanged. The communication style of doctors also impacts on the satisfaction experienced by patients. Boschoff, Hudelson and Bovier (2008) suggested that there is a link between gender and the choice of the communication strategies used by doctors in a triadic consultation model.

When the fact that gender is culturally determined is considered, its importance and effect on intercultural communication can be understood. It has been identified as a major predictor of attitudes and behaviours that have implications for health and illness (Dielissen, 2012). For example, as stated in the review of past research on the effect of gender on medical communication, doctors behave differently based on the gender of the patient. Women reported that their pains were not taken serious by doctors and that they had to work hard at convincing the doctors that their pains were real.

Research findings leave no doubt that gender is an important variable in medical consultations. Street (2002) is of the opinion that gender is related to communication in medical communication through its influence on doctor-patient expectations, goals emotion, and perception of their partner and does have major impact on the communication process and outcomes of medical consultation. When the doctor and patient are from different cultural and linguistic backgrounds, the situation creates ample opportunity. Dielissen (2012) noted that the gender bias in medical practice is noticeable in the neglect of women and women related issues either intentionally or otherwise, stereotyping or having preconceptions about the health, behaviour, experiences and needs of women. Gender bias happens as a result of the roles and stereotypes ascribed to women, the prioritization of male needs over those of females so that women need to struggle to be recognized, discrimination on the basis of gender and the interaction between gender and power.

2.7 LANGUAGE POLICY IN HEALTH IN SOUTH AFRICA

The South African Constitution provides for 11 official languages namely English, Afrikaans, isiNdebele, isiXhosa, isiZulu, siSwati, Sesotho, Sepedi, Setswana, Tshivenda and Xitsonga. It offers an ideal situation where all the languages have equal status and

people have the right to use any language of choice. Echoing the National Constitution and National Language Policy in section one, the National Department of Health in its 2011 policy on language services emphasizes its commitment to the provision of language services as a means of achieving the government's vision of "Long and healthy life for all South Africans" for 2010 to 2014. Section one of the policy further indicated that the promotion of multilingualism will allow people the use of the language they understand best and feel comfortable speaking when accessing health care. To ensure this, the department in section 5.2 commits to the provision and use of "professionally qualified and competent interpreters and translators" in the healthcare system as well as affording staff opportunities to improve their proficiency in the English language as a means of enhancing their job performances.

According to Section 5.3 of the policy, all service areas of the department should ensure the provision of professional, qualified and competent interpreters and translator for clients who need them and inform the client of the availability of such services. Providing the services for the client depends on:

(a) The client's ability to communicate in English
(b) The purpose of the communication and kind and complexity of information to be conveyed
(c) The client's ability to effectively communicate in a stressful or familiar environment
(d) The preference of the client to communication in his/her own language even when he/she can communicate in English language
(e) The risks of miscommunication to the client and the potential for legal liability or legal consequences for the National Department of Health, and finally
(f) If the client has a disability and requires and alternative mode of communication

There is a lack of emphasis on the need to provide interpreters for doctors and patients during consultation in the scope of the policy. According to Section 3 of the policy, the

policy is binding on all government structures and personnel working for the National Department of Health and in particular on those responsible for information production, printing, publication and distribution. The focus is on the production of printed material in other languages, apart from English, which is accepted as the working language as stated in section 9.2 and suggests a lack of understanding of the importance of the verbal consultation between doctors and patients. Also, in section 11, where the financial implication is stated, provision for interpreters in hospitals is not addressed specifically though there is the mention of the provision of "language services". In "The politics of language in South Africa": a compilation of selected proceedings of the 2005 annual conference of the Linguistic Association of South Africa, no mention was made of interpreting services in the health care sector. This omission underscores the fact that the need for these services in hospitals is not regarded as expedient and the government may only be paying lip-service to providing such as stated in the language policy.

Although the language policy underscores the right to use any of the official eleven languages, in reality, English is the language of business or 'working language', the medium of instruction in schools and some government institutions have opted for its use as the sole official language (Anthonissen, 2010). In spite of the seemingly widespread use of English language, many still speak little or no English in some parts of the country. From the 2011 National Department of Health language policy, it becomes clear from the 2000 statistics quoted below that English language is one of the predominant languages in only three out of the nine provinces in the country. These provinces are Gauteng with 12.5% of her population having English as the predominant language; and Western Cape and KwaZulu Natal with 19.3% and 13.6% respectively. Some areas like Northern KwaZulu-Natal, Transkei in the Eastern Cape and rural Limpopo fall into the category of those with many people speaking little or no English (Anthonissen, 2010). This study focuses on the province of Limpopo where the main indigenous languages are Tshivenda, Sepedi and Xitsonga. Against this background of language distribution and the need to use English as the language of communication

during consultation with English-speaking foreign medical doctors, problems are bound to occur and strategies must be devised to in order to promote better communication between doctors and patients.

Although the policy states that professional, trained and competent interpreters and translator should be used in the discharge of the services, it fails to address the type of training needed for the interpreters and translators. It is also observed that there is no indication on the use of medical interpreters as found in North American countries and Europe. The policy also fails to acknowledge or address the issue of the foreign healthcare workers employed in the country and the problems of communication between them and their native patients. This may be because the country already faces problems regarding the use of language in the multicultural, multilingual society that South Africa is. Providing solutions to the problems of multilingualism should resolve some of the problems of communication between English-speaking foreign medical doctors and native patients. However, the problems are also cultural in nature consequently affecting the medical communication and may require more effort than is currently done with South African doctors.

2.8 INTERPRETERS IN HEALTH CARE

Wood's (1993) prediction that the problems of interpreting in medical communication in South Africa would become more complex and pressing in future appears to be accurate and the need for interpreters in the communication between medical doctors and patients can no longer be overlooked if patients are to receive optimal care. Levin (2006) reported that 92% of consultations in a pediatric teaching hospital in Cape Town were conducted in English language and only 21% of these had the assistance of an interpreter. This is despite the fact that many patients have limited proficiency in the English language and will feel more confident communicating in their mother tongues. Without the availability of interpreters, this becomes impossible with resultant adverse effects on the consultation process.

Hsieh (2006) identified five different types of interpreters available in medical communication. The first group is the chance interpreters. These are people who happen to be around by chance. They may be family members or friends of the patient or anyone in the waiting room who is bilingual. The second type called the untrained interpreters are the bilingual support staff like nurses, cleaners and others who are often called on to help in communicating with the patient. This group also includes bilingual people employed as interpreters but have no formal training as medical interpreters. These first two groups are referred to as the ad hoc interpreters.

The third group is the bilingual health care provider. These are health care workers (usually doctors) who learn the patient's language as a second language. This group has the advantage of eliminating the need for interpreters and fosters the creation of rapport between the doctor and patient. The issue of cultural differences, however, is still a problem for this group as learning the patient's language does not make the doctor bicultural. Unfortunately, many doctors in this category are guilty of being too confident of their knowledge of the language and cultural competency. The fourth type of interpreters is the on-site medical interpreter. These interpreters receive formal training in medical interpreting and are on site in the hospital for face-to-face interpreting services. It is believed that this category of interpreters provide better interpreting than the earlier groups as they are trained in medical interpreting and have the knowledge of cultural issues and medical terminologies. Lastly is the telephone interpreter who provides interpreting services over the phone. Some patients prefer this type of interpreters as it ensures confidentiality and anonymity as they cannot be seen by the interpreter. Some of these interpreters receive specialized training in medical interpreting. Of the five groups only the last two have received formal interpreting training and may be considered as professional interpreters and expected to provide quality medical interpreting.

Regardless of the group an interpreter falls into, they perform two roles in a mediated communication. First, he/she is seen as a supporter of the interaction between two interlocutors by reproducing what had been said by the one to the other in the target language and also organizing the turn-taking thereby ensuring the progression of the interaction. Second, the interpreter may also play the role of the primary interlocutor by answering the question directed at another person, explaining cultural differences or commenting on what had been said (Wood, 1993). Wood further argues that the relationship between a medical doctor and an interpreter may be handled in five different ways. The interpreter may be seen as an interviewer in which case he/she follows the guidelines from the doctor in interviewing the patient who has no direct interaction with the doctor. Secondly, the interpreter may be an instrument to the doctor; he/she is required to translate verbatim what the doctor and patients say. This approach is limiting as many medical terms are not readily translatable into other languages and may constitute a problem in consultation, on the one hand, and the patient's conceptualization of the disease, on the other when not properly translated into the English language. Thirdly, the interpreter can be treated as an advocate of the patient who needs to protect the rights of the patient. Fourthly, interpreters can be culture brokers to bridge the cultural gap between the doctor and patient. Lastly, the doctor and interpreters may form a partnership to give the patient optimal care.

Unfortunately, professional interpreters are not available in most district hospitals making it necessary to use ad-hoc interpreters to achieve the purpose of understanding the intercultural communication. Ad-hoc interpreting is the "spontaneous use (and sometimes abuse) of the bilingual employees, family members or other available individuals to provide interpreting services" (Meyer, Buhrig, Kliche & Pawlacks, 2010: 164). Often, in South Africa, at best, the nurses act as the interpreters and at worst anyone who is deemed bilingual (from the cleaners to the family members) are called on to interpret. Nurses may be considered the best of the different type of ad-hoc interpreters as they have medical knowledge and may be able to interpret the medical terms better; however, the truth as emphasized by Meyer et al (2010) is that they are not trained professional health care interpreters and therefore cannot be regarded as

competent interpreters. A lot of danger ranging from mis-diagnosis to fatal consequences could be the result of such interpretation.

Research has established that interpretation in the hospitals is better done by a trained interpreter rather than by ad hoc interpreters. (Elderkin-Thompson, Silver and Waitzkin 2001; Hudelson and Vilpert 2009; Flores, Laws, Mayo, Zuckerman, Abreu, Medina & Hardt, 2003). In South Africa, Schlemmer & Mash (2006) concluded that ad-hoc interpreters' lack of professional training impacts negatively on the quality of interpretation delivered and consequently leads to low satisfaction on the part of the patients. In spite of this fact, Hudelson and Vilpert (2009) report that many health workers prefer to work with ad hoc interpreters because they are usually available when needed.

According to Giles (1995), a good interpreter should have a good passive knowledge of the target language. This is important as interpretation requires the ability to think fast and reconstruct what has been said in the target language without losing the essence of the message (Elderkin-Thompson et al, 2001). The difficulty in this process is best appreciated against the background of the linguistic relativity hypothesis. It involves the translation of more than the linguistic elements but all culture-specific elements of the conversation as well. When cultural mistakes are made in intercultural interactions, they may have more damaging effects on the conversation than grammatical ones, Liao (1996). Furthermore, Odlin (2005) noted that it is difficult to translate the affects, emotions and attitude of speakers into a second language.

As noted earlier, the quality of the interpretation given by the nurses is questionable though they seem to be the best in the ad-hoc category. In a study of nurses doubling as interpreters in the United States of America, Elderkin-Thompson et al (2001) concluded that a lot of errors occur in interpretation provided by untrained nurse-

interpreters. Nurses as untrained interpreters use the consecutive method of interpretation. This means they interpret only when the speaker has finished speaking, thus they have to rely on the memory which results in various errors. Common errors recorded in interpretation include omission of information, substitution, editoralization and addition of information not given by the patients or doctors in an attempt to provide information congruent with clinical expectations. Errors also occur due to use of cultural metaphors that are difficult to interpret and often are not consistent with Western medical beliefs. Doctors may also have problems changing their mindset when information contradictory to the medical axioms was given (Flores et al (2003) and Elderkin-Thompson et al (2001). Many studies in South Africa reported that a major problem faced in medical consultation is the lack of accurate terms for medical terminologies in the African languages and the inability of doctors to understand cultural and linguistic norms (Mabasa, 2006; Saulse, 2010; Ndaezitha, 2005; Mandla, 2009; Ndlovu, 2010).

The fact that the communication strategy used by the doctor affects the quality of interpreting is stressed in Elderkin-Thompson et al (2001). They noted that the quality of interpreting by the untrained interpreters varied from one setting to another based on the doctor. The nurses tried to accommodate the individual style of the doctor in relating to the patient. The nurses were also found to side with the doctors when doctors and patients had different views of a problem; often translating more of what the doctor says than what the patient says.

2.9 THE ENGLISH LANGUAGE IN SOUTH AFRICA

The British introduced the English language at the Cape in 1806 (Silva, 1997). It was introduced to the Blacks first in the Eastern Cape and later in the Natal in the early 19th

Century. In 1822, English was declared the sole official language of the Cape Colony and the official language along with Dutch in the former republics of the Transvaal and Orange Free State in 1910. The black population in the then “independent homelands’ adopted English with one or more African language/s of the region as the official languages.

2.9.1 English in South Africa

Lass (2002) with reference to the 1996 census reported that English is the mother tongue of about 3.45 million people in South Africa. De Klerk and Gough (2002) quoting the central statistics services 1994 puts the figure of black South Africans who speak English at 7 million most of them being L2 speakers having an indigenous African language as the mother tongue.

With the advent of democracy in South Africa and the policy of multilingualism, the English language has become a lingua franca receiving a more favourable attitude from the people than Afrikaans. English is perceived as the language of liberation as opposed to Afrikaans – the language of past apartheid leaders (Webb and Kembo-Sure, 2000).

Silva (1997) noted that no single variety of English in South Africa can be designated ‘South African English’ as the language has been indigenized by the different racial groups in the country. Thus, there are different varieties based on the racial group speaking it (e.g. coloured English, Indian English, many variants of White South African English and the Black South African English). Since it has become the adopted language by many non-native speakers, it has developed certain structural and semantic features based on the interference from the mother tongue. The study focuses on the Black South African English henceforth referred to as Black South

African English (BSAE) as this is the variety spoken by the black populace in the Limpopo province.

2.9.2 The Black South African English (BSAE)

As mentioned earlier, English was first introduced to the Black South Africans in the Eastern Cape and the Natal. This was done by the missionaries who used it as the medium of instruction in schools (Silva, 1997). Certain characteristic patterns of pronunciation and syntax became entrenched as norms by the Blacks due to limited contacts with the native speakers as a result of the apartheid system of government.

English is seen as the language of power, the language of the elite and the language of upward mobility (Silva, 1997). Webb and Kembo-Sure (2000) reported that many Black South African parents prefer the use of the English language as the medium of instruction in their children's schools. This, however, does not mean that the learners are proficient in the English language. Webb (1994) reports that only 25% of Black South Africans have the required level of proficiency to use the English language effectively in communicating with others.

Every variety of English has its own distinct characteristics ranging from pronunciation to the use of words. Some basic characteristics of BSAE will be highlighted below. All examples are derived from de Klerk and Gough (2002). The characteristics are divided into five broad categories with some sub divisions.

1. Phonology

a. Vowels

BSAE is characterized by the influence of the five-vowel system of the Nguni languages and the seven-vowel system of the Sotho languages. For example, the vowels in ‘bath’, ‘trap’ and ‘lot’ are articulated as /a/, /e/ and /o/ respectively. The contrast between long and short vowels may also be lost in BSAE e.g. vowels in ‘fleece’ and ‘kit’ are both articulated as /i/. Diphthongs are extended over syllables and the monothongs [e] and [o] are used as vowels. The schwa sound is also realized as a full vowel.

b. Consonants

The consonants /ð / and /Ɵ/ are articulated as [d] and [t] respectively. In this way some voiced sounds may become voiceless.

c. Suprasegmental features

De klerk and Gough (2002) are of the opinion that it is the suprasegmental features such as tone, stress and intonation that affect the intelligibility of varieties of English. In BSAE stress may idiosyncratically follow the rules in native languages.

1. Grammatical features

Many features are entrenched due to native tongue transfers. Citing several authors like Schmied (1991: 64-76); Bokamba (1992); Bamgbose (1992); Jowatt and Nnamonou (1985), de Klerk and Gough listed 23 examples of grammatical features in varieties of English as indigenized by different African Countries.

2. Vocabulary

There are many semantic extensions in BSAE with words imported from the native language to the English language. Other vocabulary features include the use of idioms loosely translated to English, the predicative use of ‘late’, as a euphemism for ‘die’, redundant use of ‘each’ and ‘every’ synonymously with ‘each’ and reluctance to use some words based on cultural taboos.

3. Discourse patterns

It is in the area of discourse patterns that the effect of a high context culture on the indigenization of the English language is most evident. There is a carry over of indirectness, respect and gender rules to the English language.

a. Speech acts – The word ‘sorry’ is used as a mark of sympathy and not necessarily for apology. The use of the performative ‘I request’ or ‘I ask’ instead of ‘could you please…?’ indicates a transfer of an African language structure and respect for the superordinate.

b. Conversational norms

Characteristics here include less frequent interruptions, self-selection to give response and longer intervals for turn taking during conversations.

c. Discourse markers

There is the evidence of the influence of the native tongue in the use of idiosyncratic discourse markers. These include

- The use of ‘in fact’ as a topic-changing or topic-initiating marker rather for emphasis.

- The use of ‘again’ as marker for additional information

- “by all means” is used as a marker of intensity rather than assurance as in native English.

Use of ‘I can say that’, ‘in my opinion’, ‘on my side’ used as equivalent to native English ‘I think’.

d. Information structure

Word order and morphological devices are used for information structure rather than stress and intonation in native English language e.g. “The best education, I need to get it.”

e. Stylistics features

There is a tendency to use circumlocution, ornamental language, idiosyncratic use of proverbs and Latinate vocabulary. All these are evidences of the transfer of African oratory practice.

4. Code-switching. The mixing of the English language and the native tongue in conversations is quite common.

2.9.3 The characteristics of a second language user

A second language user is a person who knows and uses another language other than his/her first language in communication. The level at which the person uses the language does not matter; he/she may be proficient in the language or at the elementary level (Cook, 2002). Major (2002) opined that the L2 user differs significantly from the L1 speaker of a language. Some of these differences are explained by Cook (2002).

The L2 user has the advantage of having two languages at his/her disposal. Second language users engage in the practice of code switching making it possible for them to do with language what a L1 speaker cannot do. In code switching, the L2 user is able to reinforce communication by explaining unclear concept in another language. The L2 user has the ability to think in one language and produce speech in another i.e. he/she

can translate or interpret from one language to another. In speaking the second language, the speaker is often affected by the rules, concept and cultural patterns of the first language. However, Cook (2002) argued that L2 users have their own unique characteristics and are not defective or failed L1 users. L2 users also appear to have a different mind from that of monolinguals. They are reported to think more flexibly, have increased language awareness, have better communication skills in their L1 and learn to read more rapidly in their L1. The fact that bilinguals think differently from monolinguals is supported by the research report of Athansopoulos and Kasai (2008). They report that bilingual Japanese selected shapes more significantly than their monolingual counterparts. This was attributed to their proficiency in a second language.

Various scholars like Tannen (1981); Gudykunst (1990); and Li (1999) identified problems of using a second language for communication in an intercultural setting. They obseved that second language users are more successful in sharing information when interacting intraculturally than interculturally even when the speaker is proficient in the language of conversation. They are also noted to be less involved in interactions, rarely initiating conversations and often prone to experiencing uncertainty and anxiety when interacting. Choosing a suitable communication style may prove difficult for a second language user due to a clash of styles and conversational rules in first and second languages.

2.10 THEORETICAL BACKGROUND AND CONCEPTUAL FRAMEWORK

2.10.1The linguistic relativity hypothesis

The question if the language and culture of an individual affect his/her thought is the focus of the linguistic relativity hypothesis also known as the Sapir-Whorf hypothesis. It is based on the works of Edward Sapir and his student Benjamin Whorf and divided into two categories; the strong and the weak versions. The strong version known as the language determinism posits that “diverse interpretation of reality embodied in

languages yield demonstrable influences on thought" Lucy (1997:295). This suggests that a person is unable to think beyond the ideas offered in the languages he/she speaks and that our world view or that reality is determined by the nature of the language we speak. The weak version states that the language merely influences thought and does not determine it. Thus it is possible for the speaker of a language to find a name for an alien concept or thing alien to his /her culture and language spoken.

Lucy (1997) classified existing research in linguistic relativity into three categories.

1. Structure-centered approaches. This looks at observed differences in languages and implications for thought. Examples of this include Whorf's comparison of temporal markings in English and Hopi languages and the number marking in the study of the American English and Yucatec Maya by Lucy in 1992 (Lucy, 1997)

2. Domain-centered approaches. Researchers in this field study how different languages encode realities. Examples of this are the many investigations based on colour categorization and spatial orientation. Studies like Lucy (1992) reported that colours that were easily codable were also easy to recognize and remember when performing nonlinguistic tasks. In a 1998 study of colour triads in Setswana and English languages, Davis, Sowden, Jarrett, Jarrett and Corbett (1998) found that while evidences supporting universalism, there was also reliable evidence consistent with the weak version of linguistic relativity i.e. culture influences language. Stephen Levinson led a team of researchers to investigate how different languages code spatial orientation linguistically and its cognitive effect. They concluded that speakers of different languages responded to spatial prompts based on their languages (Lucy, 1997)

3. Behaviour –centered approaches investigate and seek explanation in language concerning behavioural issues. It seeks to find correlation between the language spoken and the behaviour of speakers. An example is the study conducted by Bloom

between Finnish and Swedish speakers and their propensity to occupational accidents (Lucy, 1997).

This study is based on the assumption that due to different cultural and linguistic backgrounds, English- speaking foreign medical doctors, patients and interpreters will have problems translating their thoughts into words when speaking a shared second language, thereby causing miscommunication in medical interactions. This assumption is based on the Linguistic relativity hypothesis also known as the Sapir- Whorf hypothesis. It should be mentioned at this juncture that the study does not aim to prove or disprove the linguistic relativity hypothesis. It, however, subscribes to the belief that language influences the way we view our world and that social realities are different based on different cultures. While this does not mean that intercultural communication is impossible, it does makes it difficult to accurately translate/ interpret one language into another.

The study is concerned with the aspect of the hypothesis that states that no two languages represent the same social reality. This is evident when one considers the problems encountered in translations. Language does indeed influence how we perceive and remember events (Samovar & Porter, 2001). A culture will have no need to name or describe an experience alien to it and may find it difficult to describe it as it has no words in its vocabulary to do so. Sapir (1921) noted that:

> A society that has no knowledge of theosophy need have no name for it, aborigines that had never seen or heard of a horse were compelled to in vent or borrow a word for the animal when they made his acquaintance. In the sense that the vocabulary of a language more or less faithfully reflects the culture whose purposes it serves. It is perfectly true that the history of language and the history of culture move along parallel lines.

2.10.1.1 The implication of linguistic relativity hypothesis for interpretation during medical consultation in an intercultural setting

If the statement that two languages do not hold the same reality is correct, then the linguistic relativity hypothesis has some implications for communication across different cultures and languages. Samovar (2000) argued that the slightest cultural difference may affect translation and interpretation. Each culture is expressed in linguistic and non-linguistic ways making it distinct and unique from others. The hypothesis presents the view that the reality experienced by an individual is a function of the categories available in his/her culture (Bennett, 1998). The language of the culture is sufficient to describe its reality. However, there is always need to interact with other communities, making it necessary to reach out beyond the scope of one's experiences. This, often, necessitates interpretation when the language is not known and proves problematic, resulting in miscommunication or a total breakdown in some cases. A language must be understood structurally and culturally if effective communication is to take place. Languages are difficult to translate if there are structural and cultural differences between them (Samovar & Porter, 2001).

Consultation with regard to some illness is at best embarrassing for the patient and at worst impossible even when the doctor speaks the same language as the patient and can understand the metaphors and euphemisms that the patient may use in describing the illness. For embarrassing occasions like these, cultures have culture-specific ways of speaking that may not be understood by a second language speaker of the language. Language has many uses in the society, one of which is to make people comfortable when there is a need for delicate disclosures or discussions as in medical consultations.

This may prove difficult in situations when a patient needs to convey a symptom to the doctor and has no English vocabulary to name or describe it. Africans, as noted by Samovar and Porter (2001), are fond of the use of proverbs in their communication. Milubi (1998:18) reiterated the fact that "the value system of the enthomedicine go hand in hand with language." while Rosenberg, Leanza and Seller (2007) asserted that patients describe their illness in terms of their culture. For this reason, doctors must

understand the language and culture of the patient for effective consultation or develop communication strategies that will ensure the same. A situation described by Milubi (1998:19) helps to illustrate the use of proverbs, idioms, metaphors and euphemisms and the attendant problems:

> …when asked what the problem is, the elderly person might say: “Nowa yanga I dia n than a fhasi” (My snake hits top and bottom). A misunderstanding may ensue as to how a snake, invisible as it may be can hit an elderly person top and bottom. What the elderly person means here is that he or she is vomiting and has diarrhea at the same time.

Interpreting for these patients will proof challenging if not impossible for the interpreter and definitively difficult to comprehend by the doctor. On the problems with translation, Lewis (1961:737) observes that “… translation is simply not possible by seeking equivalent words in other languages;” Words do not have meanings in themselves but that which is ascribed to it by people. These meanings are based on the culture and experience of the interlocutors. Thus, a literal translation from one language into another will be problematic. Words that reflect health beliefs are usually stemmed in cultural beliefs that a non-native speaker may not be conversant with. Speaking a language does not guarantee an understanding of the culture that has produced it. Consequently, when describing symptons to doctors, it is likely that patients will struggle to find the right words and end up vaguely describing them. The problems of linguistic equivalence may be found in the vocabulary, idiomatic, grammatical, syntactical, experiential, cultural and conceptual equivalence. In intercultural communication, literal interpretations without recourse to the culture can prove dangerous or truncate the consultation process as they often do not give the exact meanings of messages (Samovar & Porter, 2001).

These problems are evident in the intercultural communication between foreign doctors and their patients. Mabasa (2006) noted that communication is difficult because of lack of equivalent terms for diseases and symptoms in English language and vice versa.

2.10.2 The Communication Accommodation Theory

The Communication Accommodation Theory (CAT) came into being as a means of providing an appraisal of linguistic variation in social contexts. The theory, initiated by Giles and colleagues in the 1970s began as the Speech Accommodation Theory (SAT) and became CAT to include other facets of communication apart from speech.

CAT is based on the premise that when two people meet they adjust their communication patterns to accommodate each other and improve communication between them. For example, there is the tendency to reduce speech pace when speaking with a child or people who are learning a language. For this to happen, a speaker needs to have the motivation to accommodate the other speaker in the communicative interaction.

In the communicative act, three accommodation strategies have been identified. These are convergence and divergence (Giles & Ogay, 2007) and complementarity (Street, 1991). When converging, speakers use strategies to forge a sense of closeness and identical identity. For example, in medical consultations, the foreign doctor may converge by learning to communicate with the patient in the local language and making use of universal positive nonverbal language like smiling as the patient walks into the consultation room. In Giles, Coupland and Coupland (1991) converging speakers were perceived to be more competent, attractive and cooperative. In diverging, speakers employ verbal and nonverbal strategies to highlight differences between them (Giles et al, 1991). This may be used to maintain an identity they consider unique or stress a position of power in an otherwise position of powerlessness. Examples of this would be

the refusal of a patient to speak the English language to a foreign doctor or the doctor's use of medical terms that the patient does not understand.

Using complementarity strategies, people make attempts to maintain their differences while having a fruitful communicative encounter (Street, 1991). Examples of these are communication between doctors and patient or the traditional relationship between teachers and learners. This implies that there are set boundaries and each person is aware of them. However, for this to be a successful strategy, it must be with the consent of both communicators. None of the two should feel disadvantaged or forced to take a position of powerlessness.

Speakers will act based on their belief and judgment of the other person. Thus, a speaker may decide to engage in convergence, divergence or complementarity strategies based on emotions. Thakerar, Giles and Cheshire (1982) as cited in Giles et al (1991), divided accommodation into two types: linguistic accommodation and psychological accommodation. The linguistic accommodation refers to the actual speech produced in interactions while the psychological accommodation refers to the motivations and intentions of speakers to converge or diverge. Thus, there may be a mismatch between the two and a person's intention to converge may be perceived as divergent based on speech. For example, a foreign medical doctor may intend to converge by speaking the local language but in reality may diverge if the utterance is spoken in the wrong context or without an understanding of the cultural connotations of the words.

2.10.3 Model of third culture building

John Useem cited in Evanoff (2000:127) defined third culture as "…cultural patterns inherited and created, learned and shared by the members of two or more different

societies who are personally involved in relating their society or segments thereof to each other."

The model of third culture building according to (Orbe & Harris, 2008), is based on the Asante's model of transracial communication and founded on the idea of two individuals from different backgrounds communicating towards a common goal and in the process building a culture distinct from their different cultures. Evanoff (2000) described it from a constructivist view as a cross cultural encounter which creates a new context of communication. The model suggests that it is possible to produce mutually beneficial interactions through the use of positive and ethical communication strategies (Casmir, 1997).

The attraction of the third culture building model lies in the notion that people can relate in a mutually agreed upon on third culture to interact without one culture feeling threatened or from being assimilated by another culture (Parry, 2004, Evanoff, 2000). Thus, in intercultural communication, the interaction takes place "somewhere that does not belong to neither one or (sic) the other of those seeking interaction" (Parry, 2004: 131). The communicative encounter does not dwell only on identifying and respecting the other culture but also combining the cultures in 'novel' ways (Evanoff, 2000).

The model is different from other models of intercultural communication as it focuses on the process and not the outcome of events. It also concentrates on how the interactions between individuals help to shape culture (Casmir, 1999).The building of a third culture is plausible when one understands that culture is not static but constantly changing especially as the world becomes smaller due to advancement in technology withs increased mobility and communication. Orbe and Harris (2008) argue that it is constantly being developed and maintained through interaction.

Starosta and Olorunnisola (1993) cited in Orbe and Harris (2008) present five stages in the process of building a third culture while Casmir (1999) presents four. Starosta and Olorunnisola (1993) are of the opinion that the process starts within an individual who is aware of other cultural groups and is curious about them. The process is presented in a cycle implying that the building process is a continuous one. Casmir (1999) notes that there must be an identified need for the process to continue and that it may be stopped at any phases of the building.

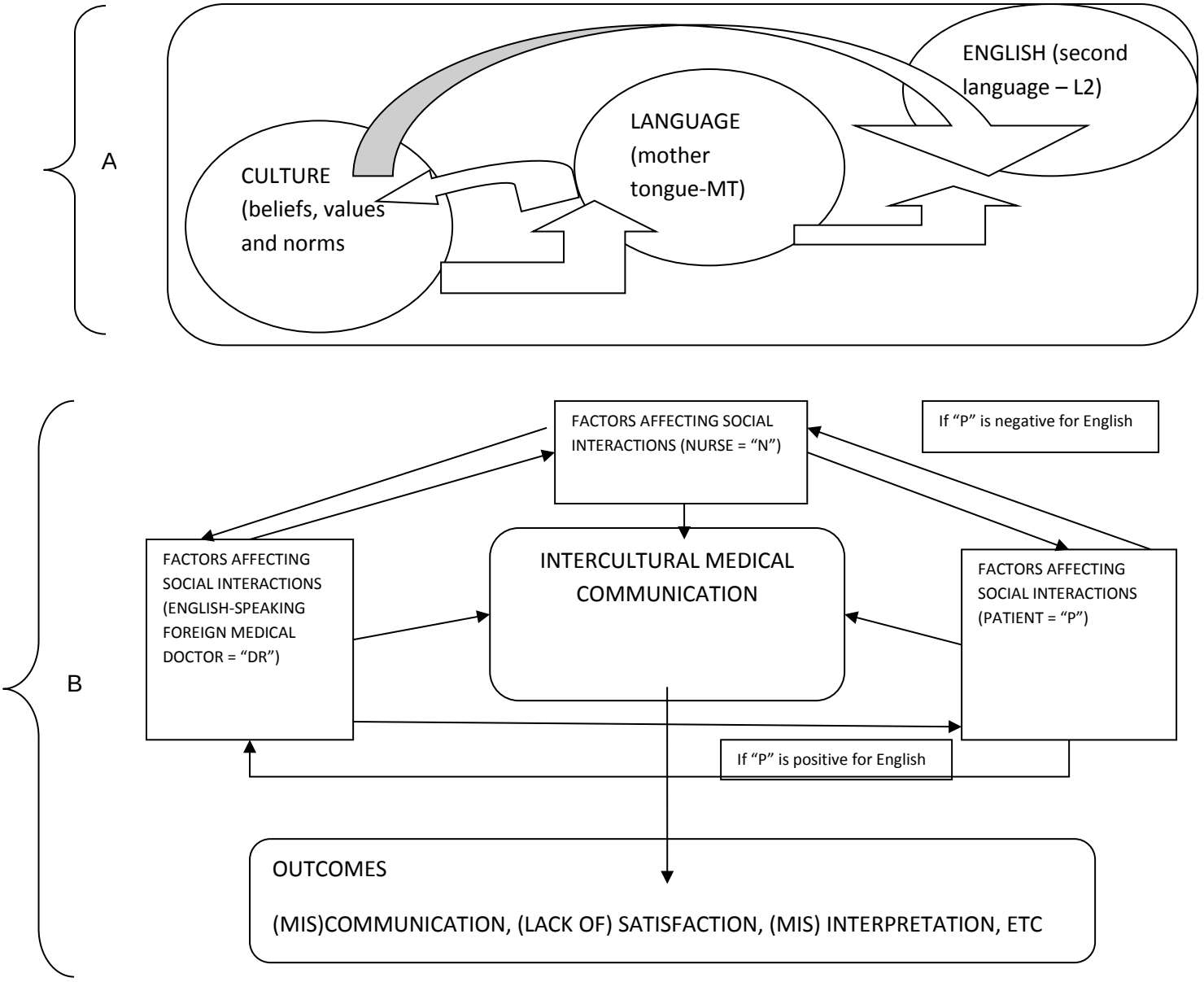
Building a third culture requires active participation of all communicators involved. There must be mutual trust, a willingness to reject racial and cultural prejudice, readiness to formulate mutually acceptable rules and roles and constantly maintain the culture that has being built (Starosta & Olorunnisola, 1993; Casmir, 1999). Casmir (1999) stressed the importance of dialogue in the development and maintenance of a third culture. As the rules and norms for the new culture does not yet exist, all participants in the building process must engage in the formulation process (Evanoff, 2000).

A third culture may be developed in South African's health care system with the employment of foreign medical doctors to work in the rural areas. In a bid to communicate and fulfil a mutual goal in consultation, a third language is used. It is possible that over the course of time, speakers of the third language will adapt the culture from the language in communicating with each other. An example would be the adoption of the youth calling an elder by a first name by second language speakers of English contrary to the African practice of using titles or honorifics. The building of a third culture made also extend beyond cultural practices to include linguistic factors. Through the use of code switching, a new way of speaking may be established.

2.10.4 Conceptual framework

Given the literature, theories and model discussed above, the following conceptual framework is derived. The framework is first presented as a diagram and followed by an explanation.

FIGURE 2.1: Selected factors affecting interactions when English as a second language is used as medium of communication during consultation



From the figure above, the “A” part illustrates how communication behaviour in social interaction is formed. Language and culture are intertwined having effects on each other

Scholars have not been able to agree on a single definition of culture. However, this study adopts the definition by Spencer-Oatey (2000) who defines culture as “a fuzzy set of attitudes, beliefs, behavioural conventions and basic assumptions and values that are shared by a group and that influence each member’s behaviour and each member’s interpretations of the ‘meaning’ of other people’s behaviour.”

Sapir (1921) defined language as a “human phenomenon that is used for the communication of ideas, emotions and desires…” According to the international organizations for teachers of education to speakers of other languages (TESOL1997), as a child learns the mother tongue (MT), it also learns the culture that reflects the values, norms and beliefs of the society. The culture is portrayed in the language and the language is generated by the culture. The learning and use of a second language is often influenced by the mother tongue and culture of the speaker.” Kellerman and Sharwood-Smith, (1986) coined the word “crosslinguistic influence” to refer to all areas (such as transfer, borrowing and avoidance) in which the mother tongue affects the second language. This will explain why English has many varieties based on the mother tongue and culture of the speaker. These variations may include phonological, semantic, and vocabulary differences, among others.

Thus, culture, mother tongue and the variety of the English spoken by an individual will have consequences on the individual’s social interaction with people from other cultures. The interaction of people from different cultural and linguistic background known as intercultural communication is defined by Ting-Toomey (1999:16) as “…the symbolic exchange process whereby individuals from two or more different cultural communities negotiate shared meanings in an interactive situation.” There is a need for negotiation to align values, norms and beliefs, which may differ from culture to culture. The variations (the influence of the culture and mother tongue on the second language) are evident in the communication process. Thus, in the “A” section of the diagram, all

three factors affect social interactions among people from different linguistic and cultural backgrounds.

In the “B” part of the diagram, where intercultural communication involving the foreign medical doctor and the patient takes place, each participant brings the influence of these selected factors (culture, mother tongue and English as a second language) into the consultation. The unifying factor is the English language as a second language as the mother tongues and cultures are different. If the patient speaks English as a second language, there will be a direct social interaction between them. However, if the patient does not speak the English language, the need for an interpreter arises. In this case, the nurse is in the vintage position to act as the ad-hoc interpreter. The nurse interprets the conversation based on his\ her own variety of English language as influenced by her culture and mother tongue.

Whether the patient speaks English and has a direct conversation with the foreign medical doctor, or does not speak English and communicates through an interpreter, certain outcomes can be expected due to the effects of culture, language and English as a second language in a social interaction depending on the communication strategies used in the interaction. These among others include (mis)communication, (mis)understanding and (lack of) satisfaction.

2.11 The gap filled by this study

It is evident that a lot of research has been conducted on medical communication generally and specifically on doctor-patient communication in different contexts of interactions. The problems inherent in the communication between foreign trained doctors and native patients have largely been explored in the western world like Sweden, Australia and USA. However, such research is scarce in South Africa and non-existent in the Limpopo province. It has been discovered from the review of past

research that research on general doctor-patient communication in South Africa has largely been carried out in the Western Cape, the Eastern Cape and KwaZulu Natal. Most of these research concentrated on identifying the problems in the doctor/healthcare –patient and do not describe efforts or strategies (if any) being used to address them. This study takes a departure from the identification of problems to the identification of solutions.

The South African studies have also not addressed the problems of communication between foreign medical doctors and native patients. This study will also fill that gap as well as proffer solutions to the problems. It is necessary that such a study is conducted in Limpopo province where as mentioned in Chapter One many foreign medical doctors are employed.

Data for most of the studies reviewed were collected through the use of questionnaires and interviews. This often presents the situation investigated from the point of view of the respondents without giving a holistic view. This study employs the use of audio recording in addition to the use of questionnaires and interviews to gain an in-depth understanding of the communication strategies used by English–speaking foreign medical doctors in medical consultation. The study also employs the use of Conversation Analysis in the analysis of all recorded talk-in-interaction.

2.12 CONCLUSION

This chapter reviewed literature on the communication between doctors and patients in dyad or triadic situations with the help of an interpreter. It discussed problems inherent in this type of communication and examined the Language Practice Policy being used in the Republic of South Africa. It also identified the gap the study hopes to fill.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Following the introduction and literature review of issues germane to this study, this chapter discusses the research methodology used in the study. It focuses on the research design, sampling methods employed in the study, the instruments used in the collection of data and the ethical issues considered. The use of Convesation Analysis and its relevance in the study is also discussed.

Table 3.1 presents the tools used to address each research objective and its derived research question. The table is considered necessary it shows at a glance, the research objective, research question and the tools used in the collection and analysis of data.

Table 3.1: Integration of research objectives, questions and tools

RESEARCH OBJECTIVE	RESEARCH QUESTION	TOOLS USED
Examine communication between doctors, patients and interpreters who are all L2 speakers of English in relation to culture and language	What are the communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters?	Interviews, (questions on problems encountered during consultations, efforts made by doctors to communicate better with patients, satisfaction of the patients, and awareness of patients that the doctor is not South African) Observation Conversation analysis
Examine politeness strategies employed by the doctors, patients and interpreters,	What are the politeness strategies used in medical interactions between English-speaking foreign medical doctors, patients and interpreters?	Interviews (questions on satisfaction of patients and efforts made by doctors) Observation, Conversation analysis
Investigate the influence of gender on the use of language by doctors, patients and interpreters	How does gender influence the use of communication strategies in medical interactions between	Interviews (question on how gender influences communication) Observation, Conversation analysis

	English-speaking foreign medical doctors, patients and interpreters?	
Outline policy implication for improving the communication strategies of doctors, patients and interpreters when a second language is used.	How can the language policy on Health be improved to facilitate the use of appropriate communication strategies by English-speaking foreign medical doctors and interpreters?	Policy on Language Services (2011) for the National Department of Health Interviews (participants were asked to suggest solutions to problems in the communication process)

3.2 RESEARCH DESIGN

The study is descriptive in nature as it describes the communication during consulation between foreign medical doctors, nurses and patients. The qualitative design was adopted as it offers an "understanding and represent the experiences and actions of the people as they encounter, engage and live through situations and where the researcher attempts to understand the phenomena from the perspective of those being studied" (Qazi, 2011:12). The research design of the study is qualitative due to the following reasons as enunciated by Creswell (2009:175-176).

1. It is usually conducted in a natural setting rather than a laboratory setting.
2. The researcher is the key data collector
3. Multiple sources of data are used
4. The use of inductive data analysis by building patterns from the bottom up.
5. There is a focus on the participants' point of view
6. Adjustment is made to the initial plan if the need arises-emerging design
7. Researchers view studies through lens of the society e.g. culture, gender etc.
8. Researchers try to interpret what they see, hear and understand
9. Researchers try to produce a holistic account of the study by reporting from different perspectives

3.2.1 Implementation of the characteristics of qualitative design in the study

Following the above characteristics, this study was conducted in the hospital recording real consultations in 10 selected hospitals in the Limpopo province of South Africa. Though the researcher was the main data collector, assistance was needed due to language limitation. Hence, assistants who speak the local languages (i.e. Sepedi, Tshivenda and Xitsonga) were recruited to help record, transcribe and translate the data. Fitting in with characteristic number three above, data collection was triangulated by using three different data collection methods and three categories of participants. Further explanation about data collection is given in paragraph 3.2.4 below. Characteristics number four is addressed by the themes got from the analysis of the interviews and observations. Effort was made to report findings through the perspectives of participants and the society in which the study takes place. This addresses point numbers 5, 8 and 9. Finally, adjustments were made to the proposal as the study progressed especially during the data collection process.

Since this study intends to identify and describe the communication of English-speaking foreign medical doctors with patients and interpreters, it adopts the use of Conversation analysis (CA). Flick (2009) quoting Bergmann (2004: 296), defines CA as “a research approach dedicated to the investigation along strictly empirical lines of social interactions as a continuing process and seeing order.”

All the four steps of CA as outlined by Have (1999:48) were taken in the study. The steps are as follows:

1. Getting or making recordings of natural interactions
2. Transcribing the tapes; in whole or in part;
3. Analyzing selected episodes; and
4. Reporting the research

3.2.2 The use of Conversation analysis in doctor –patient interactions

Developed in the field of Sociology, CA provides researchers the opportunity to study naturally occurring interactions. CA provides an avenue for this as it studies "…recorded naturally occurring talk-in-action to discover how participants understand and respond to one another in their turns at talk…" (Hutchby & Wooffitt, 2008:12).

The practice of CA is founded on some basic principles that make it distinct from other approaches in the study of spoken interactions. Hutchby & Wooffitt (2008), ten Have (2004) and Seedhouse (2004) highlighted some of these principles. The practitioners of CA see ordinary conversation as an important form of interaction between people. Conversation, according to ten Have (2004:4) is "people talking with each other". The interaction may be for social reasons or other purposes like institutional talk. Institutional talks, according to Heritage (1984) are interactions that are work-oriented, non-conversational talk in institutional settings like classrooms, courtrooms, medical consultations and meetings. Thus, conversations in naturally occurring interactions or talk-in-interaction are recorded for investigation as against the practice of gathering data through "experimental" or "researcher-provoked" methods

CA relies heavily on the use of transcription of the recorded talk-in-interaction. It is believed that the talk-in-interaction is structurally organized and procedural, not seen as a series of individual act but a highly organized event. Finally, talk-in-interaction relies on the process of turn-taking. What one speaker says is seen as hinged on what another speaker had said and each turn-taking move the interaction forward. The use of recorded audio or video recording for analysis is considered a necessity in CA and is the "focal data" (ten Have, 2007:73). Heritage and Atkinson (1984:2-3) consider other sources of data like interviews and observation as being based on preconceived ideas and reflecting a lot of the researchers' reconstructions of happenings. ten Have (2007) argues that additional data is not necessary in "pure" CA but may be necessary in applied CA where interactions in institutional settings are studied. The use of data from other sources is valuable here as it provides background and collaborative information for the study. The use of CA in the analysis of doctor-patient communication often involves the collection of large scale data. This makes it possible to identify general

“recurrent and systematic patterns” so that conclusions are not drawn from an individual’s personality or disposition (Drew, Chatwin & Collins, 2001: 60). This explains the collection of data from different categories of participants through audio recording, interviews and observation giving the opportunity to view the issue from different perspectives as characteristics of qualitative studies highlighted in paragraph 3.2.

The practice of CA also involves the transcription of recorded naturally occurring talk-in-interaction for analysis. The transcripts are not regarded as data in itself but as a “representation of the data” (Hutchby & Wooffitt, 2008:70). Against the convention of cleaning up inaudible words and correcting mistakes in transcribing recorded conversation, CA practice requires capturing the ‘what’ and ‘how’ of the conversation. The authors stressed that CA is concerned with capturing the talk-in-interaction in all its “messiness”. Thus, the timing, intonation, sequence, pace, silence, stresses, among other speech features, are noted in the transcription (ten Have, 2007). The common system used in the transcription as reported by Hutchby and Wooffitt (2008) is that developed by Gail Jefferson and improved on by other scholars. The transcription system is highly detailed and pays close attention to turn–taking and the characteristics of speech delivery. A list of transcription symbols used in this study is included in the appendix.

In the analysis of the transcribed talk-in-interaction, different types of interactional organization are recognized. These are turn-taking organization, sequence organization and repair organization (Hutchby & Wooffitt, 2008). Turn-taking organization developed by Sacks, Schegloff & Jefferson (1974) rests on the premise that that one speaker speaks at a time and that turns are taken with little time lap between them (Hutchby & Wooffitt, 2008). Speakers may be changed in different ways; a speaker may be chosen by a previous speaker, a speaker may self-elect his/her self or the speaker may continue speaking (ten Have, 2007). A unit of turn taking is referred to as “turn construction unit” (TCUs). TCUs are equivalents of sentences (Hutchby & Wooffitt 2008).

It is believed in CA that each utterance is a progression of the talk-in-interaction and that there is a sequential organization in the interaction (ten Have, 2007). In explaining the concept of sequencing, the term “adjacency pairs” was introduced to show that some utterances come in pairs with a distinct difference between the first and second utterance (Hutchby & Wooffitt, 2008).

3.2.2.1 Conversation Analysis (CA) and institutional interactions

Conversation either in everyday life or institutional settings are similar as they share the same characteristics discussed above. However, conversations in institutional setting have some distinct features as highlighted by Heritage (1997:163-164) as:

(a) Involving “participants in specific goal orientations which are tied to their institution relevant identities”
(b) Involving “special constraints on what will be treated as allowable contributions to the business at hand”
(c) “Associated with inferential frameworks and procedures that are particular to a specific institutional context”

This, in essence implies that participants usually come into an institutional interaction with an idea of what their roles are, are aware of the rules that govern these roles and are ready to abide by them. They are aware of what is not acceptable in such encounters. For example, the doctor is aware that his role is to give medical care to the patient and his speech is in line with this role. However, in some cases, patient may not be aware of the roles and the onus may rest on the doctor to uphold his role. Hence, participants are expected to behave in a particular manner

On what may be analysed in institutional talk, Heritage (1997:164) makes the following suggestions:

(a) Turn-taking organisation
(b) Overall structural organization of the interaction
(c) Sequence organization

(d) Turn design

(e) Lexical choice

(f) Epistemological and other forms of asymmetry

The organization of turn-taking may be different in some institutional interactions. According to Heritage (1997:164), some institutional interactions may involve “special turn-taking” when unlike everyday conversation where conversations are unpredictable, there is a set order from the beginning of the interaction. Effort must be made to determine if the turn-taking is special or not. In analyzing, the researcher needs to identify the structure of the conversation – to break it down into meaningful structures. The sequence organization requires the researcher to explore how each sequence of the conversation lead to another and is interwoven to create a logical conversation. The turn design focuses on the action the talk is designed to perform and the means employed to achieve it. Speakers may also “select among alternative ways of saying something or performing the same action” (Heritage, 1997:171).

In this study, CA is used in the transcription and analysis of the audio-recorded consultations paying particular attention to how turns are taken by the doctors, patients and nurses as interpreters, the turn design and choice of words in a bid to negotiate mutual understanding with a view to identifying and describing the communication act.

With reference to paragraph 3.2 point number seven (7) establishing the need to look at studies through the lens of the society where the study is carried out, it is necessary to consider cultural and gender issues in the analysis. Meierkord (2000) called for the use of a different category for analysis when analyzing non-native/non-native small talk conversation in the English language reiteraing the fact that non-native/ non- native conversation in English will reflect the cultural backgrounds of the speakers in terms of their communicative norms and standards. Thus, what is regarded as violations in native/native English conversation may not be so in nonnative/ nonnative conversation. Seedhouse (2004), however, refutes the suggestion that CA is biased as it was based on the English language by presenting CA studies done in other languages like German, Swedish, Japanese, Chinese, Korean and Thai. According to him different languages have many similarities and differences with the English language. However,

it is the researcher's belief that it is necessary that the cultural communicative rules of a first language be taken into cognizance when analyzing conversations in a second language. Failure to do so may produce inaccurate findings.

3.2.3 Sampling

The study used the non-probability sampling methods of purposive and quota in the choice of the hospitals and participants. Creswell (2009:178) noted that "the idea behind qualitative research is to purposefully select participants or sites (or documents or visual material) that will best help the researcher understand the problem and the research question" Thus in line with the aim of the study, two hospitals from each district in the Limpopo province with English-speaking foreign medical doctors were selected

3.2.3.1 Population

The study took place in Limpopo province. The study is apt in the province as it ranks the lowest with 1.8 physicians per 10 000 people according to the Health Practitioner Council of South Africa (HPCSA) figures for registered medical doctors in South Africa. This contrasts with the figures of 14.7 and 12.6 for Western Cape and Gauteng respectively. The picture becomes more dismal when the fact that the national average of doctor per 10 000 people is 6.7 is considered. Thus, Limpopo province recruits many foreign medical doctors to ameliorate the situation thereby providing ample resource for data collection. Although the study focuses on the communication strategies of English-speaking foreign medical doctors, it is impossible to have an in-depth study without recording naturally-occurring conversation which involves the patients as well as the nurses who act as interpreters. Hence, the population included the English-speaking foreign medical doctors, patients and nurses in the selected hospitals.

3.2.3.2 Sampling of participants

Using the purposive and quota sampling methods, it was intended at the onset of the study that two medical doctors (the oldest and newest) from each participating hospital be included in the study. However, this could not be followed strictly during data collection. In some hospitals, the oldest doctors were managerial staff and in other cases the doctors declined being recruited as participants in the study. At this point, the convenience sampling was used as the available and willing English-speaking foreign medical doctors were recruited. The nurses attached to the participating doctors were recruited. The patients were recruited based on their availability and willingness to participate in the study. No one was coerced to participate in the study.

3.2.3.3 Ethical issues related to sampling

Considering the nature of the study which involves the collection of data in hospitals, and the University's regulation on using humans as sources of information in research, ethical clearance was obtained first from the Turfloop Research Ethics Committee (TREC), then the Polokwane/Mankweng Research ethics committee and finally the Limpopo Department of Health before proceeding to the hospitals for data collection. Children as well as women attending the hospital for obstetrics and gynecological issues were excluded from the study. Each participant was given a brief but detailed explanation of the study and given the assurance that confidentiality will be maintained at all times. The consent form was translated into Sepedi, Tshivenda and Xitsonga for ease of understanding. All the doctors and nurses signed the English version while the patients signed according to the language of their choice. The consent forms were removed from the interview forms and kept with the researcher. Anonymity of participants was maintained by not recording their names as each participant is labeled a doctor, a nurse or a patient. Each consultation and interview was coded using an identification number.

3.2.4 Data collection

Data were collected using the tools of audio recording, interviews and observation and was collected over a period of three months in the ten selected hospitals. Two hospitals per district were purposively chosen as participating hospital based on the criteria of the availability of English-speaking foreign medical doctors.

3.2.4.1 Recruitment

Three categories of participants i.e. the foreign medical doctors, nurses interpreting for them and patients were recruited for the study. Doctors who were not South Africans by birth or obtained their basic medical degrees in South Africa and do not speak any South African indigenous language fluently formed the target population from which only two doctors per hospital were included in the study. The nurses interpreting for the doctors were recruited based on their willingness to participate in the study and permission from the Head nurse. The patients were approached for consent as they entered the consulting room. If a patient agreed to participate, the recording and observation commenced.

3.2.4.2 Audio recording

Silverman (2009:149) concludes that a major reason for recording conversations in research is that “we cannot rely on our recollection of conversations.” Thus, it is necessary to have a recording that can be replayed to guarantee the accuracy of the report. As mentioned earlier, the use of CA necessitates either the visual or only audio recordings of naturally occurring interactions and transcribing same for analysis. Perakyla (1997:203) referred to them as the “raw material” of the study and adds that they can “provide for highly detailed and publicly accessible representation of social interaction.” Naturally-occurring interactions between the doctor, patient and nurse were recorded based on the consent of all participants. The recordings were later transcribed and translated into English language for analysis.

3.2.4.3 Observation

It became necessary to observe the consultations as the request to have a video recording of the consultations was denied. The video recording would have proved invaluable in giving in-depth information about the nonverbal behavior of the participants. As it would have been difficult for one person to make a detailed observation of the doctor, patient and nurse at the same time two people observed the participants during consultation. One person observed the doctor while the other observed the patient and nurse. The observation was recorded using an observation sheet designed for that purpose. The observation focused on the nonverbal activities of the participants.

3.2.4.4 Interview

The semi-structured interview was used in the study. Interview guides were developed for the study. Each interview guide was divided into two (2) sections. The first section elicited answers about the background of the participants inquiring about the education, languages spoken and length of service in the hospital. The second section concentrated on exploring the feelings of the participants about the communication during consultation, the communication strategies and suggestions about how the communication could be improved. Attempt was made to interview all participants. The patients were interviewed post-consultation. They were informed about the interview when briefed about the study before giving their consent. Interviews for the patients were conducted in the language of choice by a trained helper who speaks the chosen language. The researcher conducted the interviews for the doctors and nurses.

The structuring of some questions was changed based on the response of the participant. For example, in answering the question about challenges faced in communicating with patients, some doctors also talked extensively about the problems they encounter with nurses as interpreters, thereby making it unnecessary to ask subsequent questions about their experiences when using interpreters.

3.2.5 Development and testing of the data collection instrument

The interview guides for the participants were self-developed and included questions specifically designed to elicit answers to the study's research questions. A pilot study was conducted in the first hospital visited to ensure the validity of the instruments.

The pilot study included the audio recording of the patients' consultation with the English-speaking foreign medical doctors. Two doctors, two nurses and four patients were included in the pilot study. During the pilot study it became evident that some of the questions for the semi-structured interview were unnecessary and did not address the focus of the study. Subsequently, other questions were developed to elicit answers to the main question of the study. The pilot study also gave an indication on how best to recruit the participants for the study.

3.2.5.1 Ethical consideration related to data collection

The anonymity of all participants was ensured at all times during the collection of data. The consent forms which had the names and signatures of the participants were collected from the research assistants and held by the researcher. They were not at any time matched with the interview schedules, audio recordings or interviews.

The consent forms were made available in four languages namely English, Tshivenda, Sepedi and Xitsonga. The research assistants educated the participants about the study in their language. They were informed that their participation in the study was voluntary and that they could withdraw from it at any point without explanation.

3.2.6 Data processing and analysis

All audio recordings were transcribed by the researcher and research assistants. The transcribers were selected from the Department of Translation Studies and Linguistics.

As Sepedi was the main language of conversation in many hospitals, two people were engaged to interview participants, as well as transcribe and translate data in the language. All the assistants were trained on how to transcribe using the conversation analysis symbols. The transcribers also interviewed the patients and it is believed that this made the transcription easier. As there was no way to judge if the transcriptions were correctly done in Sepedi, Tshivenda and Xitsonga, the transcribers were also asked to transcribe the interview conducted in English. Some mistakes were detected in the English transcription suggesting that there were also mistakes in the transcriptions and translations of the other languages. All discrepancies found in the translation and transcriptions were corrected. Each transcription was checked by another transcriber to ensure correctness. The translations were checked by language experts.

Continuous reflection about the data is a hallmark of qualitative analysis (Creswell, 2009). The researcher interacted with the data by reading it several times to get familiar with it and made notes. The Statistical Package for Social Science (SPSS) software was used to analyse and present the demographics of the participants of the study. The interviews and consultations were coded using the Nvivo 10; a qualitative data analysis software. The coding helped the researcher to identify patterns in the data. The patterns were categorized and labelled for use in the study.

3.2.7 Methodological Limitation

A major limitation in the study was the researcher's inability to speak the indigenous African languages (Sepedi, Tshivenda and Xitsonga) used in the consultations and interviews creating the need to rely on others for the transcription and translations. However, this shortcoming was addressed by the rigorous editing by senior language practitioners.

Another limitation was the influence created by the presence of the researcher and assistants in the consultation rooms for observation. Their presence could have affected the behaviour of the participants causing them to behave and say what they believe the researchers wants to see and hear.

3.3 RELIABILITY

Reliability in qualitative research refers to how consistent a researcher's approach is across different researchers and projects (Creswell, 2009:190). A major way of ensuring reliability according to Creswell (2009) referring to Yin (2003) is to "document as many of the steps of the procedure as possible." Effort has been made to achieve this by documenting the data collection process and the analysis.

In CA, reliability is hinged on the quality of tapes and transcripts (Perakyla, 1997:203) According to the scholar, the key aspects of reliability in CA are as follows:

(a) Selection of what is recorded and how much of it to record;
(b) The technical quality of the recording, and
(c) The adequacy of the transcripts

Considering the focus of the study, the consultation of English-speaking foreign medical doctors with patients with or without the use of interpreters was chosen for recording. To have a broad view of the communication, consultations from twenty (20) doctors were included in the study to ensure the adequacy of data for analysis. The consultations were recorded using high-tech voice recorders to ensure clarity and clearness of the recordings.

3.4 VALIDITY

"'Validity' is another word for truth" (Silverman, 2000) referring to how truthful the study findings may be considered. It is often referred to as "trustworthiness, authenticity and credibility" in qualitative studies (Creswell, 2009:191). The author also suggested eight strategies that may be used to strengthen validity. These are:

(a) Triangulate different data sources
(b) Use member checking to determine accuracy of the qualitative findings
(c) Use rich, thick description to convey findings
(d) clarify the bias the researcher brings to the study

(e) present negative or discrepant information

(f) Spend prolonged time in the field

(g) Use peer debriefing to enhance the accuracy of the findings and

(h) Use an external auditor to review the entire project

Use was made of these strategies in this study. To ensure validity of this study, there was triangulation of participants and data. Data was collected from doctors, nurses and patients. Three methods were also used for the data collection i.e. audio recording, interview and observation. It is believed that obtaining information from different sources will offer a more detailed description of what happens in the consultation rooms. Perakyla (1997:209) noted that 'proof procedure' as explained by Sacks et.al (1974) is a way that validity may be established in CA. Proof procedure means that "the next turn will show whether the interactants themselves treat the utterances in ways that are in accordance with the analyst's interpretation." This ensures that a researcher cannot arbitrarily give meanings to conversations as each turn is usually determined by the one before it.

3.5 CONCLUSION

This chapter discussed the research design and methodology of the study. Furthermore, it discussed the challenges and limitations of the study. It focused on the research design, sampling methods employed in the study, the instruments used in the collection of data and the ethical issues considered. The use of Convesation Analysis and its relevance in the study was also discussed. The analysis of the data collected is discussed in the next chapter.

CHAPTER FOUR

DATA ANALYSIS: INTERVIEWS

4.1 INTRODUCTION

This chapter presents the findings from the SPSS analysis of the demographics of participants interviewed and the themes that emerged from the coding using the Nvivo software. The interviews were conducted with the 35 patients, 13 nurses and 18 English-speaking foreign medical doctors in the 10 hospitals visited. They were interviewed to provide additional information for the conversation analysis of the recorded consultations. The interviews were considered necessary as the researcher is of the opinion that not all communication strategies, politeness strategies and issues relating to gender may be displayed during consultation due to the limited time of recording. It is hoped that a more holistic view of communication during the consultations will be achieved by combining different methods of data collection. The descriptive analysis of the interviews of doctors, patients and nurses using the SPSS software will provide background information on the participants in the study. The study adopts quasi statistics for the presentation of the background information of the participants. Quasi statistics, according to Becker (1970), cited in Maxwell (2010:476), involves “simple counts of things to support terms such as some, usually, and most.” These numbers, he argued help to make claims made by qualitative researchers “more precise.” Hence, specific figures are provided in the analysis.

4.2 FINDINGS FROM THE INTERVIEWS

As qualitative research seeks to provide different perspectives of a situation, results from the three categories of participants will be presented. The interview schedule was divided into two sections. The first section is the background information of the participants regarding the gender, age, level of education, languages spoken and proficiency in the English language and other relevant areas in relation to the category of participants being interviewed. The questions in the second section of the interview guide focused on communication during consultation. Please refer to

the annexure for the interview guide. The background information of the participants is presented in this section.

4.2.1 Background information of patients

This section of the interview guide focuses on the background of the patients recruited to participate in the study and gives information on gender, level of education, home language, language spoken during consultation and location of the hospitals where the study was conducted. The patients were interviewed post-consultation.

4.2.1.1 Gender of participants (patients)

This information was to determine the number of recruited patients that were male or female. Table 4.2 indicates that more females were interviewed. Effort was made to recruit an equal number of men and women but this was not possible as recruitment was on voluntary basis and more women than men were willing to participate. Twenty-three accounting for 68% females and twelve males constituting 34% of the participants were interviewed.

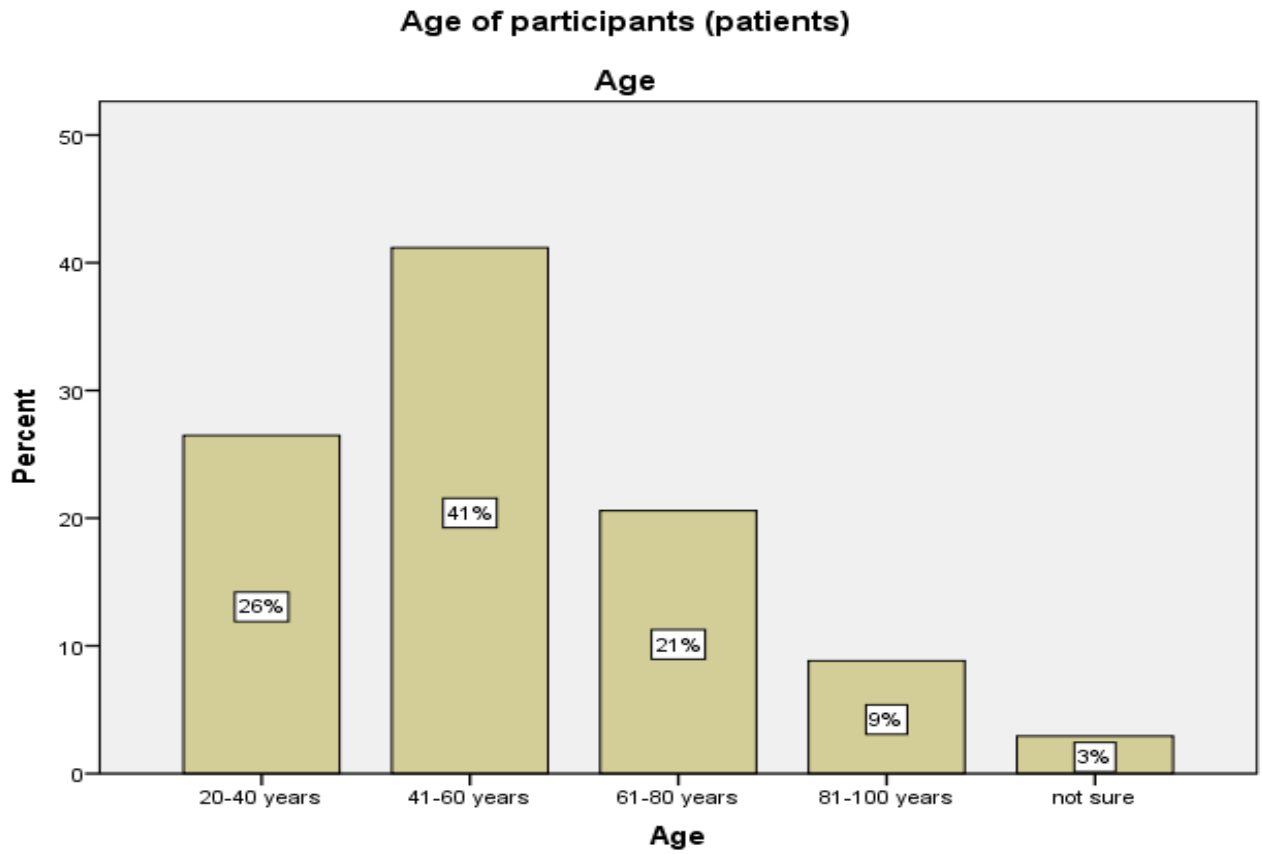
Table 4.1: Gender of participants (patients)

Gender	Frequency	Percent
female	23	65.7
male	12	34.3
Total	35	100.0

4.2.1.2 Age of participants (patients)

This was to determine the age of the patients who participated in the study. Fourteen which accounts for 41% of the participants, constituting the highest group, were between the ages of 41 and 60. Other groups in descending order were 20-40 years with ten people constituting 26%, 61 – 80 years accounting for seven, 21% of the participants and three, accounting for 9% between 81 – 100 years. A participant was not sure of his age.

Figure 4.1: Age of participants (patients)



4.2.1.3 Location of hospitals where study was conducted

This was to determine the number of consultations recorded in rural and urban areas. A total number of twenty-three (66%) consultations were recorded in the urban area while twelve (34%) were recorded in the rural area. More consultations were recorded in the urban areas as more patients were willing to participate there.

Table 4.2: Location of hospitals where study was conducted

Location of study	Frequency	Percent
Rural	12	34.3
Urban	23	65.7
Total	35	100.0

4.2.1.4: Home language of participants (patients)

Twenty-five patients (constituting 71%) of the participants spoke Sepedi as their home language, making it the largest language group in the study. 11% accounting for four participants who spoke Tshivenda, two accounting for 6% of the participants each spoke Afrikaans and Xitsonga as the home language, while one which is 3% each spoke Shona and Tswana. This reflects the language distribution of the province where most people are Sepedi-speaking.

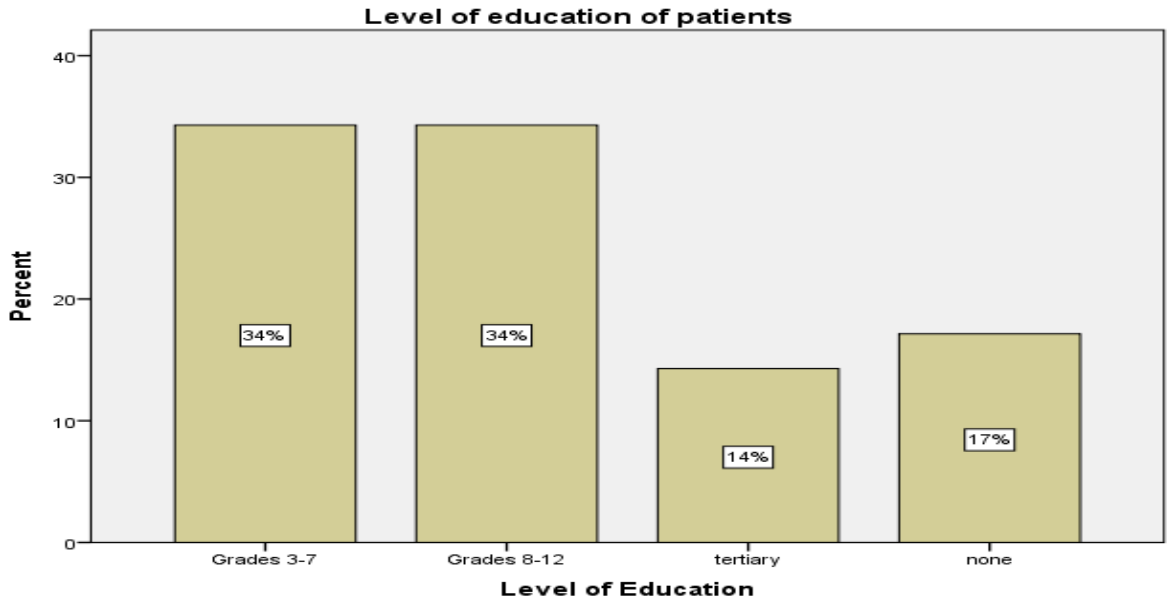
Table 4.3: Home language of participants (patients)

Home language of patients	Frequency	Percent
Afrikaans	2	5.7
Sepedi	25	71.4
Shona	1	2.9
Tshivenda	4	11.4
Tswana	1	2.9
Xitsonga	2	5.7
Total	35	100.0

4.2.1.5 Level of education of participants (patients)

Figure 4.2 shows that of the thirty-five patients interviewed, only 14% constituting 5 patients had tertiary education. 6 patients (i.e. 17%) had no formal/western education and twelve, (34%) each were in the group of the third to the seventh grade (primary) and eighth to the twelfth grade (secondary).

Figure 4.2: Level of education of participants (patients)



4.2.1.6 Proficiency in English (patients)

The participants were asked to self-rate their proficiency in English language. The rating was from “very good”, “good”, “basic” and none. From the results shown in Figure 4.2, the proficiency of the patients in the English language may be linked to their level of education. Only four, (11%) responded that they had a very good command of the language. Twice this number accounting for 23% said they were good, while 13, accounting for 37% of the participants responded that they had a basic knowledge of the English language. This number is followed by ten (27%) participants who said they could not speak or understand English.

Table 4.4: Patients’ proficiency in the English language

Proficiency	Frequency	Percent
Very good	4	11.4
Good	8	22.9
Basic	13	37.1
None	10	28.6
Total	35	100.0

4.2.2 Background information of the nurses

This section of the interview guide focuses on the background of the nurses recruited to participate in the study and gives information on gender, qualifications, home language as well as other languages they speak.

4.2.2.1 Gender of nurses

All the nurses interviewed were female.

4.2.2.2 The qualifications of the nurses

Most of the nurses who interpreted for the doctors were still students. These include three (3) enrolled nurses representing 23% of the participating nurses, two, (15%) enrolled nursing assistants; auxiliary student nurse, awaiting registered nurse, awaiting staff nurse and staff nurse account for one (8%) each of the participating nurses. Most of the nurses who interpreted for the doctors were still studying. Older and more qualified nurses i.e. professional nurses and those with diploma in general nursing account for only 30 % of the nurses who interpreted. The observation that the interpretation is mainly done by junior nurses may lead to poor interpretation due to lack of experience.

Table 4.5: Qualification of nurses

Nurses' qualifications	Frequency	Percent
Auxiliary student nurse	1	7.7
Awaiting registered nurse	1	7.7
Awaiting staff nurse	1	7.7
Diploma in general nursing	2	15.4
Enrolled nurse	3	23.1
Enrolled nursing assistant	2	15.4
Professional nurse	2	15.4
Staff nurse	1	7.7
Total	13	100.0

4.2.2.3: Home language and other languages spoken by the nurses

Table 4.7 shows a total number of nine nurses (accounting for 69%) out of the thirteen nurses interviewed spoke Sepedi as their home language corresponding to the language distribution of the province. 0ne each, which is 8% of the group, spoke

isiZulu and Shangan. Only 2 (15%) of the nurses spoke Xitsonga as the home language. However, many of them spoke at least one other language apart from their home languages. This makes it possible for them to sometimes interpret for patients who speak a different language. All the nurses speak English as an additional language. Almost all the nurses have unique combinations of additional languages with only two, 15% having the same combination of additional language of English and isiZulu. One nurse spoke only English as an additional language.

Table 4.6: The home language of the nurses

		Frequency	Percent
Valid	isiZulu	1	7.7
	Sangan	1	7.7
	Sepedi	9	69.2
	Xitsonga	2	15.4
	Total	13	100.0

Table 4.7: Other languages spoken by the nurses

Other languages spoken by nurse	Frequency	Percent
Afrikaans, Xitsonga, Tshivenda, isiZulu	1	7.7
English	1	7.7
English, Afrikaans, isiZulu, Sepedi	1	7.7
English, isiZulu	2	15.4
English, Sotho, Afrikaans, Tshivenda	1	7.7
English, Tshivenda, Xitsonga, Tswana, isiZulu	1	7.7
English, Xitsonga, Afrikaans	1	7.7
English, Xitsonga, isiZulu	1	7.7
English, Xitsonga, Tshivenda, isiZulu	1	7.7
English, Sepedi,	1	7.7
English, Tshivenda, Xhosa, isiZulu, Sotho	1	7.7
English, Xitsonga, Tshivenda, isiZulu,	1	7.7
Total	13	100.0

4.2.2.4 Proficiency in the English (nurses)

The nurses were asked how proficient they considered themselves to be in the English language. Ten nurses believed they were good while only three of them considered themselves very good in the English language in Table 4.9. This gives some assurance that they will be able to interpret based on their knowledge of English and the local languages.

Table 4.8: Nurses' proficiency in English language

Proficiency	Frequency	Percent
very good	3	23.1
good	10	76.9
Total	13	100.0

4.2.3 Background information of the doctors

Eighteen English-speaking foreign medical doctors were interviewed. The background information sought included gender, country of birth, languages spoken and areas of specialization as well as the number of years of practice and domicile in South Africa.

4.2.3.1 Gender of participating doctors

Table 4.10 shows that 83% of doctors interviewed were males, while 17% were females. A possible explanation for this big difference may be that more men migrate for economic reasons than women.

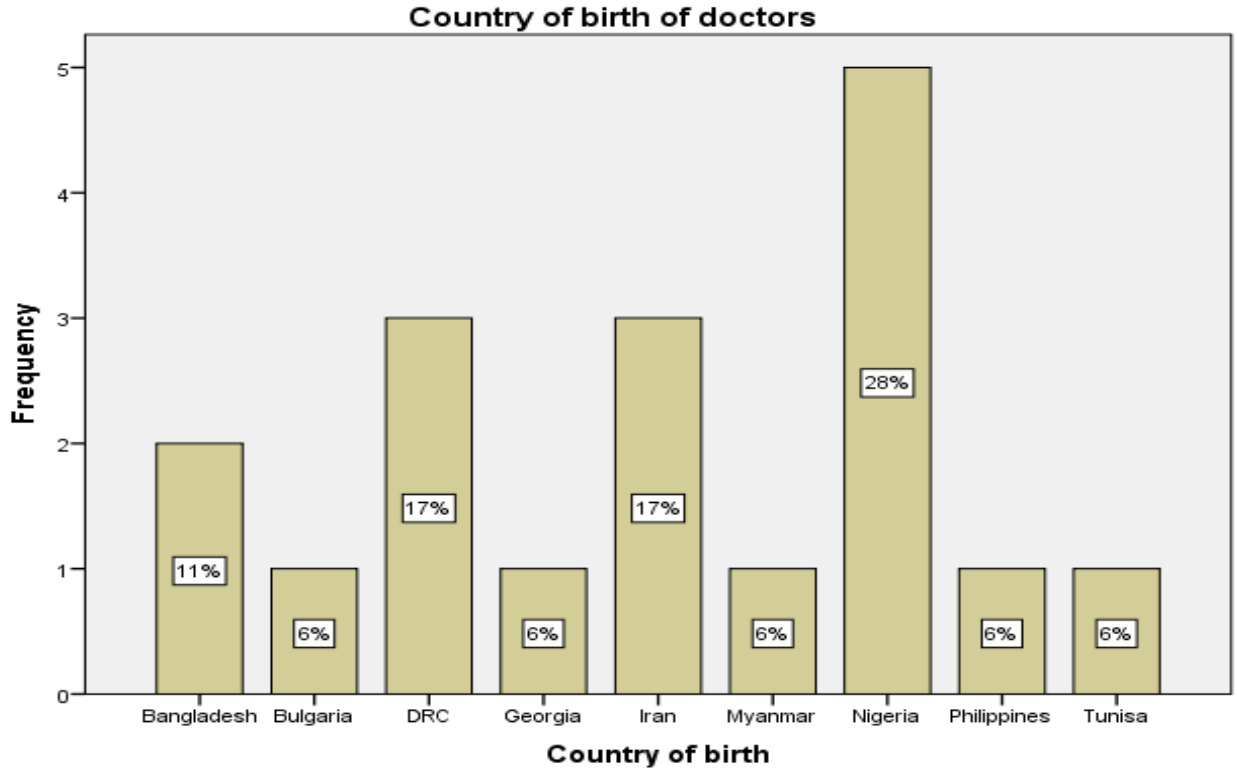
Table 4.9: Gender of doctors

Gender	Frequency	Percent
Female	3	16.7
Male	15	83.3
Total	18	100.0

4.2.3.2 Country of birth of doctors.

The English-speaking foreign medical doctors interviewed in the ten hospitals selected for this study were from various countries. Figure 4.3 indicates the largest number (28%) of the doctors interviewed were from Nigeria. This is followed by doctors from Iran and Democratic Republic of Congo (DRC) with 17% each. 11% are from Bangladesh and Bulgaria. Georgia, Myanmar, Tunisia and Philippines account for 6% each of the participating doctors.

Figure 4.3: Country of birth of doctors



4.2.3.3 Home language and other languages spoken by the doctors

English is not spoken as a first language in any of the countries of birth, though it may be an official language. 12% of the doctors listed English as a home language along with their local languages of Arabic, French and Pilipino. Bengoli and Igbo are spoken by 11% each of the doctors while Bulgarian, Calabar, Myanise and Yoruba are spoken by 6% each. Half of the doctors spoke only English as an additional language while the other half spoke at least one more language in addition to English. One doctor also listed a South African language, Sotho as an additional language.

Figure 4.4: Home languages of the foreign doctors

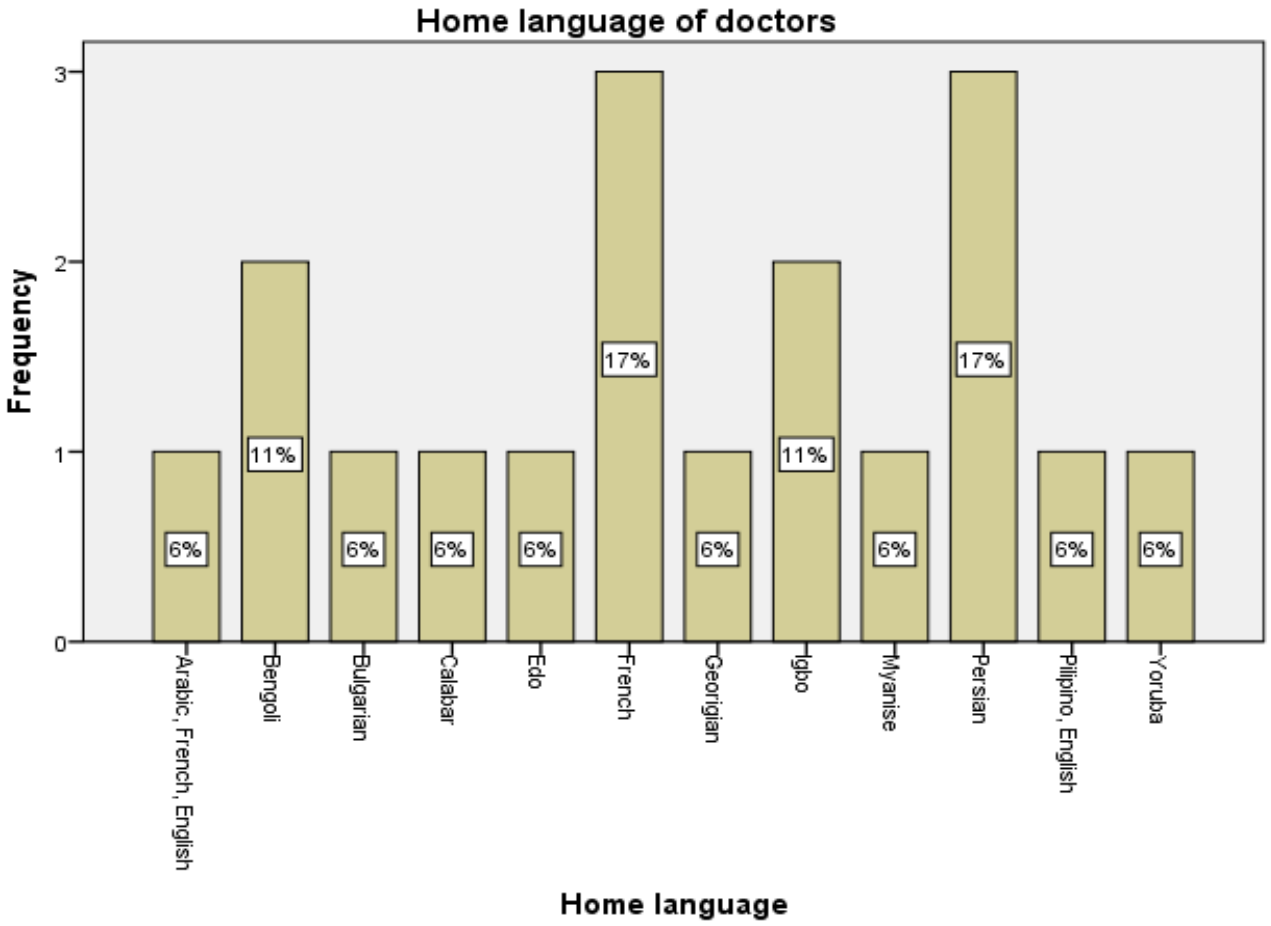
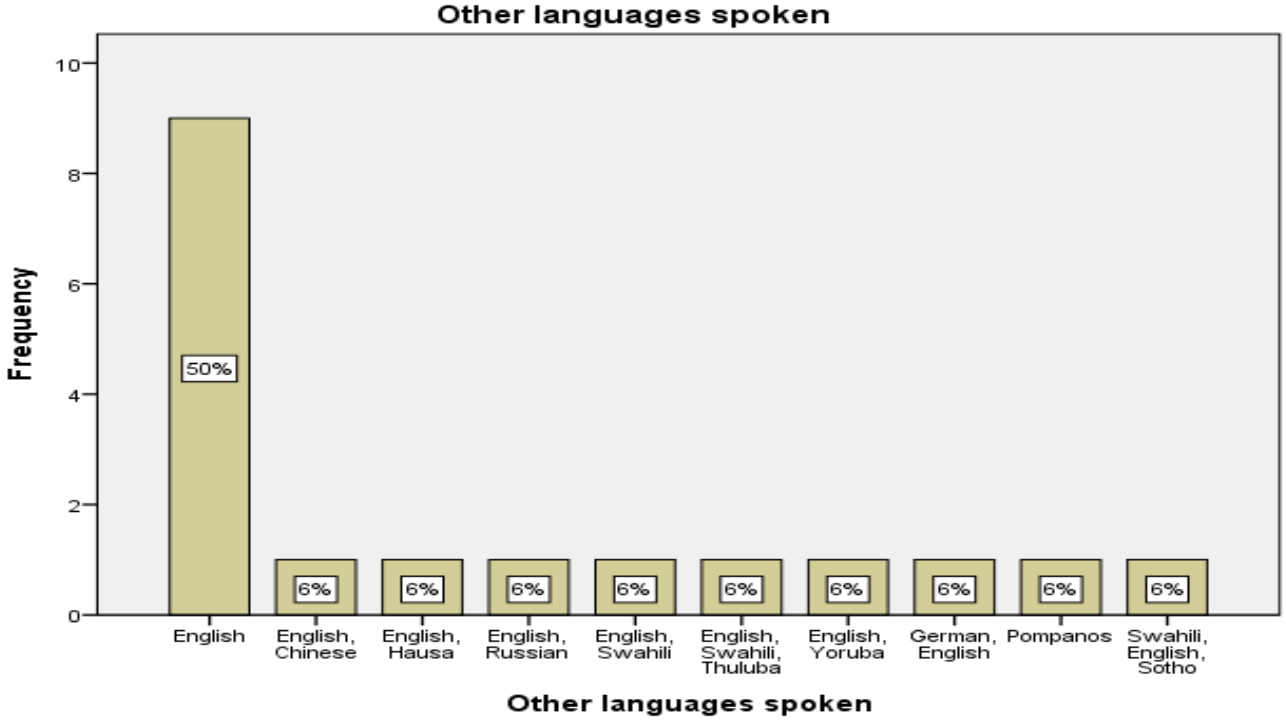


Figure 4.5: Other languages spoken by the foreign doctors



4.2.3.4 Area of specialization

Table 4.11 shows that 61% of the participating doctors were general practitioners (GP), 11% specialise in family medicine and 6% in internal medicine. 22% were medical officers (MO) which means they were not yet specialists. However, this distribution indicates that these doctors are often the first doctors the patients meet in the hospitals and underscores the importance of good communication with them.

Table 4.10: Area of specialization

Area of specialization	Frequency	Percent
Family medicine	2	11.1
GP	11	61.1
Internal medicine	1	5.6
MO	4	22.2
Total	18	100.0

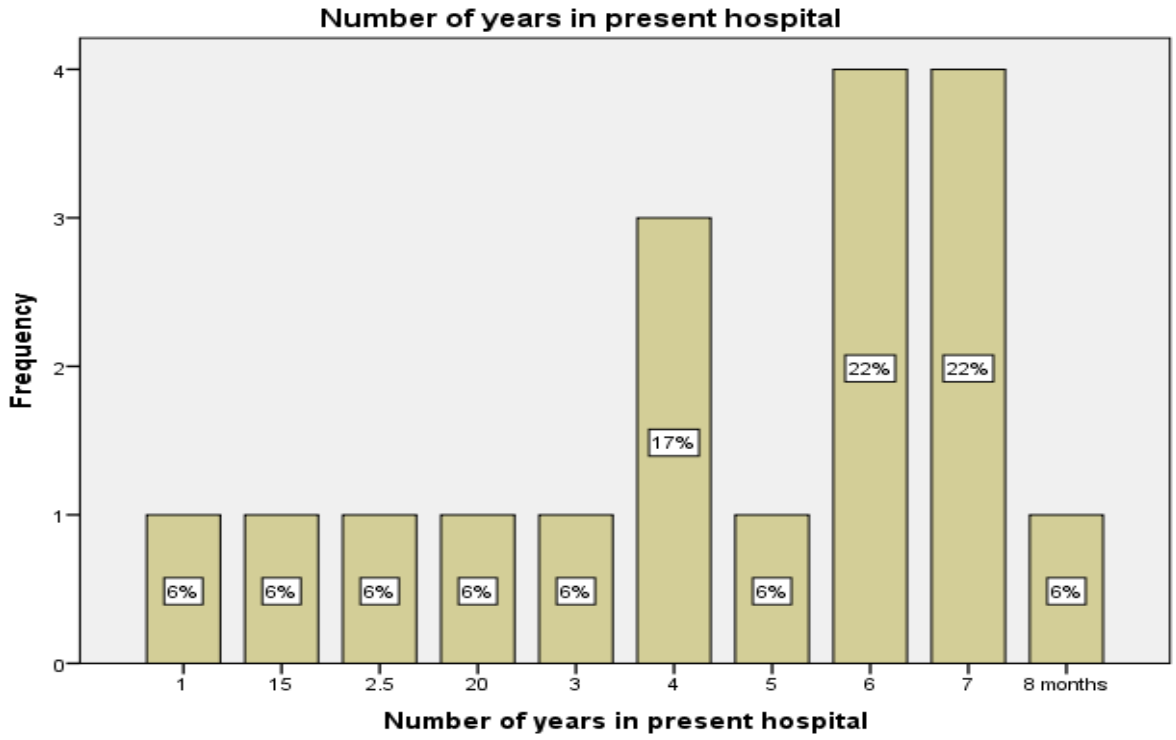
4.2.3.5 Year of registration

Many of the participating doctors were registered in 2006 and 2007 with 22% registered in each year indicating that they have practised for seven and six years respectively. 17% registered in 1995 indicating that they have been practicing medicine in South Africa for eighteen years. 11% registered in 2008 and 2011. A doctor each registered in 1996, 2009 and 2012. These figures show that most of the doctors have spent less than ten years practicing in South Africa. The doctors were also asked how many years they had spent in the hospital where they work. Their responses (in Figure 4.6) mirror those indicating the year of registration suggesting that most doctors have worked in the same hospital since been registered as medical practitioner in South Africa. The length of time spent in the same linguistic area may have afforded the doctors the opportunity to learn the local language and be more effective in communicating with the patients.

Table 4.11: Year of registration in South Africa

Year registered in South Africa	Frequency	Percent
1995	3	16.7
1996	1	5.6
2006	4	22.2
2007	4	22.2
2008	2	11.1
2009	1	5.6
2011	2	11.1
2012	1	5.6
Total	18	100.0

Figure 4.6: Number of years the doctors have spent in present hospitals



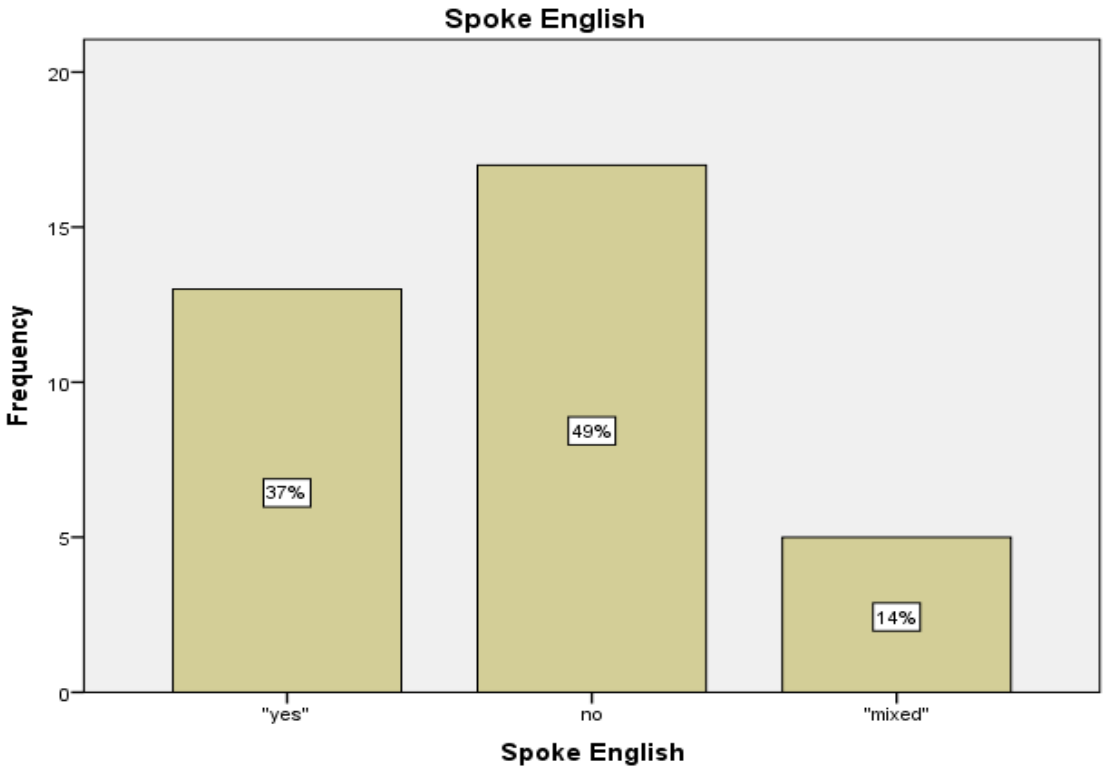
4.3 AN EXAMINATION OF COMMUNICATION DURING CONSULTATIONS

This section presents findings from the interview of participants in relation to the research objective 1 which is to *examine the communication between the English-speaking foreign medical doctors, patients and nurses in relation to culture and language.* Responses from the three categories of participants are presented

4.3.1 Language used by patients during consultation

Seventeen patients accounting for 49% of the patients spoke only the local languages during consultations. Thirteen people (37%) communicated directly with the doctor in English, while five people, (14%) spoke both English and the local languages. These figures are understandable as most participants could not speak English or at best only had a basic knowledge as indicated in Table 4.4 It is, however, evident that those who had a basic knowledge also tried to communicate directly with the foreign doctors.

Figure 4.7: Language spoken by patients during consultations



4.3.2. Awareness of the patients that the doctor is not South African (and how this affects the communication during consultation)

The questions explored the patients' awareness that the doctor they consulted with was a foreign doctor and if this fact affected the communication with the doctor. *Are you aware that the doctor is a foreigner? Did this affect your communication with the doctor?*

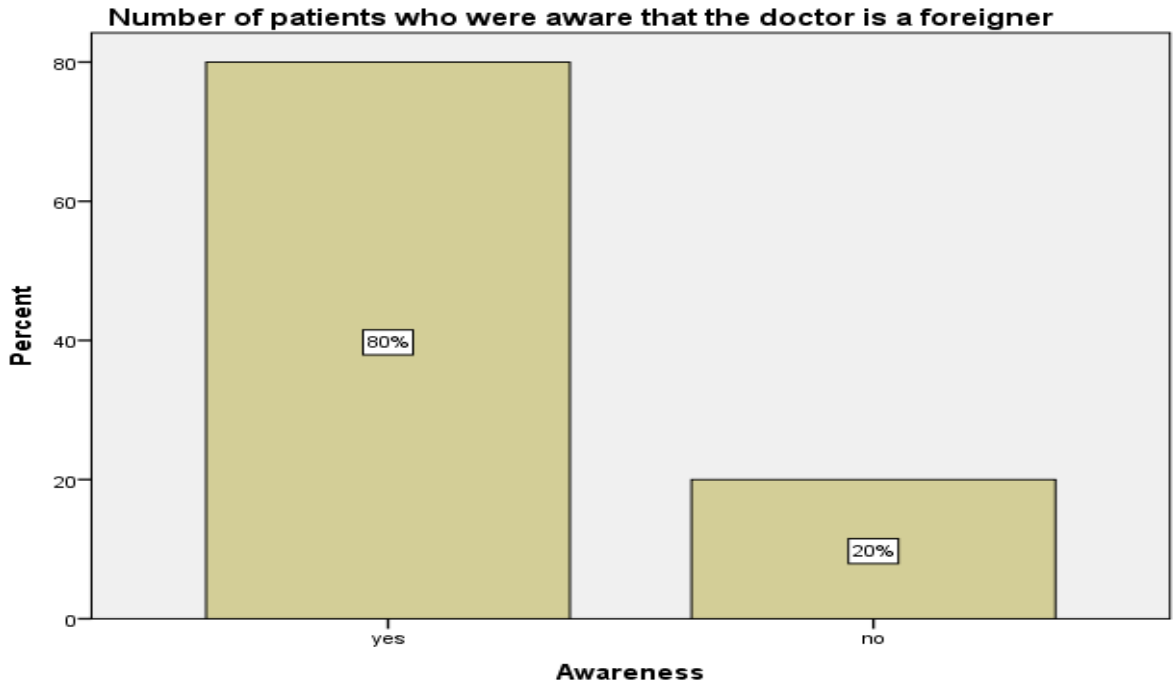
Twenty-eight (80%) of the participants said they were aware that the doctor they consulted was not South African; while only seven responded that they were unaware. Examples of the responses from those who noted they were aware are:

"Yes, I heard when he spoke. I was able to understand what he was saying but I heard by his accent that he is not South African." (26 years old female)

"Yes, she cannot speak our language" (53 years female)

"Yes, I know. He is Greek, right?" (70 years old male)

Figure 4.8: Awareness of the patient that the doctor is foreign



The responses indicate that patients who were aware that the doctors were foreigners did so mainly through the manner of speaking of the doctors. Some of them tried to place the nationality of the doctors. This confirms the effect of mother tongue on the English language which leads to different varieties.

The small number of patients who were not aware that the doctors were not South African responded:

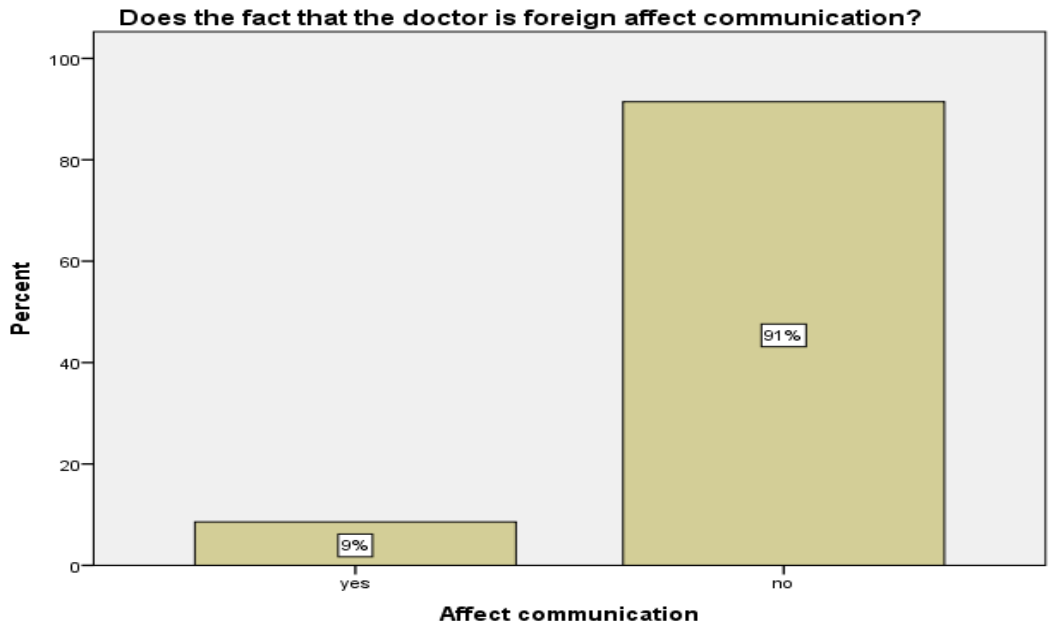
“I didn’t know” (24 year old male who spoke English)

“I just hear when he speaks, isn’t it that I don’t see him Ah, he is South African” (78 year old blind patient, who does not speak English at all)

The 24 year participant’s age, level of education and the choice of language of communication with the doctors lend credence to the hypothesis of the formation of a third culture. It is possible that differences in speech are being obliterated due to exposure to people from different cultural and linguistic backgrounds. The second patient could not detect from the doctor’s speech that he was a foreigner possibly because he does not understand English at all. He argued with the interviewer and maintained that the doctor was South African. An explanation for lack of awareness of some patients may be the multicultural and multilingual nature of South Africa, with its vast land mass where South Africans from one area may think that someone who speaks differently is from another part of the country and not a foreigner.

A follow-up question to this was: *Did the fact that the doctor is a foreigner affect your conversation with him/her?* As indicated in Figure 4.8 most patients; thirty-two accounting for 91% of the participants stated that it did not affect their communication during the consultation while three (9%) indicated otherwise. Examples of the responses from those who said that the fact the doctor was foreign did not affect their communication are:

Figure 4.9: How the awareness of patient affects communication



"No, she was speaking with this one explaining in English. I didn't hear but with others I heard her" (82 year female)

"No, he is a good doctor" (29 year old female)

"No, there was an interpreter" (42 year old female)

"Even though he is not South African, I am thankful for his cooperation" (53 year old male)

"I do not have a problem with him speaking English because he is friendly and I am comfortable speaking to him" (43 year old female)

Some reasons can be deduced from the responses of the participants for stating that communication was not adversely affected even though the doctor was foreign. These are:

- The presence of an interpreter; either the nurse or a family member seem to satisfy the patients
- The expert medical knowledge displayed by the doctor
- The behaviour and demeanour of the doctor, for example, friendliness

The patients who indicated that they were affected by the doctor being a foreigner were mainly those who could not speak English and had no one to interpret for them.

"I didn't understand because she was speaking her language without interpreting" (72 years old female)

"Yes, I didn't understand her well because that language she was speaking is not Sepedi" (53 year old female)

4.3.3 Problems encountered during consultations

The problems of communication encountered during consultations are highlighted here.

4.3.3.1 Problems encountered by patients

As indicated in 4.3.2 above some of the patients complained that they did not understand the doctors as there were no interpreters to help them

Another problem mentioned by a participant is not having a permanent doctor. She explained that they were made to see a different doctor each time they visited the hospital:

"You'd find that they change and change every month. It confuses us the patients."

4.3.3.2 Problems encountered by nurses

The problems encountered by the nurses in working with the English-speaking foreign medical doctors among other issues, relating to communication were explored in the interview with the nurses. Four (31%) of the nurses out of the thirteen interviewed said they did not encounter any problems in working with the doctors. The remaining 69% nurses stated that they had encountered problems with the way the doctors speak in relation to the tone and pronunciation of words in the English language. The problems may be summarized into four main areas, namely, difficulty

in communication between the patients and doctors, inability of some doctor to communicate in English on initial arrival in the country, interpreting and the way the doctor speaks.

Figure 4.10: The problems encountered by nurses

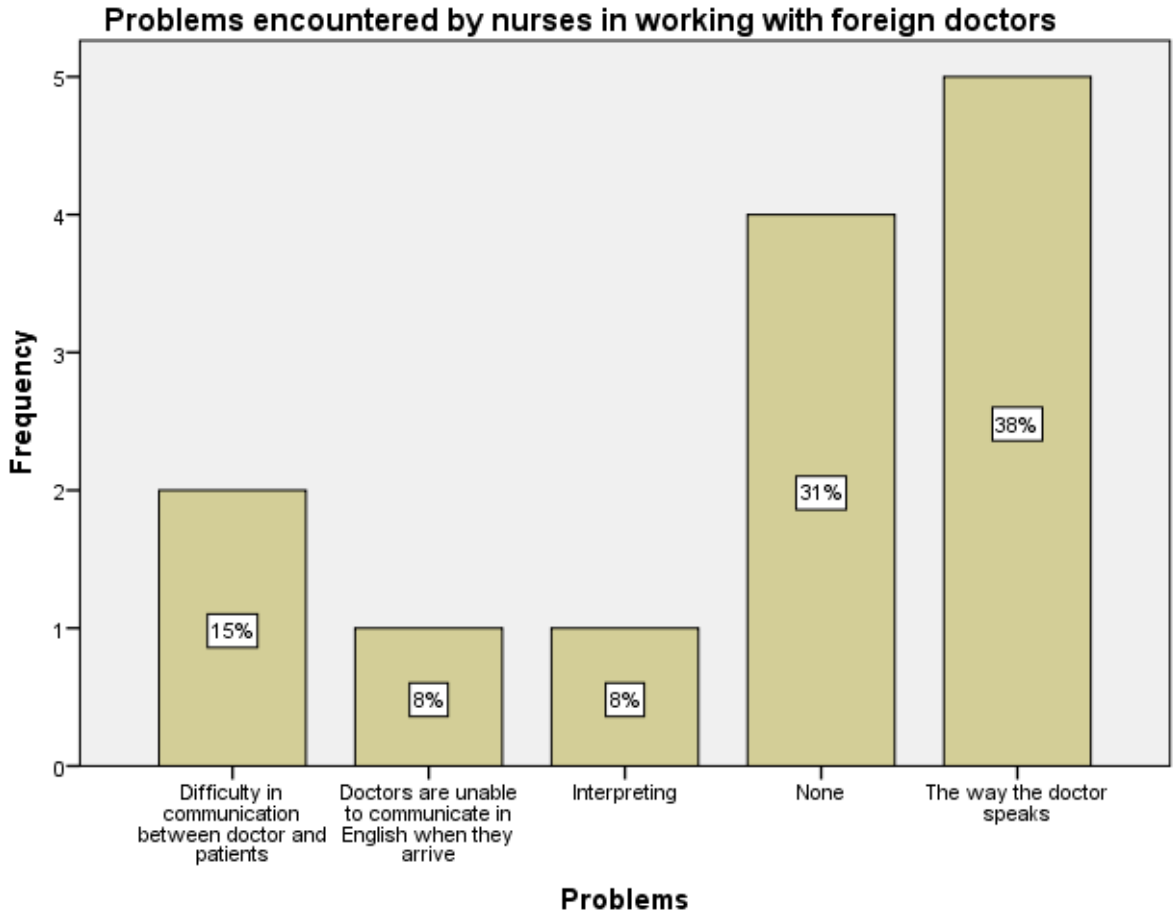


Figure 4.9 indicates that 38% of the nurses noted that the way the foreign doctor speaks is a major problem in working with them. Nurses were asked if they noticed any difference in the doctors' spoken English. An overwhelming 85% of the nurses noticed a difference whereas the remaining 15% said they did not notice any difference. Examples of responses from nurses who noticed differences are:

> *"I do understand them. Their tone, akere, you can hear they are not South Africans but I am used to their tone."* (Nurse 13, Auxiliary nurse)

"Sometimes they speak softly. I try to listen carefully so I can hear when they talk… I listen carefully so I will be used to their language" (Nurse 1, Awaiting staff nurse)

"The tone, you know when they speak something in a different tone, the meaning is no longer the same, even the words themselves they are not pronouncing them as we do" (Nurse 5, Diploma in general nursing)

The difference in the way English is spoken and the fact that the doctors are from a different country sometimes becomes evident when they need to prescribe:

"In most cases (the problem is) the tone…and you find like his calling like some medications. He is calling them differently to how I know them." (Nurse 12, professional nurse)

Table 4.12: Nurses who noticed differences in doctors' spoken English

Noticed Differences	Frequency	Percent
Yes	11	84.6
No	2	15.4
Total	13	100.0

Relating to the difficulty of communication between patients and doctors, a nurse noted that:

"If you are not used to him or her, sometimes you might end up not hearing what he or she is saying" (Nurse 4, Awaiting registered nurse)

Another nurse noted that:

"They can't even hear what he's saying because one of the patients asked me, "Sister, do you hear what this doctor is saying. His English is very deep. I can't even hear. Can you hear him?" I said yes." (Nurse 7, Enrolled nursing assistant)

Another problem mentioned is that encountered in interpreting. All nurses interviewed stated that they had no training as interpreters but interpreted because

they were bilingual or as a nurse said…*because I can understand them and I can understand the patient." (Nurse 13, Auxiliary nurse)*

The same nurse noted that:

> *"There are times where you find it difficult to interpret for the doctor or the patient. You find it difficult to translate… to interpret what they are saying in the native language to English or from English to Sepedi" (Nurse 13, Auxiliary nurse)*

Nurse 3 also made the same point saying:

> *"Sometimes, the patients are saying some of the things that you cannot even explain in English" (Nurse 3, Awaiting registered nurse)*

The problem encountered in interpreting is summarised by Nurse 12 thus:

> *"When someone is taking about this traditional healer thing, sometimes they talk about things like THEMA. The doctor does not know thema. They also say the baby is having thema even though the child may be sick of diarrhoea and whatever, so they say thema and you cannot explain to the doctor what a thema is. There is no thema in English" (Nurse 12, Enrolled nurse)*

Nurse 8 also mentioned that it is a fact that some patients feel uncomfortable because the doctor does not speak their language:

> *"They are not comfortable. They already feel that they are not going to get their message straight to the doctor" (Nurse 8, Diploma in general nursing)*

This may influence how the nurse feels when interpreting as indicated by a nurse:

> *"It makes it difficult. It makes it so difficult because sometimes you find like the patient does not understand, you are stuck even you know and sometimes the patient think I do not understand, like I'm stupid or something because I have nothing to say. It is confusing because you don't even know what to say, sometimes you are just stuck and you feel that maybe if they understood each other, it could be better." (Nurse 11, Professional nurse)*

A nurse mentioned that more problems are encountered when the foreign doctors are new as some of them do not speak English at all.

> *"Mostly while the doctor is new, just coming from home and it's the first time coming to work in that hospital, so because he is not used to the language, it will be a little bit difficult but well, after six, seven…six months and years, they are fine. There is no problem*." (Nurse 1, Registered staff nurse)

4.3.3.3 Problems encountered by doctor

The doctors were asked to mention problems they encounter in communicating with patients. From their responses it was deduced that the problems are from various sources i.e. from the patients, from the nurses as interpreters and lack of cultural understanding.

The main problem faced by doctors in interacting with patients is that many of them (patients) are old and do not speak English. For example two doctors had these to say:

> *"My main challenge is that some patients sometimes very old patients… because they can't communicate properly." (Doctor 2, urban hospital)*

> *"We see mostly old people who can't speak English. It is always a problem when there is no interpreter. They can't hear English and I can't hear what they are saying. I can only hear little of their language but deep ones like what is really wrong with them you won't be able to get it because if you don't have an interpreter, it will be very difficult" (Doctor 18, rural hospital)*

Due to the multilingual nature of South Africa, some doctors face problems when they have to move from one linguistic area to another as experienced by Doctor 10:

> *"When the local language is Sepedi, I understand. It is not really a big problem but because I moved here recently, there's sometimes shangan, sometimes Venda, so I am still struggling." (Doctor 10, urban hospital)*

Others face problems when non- South Africans who cannot speak English or any of the local languages come for consultations.

> *"Foreign patients who do not speak English, they are not speaking any South African languages. So sometimes, it is difficult to communicate with those foreign patients as well" (Doctor 7, urban hospital)*

Some patients who can speak English refuse to speak it during consultation:

"Most of the patients we see are old people. You hardly see one that speaks English, but many times when you ask them even some that speaks English, if you speak English to them, they speak the local language to you. Most of them don't want to speak English except some of them. There are times when the interpreter is saying something else and the patient just say you know that is not what I am saying, this is what I am saying and she speaks in English" (Doctor 17, rural hospital)

Other problems encountered are problems in understanding the culture of the patient:

"Sometimes traditional things, you know tribal things and the whole local customs. You need to sometimes to understand, you know, the local believes. Sometimes you have to take these things into consideration" (Doctor 1, rural hospital)

"If the patient can speak English, it is good. But most of the time, even when the patient can speak English, it is better I have an interpreter because I don't really know the culture. I cannot understand their tradition because I am not native. I ask the sister what is the tradition, what is their belief, what is their behaviour and the sister can describe for me. It is better I have an interpreter not for their own language, only for describing the situation and exploring the tradition and heritage." (Doctor 12, urban hospital)

Doctors also mentioned problems that they experience as regards interpretation done by the nurses:

"We have a problem because when you are translating, you translate exactly what the patient… or the nurse translates what she understands the patient is saying. So, in this case we have a bit of a problem because the patient will end up not satisfied, thinking that what she is saying is something else, and the nurse is telling the doctor something else. But finally, we end up satisfying the patient because, as I say in almost five, six years that I have been around, even if the nurse is translating, but I can tell myself that what she is saying may be is not correct, I can always correct her." (Doctor 3)

Sometimes the nurse does not speak the patient's language and is unable to interpret:

> *"The sister who is helping me in regard with interpretation does not know that particular language and that is a bit of a problem. "(Doctor 7, urban hospital)*

At other times, the ability of the nurses to interpret is questioned:

> *"With interpreters at times you get ones that don't really know how to express themselves. I have had interpreters who will tell you, "What this woman said, I can't remember. She is trying to say …" She will now try to describe it for you." (Doctor 17, rural hospital)*

Still on the problems encountered with nurses as interpreters, the same doctor described a situation when the nurse tried to add some information to what the patient said:

> *"There was this incident about a patient. She said something I did not hear what she said but when she was speaking I didn't hear panadol. So, my interpreter says, "Doc, this patient says she wants panadol." I said how can a patient say panadol? You are lying to me, tell me the truth. She said, "Ok, she said she is feeling pains and I guess she probably needs panadol". (Doctor 17, rural hospital)*

4.4 RESEARCH QUESTIONS

4.4.1 Research question 1

What are the communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters?

All categories of participants were asked to mention the efforts they had noticed the English-speaking foreign medical doctors making to communicate better with patients during consultations. The responses were coded using the Nvivo software. Five themes emerged from the analysis, namely, clarification strategies, continuation strategies, interpersonal strategies, knowledge strategies and avoidance strategies.

Table 4.13: Communication Strategies employed by English-speaking foreign medical doctors

S/N	STRATEGY	RESPONSES
1	**Clarification strategies** These are strategies used by the foreign doctor to gain better understanding of the conversation at hand. Using this strategy, the doctor may use examples, ask someone else for clarification, repetition, ask what the patient wants, give explanation and ask more questions.	
	a. Using examples The doctors common examples to help the patient understand	Sometimes my interpreter is a student, and he or she doesn't know enough about medicine, so if I see that interpretation doesn't work properly, I use examples and I just try to make it simpler, especially using examples, like so to try to say what I mean, to make it easier. (Doctor 3, urban hospital)
	b. Repetition The doctor keeps repeating what is said until the patient or nurse understands.	Sometimes the nurses cannot understand our English and sometime they interpret wrongly but we have to be very careful about those things and we have to ask again and again to get a correct answer (Doctor 9, urban hospital) Nurse: If the patient doesn't understand he repeats the

	c. Asking someone else for confirmation When not sure of an interpretation, the doctor may ask someone else to confirm what has been said. d. Ask what the patient wants The doctor asks the patient what he/she can do for him/her. e. Explanation Detailed explanation is given to the patients. The information may be broken into bits for the patients. f. Asking more questions The doctors asks more to get appropriate answers	question frequently so until the patient understands what he wants to know about the patient (Nurse 4, Professional Nurse) I have no real way of gauging if the translation is correct or not but what I do when I have doubts I ask other staff or other resource person to confirm if that is the exact interpretation (Doctor 14, rural hospital) We try by all means to satisfy the patient to satisfy by asking what the patient really wants. (Doctor 3, urban hospital) It is because he explained everything which I needed to know (24 years oldmale) He gives you a chance to explain yourself and explain to him (25 years old male) Sometimes I have to ask more questions to get my answer. Even when it's the sister or someone else is interpreting for me, I may not get the right kind of reply, and then I have to specifically ask some other questions or just to trace my questions so that I can get the answer. It takes a little bit more time, but eventually at the end of the day you get your information (Doctor 6, urban hospital)

2	**Continuation strategies** These are strategies that are used to continue the consultation when a problem occurs in communication. a. Ask for help When the doctor encounters a problem in communication, he/she asks those around for help to interpret. b. Learning the local language In a bid to communicate directly with the patient, the doctors make effort to learn the local language.	If I'm not satisfied with the conversation I usually go to the sister or any staff to help me. (Doctor 14, rural hospital) He asks us the sisters "Sister, what do you say when you want to ask the patients this" (Nurse 8, Diploma in general nursing) Doctor: well I'm learning Shangan and trying to learn the local language as much as possible (Doctor 5, rural hospital) I've got the medical Sotho. (Doctor 16, urban hospital) We are trying to learn. We are able to say few words in the local dialect. I mean Sepedi, so it is actually helping because now you will be able to say this patient is saying I have a headache. I think learning the language will actually help because you will know when the interpreter is actually deceiving you or when she is telling you something else. It is not so easy to learn actually but learning it will actually go a long way (Doctor 17,rural hospital) When I first came I had a small book where wrote down the basic things. You know, but those are like simple words like stomach, leg. I asked someone to teach me the basic things, like to ask "what is the problem?" Then,

	c. Use of an interpreter The doctor communicates through an interpreter. This seems the easiest and most popular strategy used by the doctors	you just get stuck because you ask bothata ke eng what is the problem and they start saying a lot of things then you start getting confused because you have asked him an open question and he's just going to go on and on and on. I learned those things but it's still difficult (Doctor 9, urban hospital) If we have the interpreter: we don't have a problem but most patients can speak English and understand English (Doctor 13, urban hospital) Doctor: When a patient is consulting me and we are talking, like I said I do not speak very fluently in the local language, so I always have an interpreter by my side in case some of the difficult things I do not understand very well (Doctor 11, urban hospital) I speak English most of the time but some can understand. Some can even speak. but most of the time especially the older patients sometimes we manage: we manage consultations because most of the problems are written in the file (Doctor 14, rural hospital) It doesn't give you fulfilment as a doctor just to sit down and keep prescribing just because you cannot speak the language. You just take the files and you just copy out the previous prescription and you are not actually interacting

		with the patient. (Doctor 9, urban hospital) When the patients are talking, when they are moving their hands and even talking in their language I can understand some of the problem.(Doctor 7, urban hospital)
	d. Get information from patient's file To ensure that the consultation does not come to a halt, the doctor resorts to reading the file rather than speaking with the patient.	Sometimes we make use of sign languages (Doctor 14, rural hospital) Gesticulations, I mean some sort of informal sign language (Doctor 11, urban hospital) she was using her hands she was speaking with the demonstration of the hands (65 year old female)
	e. Nonverbal communication The doctor uses sign language to communicate with the patients as well as watches the body language of the patients and nurses to gain better understanding of the conversation.	It's so hard that sometimes you can stay the whole week and you don't have a nurse to interpret for you because they are not paid to do that. What we do in such instance is that you just get those who are coming for refills, who don't really have problems, then you see those one. (Doctor 9,urban hospital)

	f. Patient selection Using this strategy, the doctors attend only to patients who do not require in-depth interviews and are there for prescriptions.	

3	**Interpersonal strategies** These strategies are those displayed by the doctor in his conduct with the patients. a. Use of time Time is a significant factor in medical consultation as doctor-patient ratio is often high and doctors need to see as many patient as possible within a short space of time b. Doctor's behaviour	I have to spend more time to get the answer from the patients (Doctor 6, urban hospital) There are some patients that are not open when they see the doctor. When patients talk to the doctor they feel like something is being healed. They feel like they are so alive again because he gives them time to express their feelings. He interviews them wanting to know what actually the problem is. (Nurse 6, Enrolled nursing assistant) He gives you a chance to explain yourself and explain to him (25 year old male) I do not have a problem with him speaking English because he is friendly and I am comfortable speaking to him. This people are useful to us but God knows. They don't have problems, they don't sulk and they are very much useful in the way that we want. (75 year old female) Isn't that when a person smiles at you, you also feel free. When I am too sick and you don't show me your smile You know to me I would say you didn't treat me well. But if when I enter and you laugh everything becomes ok. I feel happy about the way that I am that I am welcomed in here. (75 year old female)

		it is because I was comfortable by the way he was addressing me (24 year old male) He was not rude to me (53 year old male)
4	**Knowledge strategy**	You know, he is good you know he understands what he says and I think he understands what is wrong.(56 year old male) As for me every time I came here I always find him. This child does things for me very well!- (75 year old female) He gives me pills that work well with my body. His pills treat me well. I take them the way he told me I should take them and I was for a long time without being sick besides now I last came in February. (75 year old female) When I came here I came with another illness then when I came in here and when he was busy examining me he found out that I have kidney problem (65 year old female) He understands my situation and what I feel (26 year old female)
5	**Avoidance strategies** The avoidance strategy is used when it is impossible to continue a conversation with the patients as all avenues have been exhausted. a. Refer patient to a colleague who speaks the local language	The ones who really have problems we keep them until

	The doctor is forced to cease consultation as there was no one to interpret	may be when we can find someone or refer to one of your colleagues who can speak the language to deal with those ones (Doctor 9, urban hospital)
	b. Ask patient to bring an interpreter When the patient is a foreigner who cannot communicate in English, the doctor asks the patient to bring an interpreter.	If it's not an emergency I rather tell them, "Can you bring someone who can come here and interpret your language to me?" (Doctor 6, urban hospital)

4.4.2 Research question 2

What are the politeness strategies used in medical interactions between English-speaking foreign medical doctors, patients and interpreters?

The participants were not asked questions about politeness during consultations as the researcher was of the view that politeness is better observed rather than talked about. Participants are likely to classify themselves polite irrespective of their actions. Hence, this question will be addressed in the analysis of the observation as well as the conversation analysis.

4.4.3 Research question 3

How does gender influence the use of communication strategies in medical interactions between English-speaking foreign medical doctors, patients and interpreters?

The doctors were asked to expatiate on the influence of gender on communication during consultation. The responses were coded using the Nvivo software. The following themes and subthemes were identified.

No gender influence. When asked if gender influenced communication with patients, it is noteworthy that most of them initially said no and proceeded to mention at least a difference they have noticed and often end their replies by saying there was no gender difference in communication. Examples of the responses are:

> *"No, no difference, it is the same they are all my patients" (Doctor 7, urban hospital)*
>
> *"Not really, no, there's no gender difference" (Doctor 5, rural hospital)*
>
> "*In general nothing no difference at all but mostly I find older male patients use English. They speak English much better than older women." (Doctor 14,*
>
> *"Generally no, we do not encounter problems. But males sometimes do not tell you everything, you understand."*
>
> *"Not really, not really, not really but females need maybe more attention, but generally no. "(Doctor 1, rural area)*

A theme of speech was identified with the subthemes of talkativeness, education and better English. Women were identified as speaking more than men. Doctor 18 from a rural hospital noted that:

"No, not really, I think all of them are the same but the female tend to be more talkative as in they talk more than the male because the male will come: and say one or two things. The female ones, the older ones, they want to tell you everything like headache, back pains this one and this one but they are almost the same except for few females. Yah, they talk a lot." (Doctor 18, rural hospital)

The doctors also perceive the men to be better educated and consequently speak English better than the women,

"In general nothing no difference at all, but mostly I find older male patients use English. They speak English much better than older women." (Doctor 14, rural hospital)

Another theme identified is that relating to behaviour during consultations. Doctors noted that women are more relaxed during consultations while the men are considered more aggressive in communicating with doctors. The female patients were also considered more respectful than their male counterparts

"Not really is just that the female ones are more respectful and the older ones are more respectful but the male ones they feel like "hey I am not fine on this side so you have to do it" (Doctor 17, rural hospital)

A theme of sex concordance of nurse and patient was also identified. The doctors and nurses believe that it is safer when examining patients to have a nurse of the same sex as there have been allegations of sexual harassment by patients. The doctors also prefer a sex concordance as patients are more relaxed and are more forthcoming with information in such situations.

Any of the patients can say the doctor raped her whereas they don't understand why or how the doctor needs to examine them like that, like a pv or something like that. (Nurse 7, Enrolled nursing assistant)

In terms of gender there is no difference, but sometimes if it's a male patient, for example ,and the nurse is a female, some of the male patients may to speak to me: in the presence of another man not a woman. I always enquire

from the patient which is usually easy to say if the patient does not mind the nurse as a female patient being around especially during the when I'm here taking the examination If there are male patients, I always bring male nurses so that the patient can be free to express himself. (Doctor11, urban hospital)

Some doctors and nurses are, however, of the opinion that the influence they observe is not gender related but an age factor as well as personal characteristics of the patients. The elderly patients are known to be more respectful than the younger ones.

It's just that the difference I can say is that the older ones are more respectful than the younger ones. The old ones will come and clap their hands and they start calling you their KHOŠI meaning king, but the younger just come and some even don't greet you some come greeting you but the older ones when they come here they always greet you (Doctor 17, rural hospital)

Nurse: It is not because is a male or a female. It depends from the patient. (Nurse 3, Awaiting registered nurse)

4.4.4 Research question 4

How can the language policy on Health be improved to facilitate the use of appropriate communication strategies by English-speaking foreign medical doctors and interpreters?

To provide answers to this question in the interview, the participants were asked to suggest ways of improving communication between the English-speaking foreign medical doctors, the patients and the nurses as interpreters. The responses of the participants were coded using the Nvivo software. The following identified themes are discussed below: use of interpreter, language learning, community integration and linguistic postings of doctors.

A major suggestion from the participants is the use of interpreters in consultations involving foreign medical doctors. Some responses from participants are:

"I think interpreting is the only thing. I think it is better to have an interpreter if there is someone unable to speak in English, but if he/she can, there is no

problem because they are very good people you can talk to." (24 year old male)

"An interpreter is important and it is wanted." (25 year old male)

Some participants noted that an interpreter was necessary because it is not easy for the foreign doctors to learn the local languages

"There is no other way because there is no Nigerian who can speak Tshivenda. It means that there must be an interpreter"

"You see a white person like this; it's difficult for him to learn it" (24 year old female)

Doctor 18 agreed with the view that learning the local language is difficult. However, recognising the problem of lack of trained interpreters' insufficient nurses as stated in the communication problems encountered during consultations, he insists that learning the local language is still the best option for the foreign doctor.

The best thing is we need to do is to learn the language which is very difficult. There is nothing else to do unless the government gives us the people that were trained for this because interpreting is not a nurse's job. That is not their job, they are meant to give the patients injections (Doctor 18, rural hospital)

Language learning

Participants were also of the opinion that the English-speaking foreign medical doctors should learn the language of the people who consult them.

"I think the doctor must try learning the local language" (Doctor 13, urban hospital)

"The foreign doctor must just try to speak the language" (27 year old female)

"Isn't that the government must plan that the doctors must know all the languages" (60 year old female)

"The foreign doctors must study or understand the local language because it is them who are foreign to the place they must be the one to adapt to the local language" (Doctor 14, rural hospital)

There were also suggestions about how the learning should be done. Some suggested organising language workshops for the doctors

> *"You must sometimes give them workshops so that they can be able to understand us when you are not there." (75 year old female)*

Doctor 9 suggested that foreign doctors from countries that do not speak English be given time to learn English before they start practising in the Republic.

> *"I know each province get foreign doctors especially doctors who cannot speak this language so if there's a program where you can come in like and you have like maybe the first two or three weeks to learn like the Cuban doctors who spend six months to learn English. I feel the same thing could be done to us like two to three weeks just to introduce you to the basic terms" (Doctor 9, urban hospital)*

From above, language training falls into two parts. The first is for foreign doctors who speak English but need to learn the local languages and the second for foreign doctors who do not speak English and need to learn it before they begin practicing.

The provision of a bilingual medical dictionary that lists common words and phrase used in consultation for foreign doctors is considered an essential tool for the foreign doctors.

> *"I think if the province can be good enough to print those things like basic things you ask from every department paediatric or internal medicine. There are terms you use over and over again and you know how to phrase it. Just a small medical translation you know, like the Oxford English Dictionary. The most important thing you can do is print out things like English- Pedi translation booklet for foreign doctors. I think that would really help because you can look at it." (Doctor 9, urban hospital)*

In learning the local language and getting better interpretation, the role of the nurses must not underestimated. The doctors as well as the patients recognise this fact:

> *I've got sister if I'm stuck, who can try to interpret for me. (Doctor 16, urban hospital)*

> *Each time we want to see our patients they usually give us a nurse which interpret for us for a better communication with the patient (Doctor 18, rural hospital)*

If the nurse is here everything is fine. (Doctor 7, urban hospital)

Isn't when I don't know English, I would ask the nurse then she will come to interpret for me. (Doctor 8, urban hospital)

The nurse as the link between the patient and the foreign doctor must understand what the one party says to interpret accurately to the other party.

When I work with them the whole day, I try to listen carefully so I can hear when they talk, I listen carefully so I will be used to their language. (Nurse 2, Awaiting staff nurse)

It is a challenge to say some of the things in Sepedi with the English; we try by all means to simplify things for them, to make sense of everything. (Nurse 11, Professional nurse)

The patients found it easy to speak to the nurses as well probably because they believe the nurses are more likely to understand their need to see a traditional healer:

They are ashamed to divulge to me that they went go to a traditional healer but they can easily explain to the sisters. They can are not ashamed to divulge this fact to the sisters. (Doctor 12, urban hospital)

They are often in the best position to teach the foreign doctors the local languages:

"Usually, we teach the doctors the usual things that the patients complain about. Like when the patient is having diarrhoea the doctor wants to know that from the patient we just teach them like o sa tŠhologa I which means are you still having diarrhoea? The main thing is for us to teach those doctors and they must also be willing to learn because they are here to help us we are here to help each other." (Nurse 8, Diploma in general nursing)

The same nurse succinctly describes the role of the nurses by saying:

"I think if the nurses were not there for the interpretation and the guidance, there wouldn't be any communication." (Nurse 8, Diploma in general nursing)

Community integration of doctors

It is considered necessary that apart from learning the local language, the foreign doctors should also be properly integrated into the community where they serve. This should be done in conjunction with traditional leaders. Doctor believes that learning the lifestyle of the people will ensure better communication.

> *"They must do it in such a way that incorporates the life style of the local people because you learn fast you learn better if you know how they live or how the community is set up." (Doctor 14, rural hospital)*

Linguistic posting of foreign doctors

As stated in problems encountered during consultations, it is confusing for patients when they see a different doctor at each visit.

> *"If they find a person who works alone like so that people can get Used to him or her the person should be able to speak sepedi and must also be able to speak setsonga it mustn't be like this week when you come you find different one then you find that you not relax when you speak to them you get nervous and you say "Eish, this one does not speak like the other one I was with last month" (26 year old female)*

Due the multilingual landscape of South Africa, a doctor may need to learn a new language when moving to another hospital.

> *"I'm working here say where more of the patients speak Sepedi but it's not fixed that I'm going to working here for next five years, maybe next month I can go somewhere else as well and I have to learn another language." (Doctor 9, urban hospital)*

4.5 CONLUSION

This chapter has presented the results of the interviews of doctors, nurses and patients in relation to communication during consultations. The backgrounds of each category of participants were presented.

CHAPTER FIVE

DATA ANALYSIS: CONSULTATIONS AND OBSERVATION

5.1 INTRODUCTION

This chapter presents the analysis of thirty-five consultations recorded in ten hospitals visited in the Limpopo province. Conversation analysis was used in examining the consultations. This analysis does not seek to place data into pre-defined or pre-conceived categories but rather to find "patterns" (ten Have, 2007:120). Ten Have (2007) also noted that the researcher is "open to discovery of phenomena rather than searching for instances of already identified and described phenomena or for some theoretically pre-formulated conceptualization of what the phenomena should look like." The conversation analysis of these consultations therefore will not focus on identifying and describing strategies and theories discussed in chapter two but rather engage in an examination and description of what actually occurred during the consultations.

5.2 TURN-TAKING IN CONSULTATIONS OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS

It was observed that turn-taking is affected by the language spoken and understood by the doctors and the patients. Two major factors that were found to affect turn-taking are if the patient understood English or not and if the doctor had knowledge of the local language.

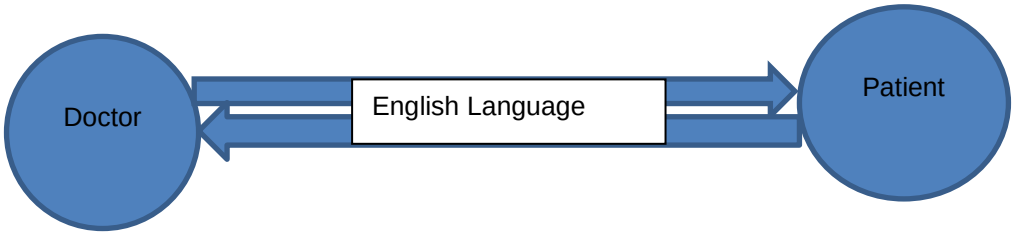
5.2.1 Monolingual consultations

Monolingual consultations are either in English or in the local language of where the hospital is situated and take place without the aid of an interpreter.

5.2.1.1 Monolingual consultations in English language

Monolingual consultations in the English language occur when the patient understands or is assumed to understand, is willing and confident enough to communicate with the doctor in the English language. Such consultations usually have only two interlocutors in the monolingual consultation with each participant taking a turn after the other. However, in some cases the nurses are also involved in the consultation as nurses and not as an interpreter. The turn-taking is thus Doctor-Patient-Doctor-Patient-Doctor (D-P-D-P-D) as indicated in the extract below.

Figure 5.1: Turn-taking in monolingual consultations in the English language



EXCERPT 5.2.1:MKH001 (F) CONSULTATION

1. *Doctor: good mor:ning(.) how are you*
2. *Patient: i'm fine how are you*
3. *Doctor: alright tha::nks(.) o::ka:::y () (0.9) have you been vomiting any vomiti:ng*
4. *Patient: (mm hh)*
5. *Doctor: any diarrhoea*
6. *Patient: (°no::)*
7. *Doctor: anything that bothers you*
8. *Patient: ()*
9. *Doctor: are you feeling well*
10. *Patient: °ye:s*
11. *Doctor: okay let's see how is the blood pressure (0.12) your: blood pressure is normal now (°let me go and check the sugar°) ((clears throat)) (0.7) the sugar is very well controlled as well (.) okay ((clears throat))(.) ↑it's perfect↑ so what you are waiting for i::s the sonar on the kidneys today(.) you know that*
12. *Patient: the sonar*
13. *Doctor: ye:s the sonar () (.) oh had the sonar*
14. *Patient: y::es*
15. *Doctor: oh you had the sonar ye:s:terday okay that's that's great(.) let's just have a look(.) >yes yes yes< it was yesterday (.) it's my mistake (.) (hh) okay (0.14)okay the sonar is alright it's just showing that the kidneys are smaller size than normal*
16. *Patient: (°okay)*
17. *Doctor: she is due to er:: you know the hypertension the diabetes that you () (for years) had done some damage to the kidneys:: but there was (.) noTHING ELSE that she need to do a:CT o:n so what we'll do from now on is: er: today we'll () make a booking for er: the KIDney clinic at polokwane hospital () at polokwane hospital then after that we will be able to discharge you and send you home just to get your date for the kidney clinic so that we'll discharge you (0.5) ↑o:kay↑ thank you:*

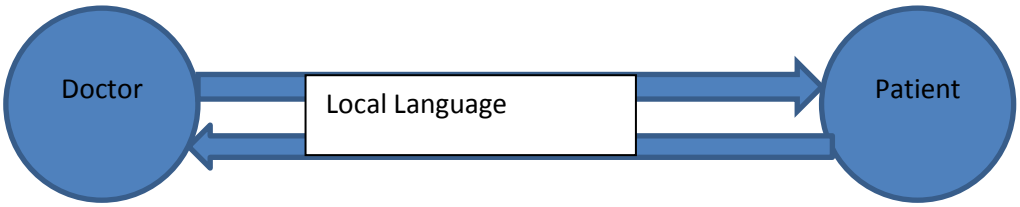
Excerpt 1 above shows a monolingual consultation between the foreign doctor and a patient with each having a consecutive turn. It was observed that the doctor did

most of the talking with the patient giving monosyllabic answers. In lines 3-10, the doctor's questions which should have elicited more comprehensive answers from the patient did not. However, the doctor did not appear to notice this and did not probe the patient further. The consultation though monolingual as there is no interpreter involved suggested that the patient did not fully understand the doctor or was not confident enough to communicate fully in the English language. The consultation might have been more successful and enriching if the patient had spoken the local language and an interpreter had been involved.

5.2.1.2 Monolingual consultations in local languages

In some cases when the doctor has an understanding of the local language, there is an attempt to have a monolingual conversation with the patient in the local language as evidenced in excerpt 2 below. The turn-taking remains the same as with the English language.

Figure 5.2: Turn-taking in monolingual consultations in local language



EXCERPT 5.2.2: JFH002 (M) CONSULTATION

1. *Patient: ke kgopela dihlare*

Patient: I am asking for medicine

2. *Doctor: ga o na mathata*

Doctor: you don't have a problem

3. *Patient: aowa mathata ona gake nao, ke no kgopela dihlare tsa ka*

Patient: no I don't have a proBLEm, I am just asking for my medication

4. *Doctor: clinic ke ya kae*

Doctor: which clinic

5. *Patient: eerr (.)*
6. *Doctor: clinic*
7. *Patient: ke Mphanama*

   Patient: its: Mphanama
8. *Doctor: Mphanama*

9. *Patient: ee*
   Patient: yes
10. *Doctor: help me ask papa what is wrong with him*
11. *Interpreter: ba re bothata bja lena ke eng papa*
    Interpreter: he is asking what your problem papa is

The consultation started as a monolingual consultation in the local language based on the doctor's ability to speak the local language and confidence to converse with the patient without the aid of an interpreter. The doctor not only understood but also spoke the local language and did not require an interpreter to communicate with the patient at the earlier stage of the consultation. In line 5, the patient did not understand the doctor's question and it was necessary for the doctor to repeat it. He, however, required an interpreter when he wanted to know the patient's symptoms as that might require more than a basic knowledge of the local language. It is possible that the use of the local language at the beginning of the consultation might have helped to create rapport with the patient making it easier to communicate.

Though monolingual conversations are considered less problematic than interpreted ones, it may not be desirable or beneficial in cases of intercultural communication where the competence of one or both speakers in the language of communication is not optimal. A successful monolingual consultation requires that the doctor and patient speak the language of communication at a level where mutual understanding is achieved. If this condition is not fulfilled the situation in excerpt 2 may be expected. The solution to such situation is to enlist the services of an interpreter as done by the doctor.

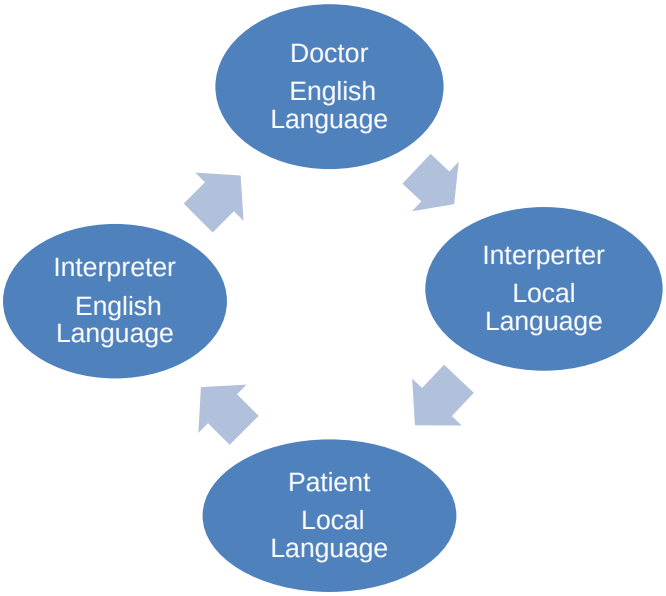
5.2.2. Interpreted consultations

Interpreted consultations occur when the patient and foreign doctor are unable to communicate in a common language. The patient is unable, unwilling or not confident enough to converse with the foreign medical doctors in the English language while the foreign doctor does not understand or speak the local language or at best has a basic knowledge of it. Interpreted consultations may be fully interpreted or semi-interpreted.

5.2.2.1 Fully interpreted consultations.

These are consultations where the patient speaks and understands only the local language and does not understand or speak English. In such situations, there is a need for the interpreter to repeat everything said by the doctor and patient. The doctor speaks English while the patient speaks the local language and the interpreter speaks the language of the first speaker. The turn-taking and language spoken is presented below.

Figure 5.3: Turn-taking in fully interpreted consultations



The interpreter must be competent in the two languages of communication during the consultation emphasising the pivotal role of the interpreter in the communication process highlighted in the diagram.

EXCERPT 5.2.3: JFH001P2M CONSULTATION

12. Doctor: But does he have a problem today
13 Nurse: are ga le na bothata lehono
Nurse: Don't you have a problem today
14 Patient: akere ke sa nwa dipilisi tsela, ke kwele okare pain tsela di eme nyana
Patient: I am still taking those pills right, I felt like those pains have: stopped a little
15 Nurse: ↓No he is fine↓[he said that!-]
16 Doctor: [No pain,] nothing, everything (IS) right, no problem
17 Nurse: yaa

Nurse: Yes
18 Patient: mmm
Patient: Yes
19 Doctor: Ok

Each turn moves the conversation forward with the doctor and patient responding appropriately to the interpreter.

EXCERPT 5.2.4: MGH002 (F) CONSULTATION

1. *Doctor: so MAMA what's wrong with you::*
2. *Interpreter: (0.2) MAMA BAre bothata KEng::*
3. *Interpreter: (0.2) MAMA SHE is asking what the problem is today::*
4. *Patient: ke a gohlola::[*
5. *Patient: I am coughing::[*
6. *Interpreter: [she is coughing and feeling pain:*
7. *Doctor: she is coughing::NOT because of this MA:SS::?*
8. *Patient: ketlile kgedi ya go feta ke sa gohlolaLA*
9. *Patient: I came last month and I was coughing still:*
10. *Doctor: Ok ::(.) she had ANY mediCATION ?*
11. *Interpreter: BAre o ne dihlare tŠe::di::*
12. *Interpreter: HE is saying do you have any other::med::*

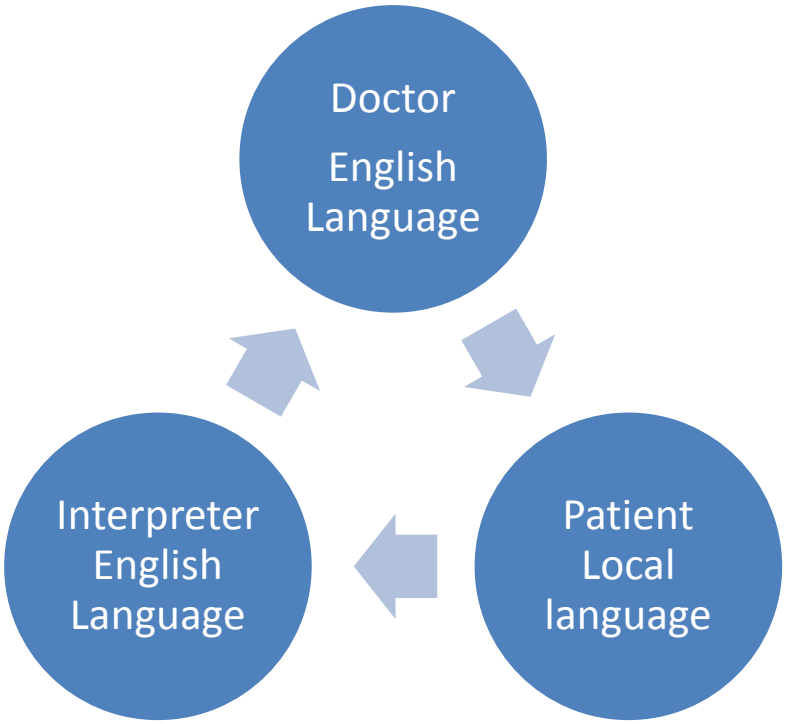
In the extract above, the doctor, perhaps conscious that the patient does not understand English, compensates by speaking in a raised tone at the beginning of the conversation. This action is mimicked by the interpreter who is a nurse as she tries to repeat everything said by the doctor in the local language.

This is a fully interpreted consultation, where the patient does not understand English; however, the interruption of the interpreter in line 5 leads to the loss of vital information by both the doctor and patient. The patient is interrupted by the interpreter in line 3 and continues to list her symptoms in line 6, goes on speaking without waiting for an interpretation from the nurse and the doctor's question in line 5 is neither asked and consequently not answered leading to a loss of an important information for diagnosis.

5.2.2.2 Semi-interpreted consultations

This often happens under the following circumstances: The patient understands English but cannot speak it. Under such circumstances, the patient is sometimes able to respond directly to the doctor but does so in the local language, thus requiring an interpreter. The turn-taking in this type of consultation is: Doctor-Patient-Interpreter-Doctor-Patient-Interpreter (D-P-In-D-P-In)

Figure 5.4: Turn-taking in semi-interpreted consultations



EXCERPT 5.2.5: ELM001 CONSULTATION

13. Doctor: am asking since when did she stop menstruating
14. Patient: ndo di wana:: uthoma:: ndo fhedzisela u mensturator nga march
15 .Nurse: it stopped in march
16. Doctor: march so she was not using any prevention

The extract shows a semi-interpreted consultation where the patient understands and speaks English but whose level of competence is not high enough to communicate with the doctor without an interpreter. Though the question was directed to the nurse, the patient understood the doctor and responded directly to his question in the local language, making it necessary for the nurse to interpret.

5.2.2.3 Un-interpreted bilingual consultations

Another dimension is added when the foreign doctor has knowledge of the local language, understands and speaks it a little. The doctor and patient communicate without an interpreter, though in English and the local language. The exchange involves greeting as the patient enters the consultation room. The un-interpreted interaction, though short, creates a rapport between the patient and doctor and sets the tone for the rest of the consultation.

EXCERPT 5.2.6: SH002F1 CONSULTATION

02 Doctor: how are you mama::
03 Patient: RE GONA re ra Lena:::
03 Patient: I AM FINE and you:::
04 Doctor: thank you mama

5.2.2.4. Extended turn-taking between the nurse and patient leading to uninterpreted turns

The role of nurses as interpreters in South Africa cannot be over emphasised as has been noted in chapter four. Without their presence and participation in the interpretation process, communication becomes chaotic between the patient and doctor and impossible at times as in addition to their duties as nurses, they also take on the role of interpreters in most consultations between the English-speaking foreign medical doctors and patients. The turn-taking in interpreted consultations involve three participants namely the doctor, the nurse and the patients. However, during the consultations there are instances where the exchange is between the patient and the nurse for an extended period of time. The extended turn-taking between the nurse and patient may happen for various reasons. Reasons deduced from the consultation are:

a. To fill the gap during which the doctor does not take his/her turn to speak but concentrates on writing in the case file. The nurse may use such time to engage the patient in non-medical topics.

b. The nurse may take the initiative to ask the patient some relevant questions that the doctor had not asked.

EXCERPT 5.2. 8: ELM001 CONSULTATION

21. Doctor: and this headache; how long is this headache
22. Nurse: thoho yo thoma lini
Nurse: when did the headache start
23. Patient:haa: thoho idzula itshi khou pina tshifhinga tshinzhi
Patient: haa: I usually experience this headache
24. Nurse: all the time
25. Doctor (0.2) any problems like stress
26. Nurse: vhana stress kana zwinwe zwithu zwine zwa khou vha remisa thoho
Nurse: do you have stress or anything which you think of which can contribute to this headache
27. Patient: ndo tou vha na problem ya nwana mara nda da nda fhiwa philisi zwa di nga zwi a tuwa nga zwituku nga zwituku
Patient: I had a problem with my child but they give me some pills it is getting better
28. Nurse: o vha a khou ita mini nwana
Nurse: what was the child doing
29. Patient: utou vha na problem a tshi shuma a sa nthumeli tshelede
Patient: he had problems so whenever he worked he didn't send any money to me
30. Nurse; the problem is the child who is working and doesn't give her anything at home
31. Doctor: oh the problem is family problem
32. Nurse but they gave her medication previously
33. . Doctor: (they used something last time) =
34. Patient:ok ndo sokou fhiwa dziphilisi ndi tshi di nwa na hanefha zwo nwalwa=
Patient: I was just given this other pills I've been taking them it is written here=
35. Nurse: zwino tshelede u ya fha nwana
Nurse: is he giving you money now
36. Patient:ha:: zwino u ya vhuya
Patient: ha::: he come back home now
37. Nurse: u shuma gai
Nurse: where does he work
38. Patient: (.) u shuma tshikhuwani
Patient: (.) he works in town
39. Nurse: GAI
Nurse: WHERE
40. Patient: NNE THI DIVHI vha to shuma u fhata madamu vha ita zwa u pfuluwa pfuluwa a si fhethu huthihi
41. Nurse hoo>u tenda nga thoho<
42. Patient: I don't know they build dams they don't work at the same same place they move around
43. Nurse: hoo>nodding<
44. Doctor: (0.3) and mmh she has been having this headache for a long time , now she has stop with the menstruation she was menstruating previously and uhmm there was no problem so now she stop menstruating so she is wondering if she have a problem so we are going to issue the (form) prescribe some medication for her, we will reveal …) we don't have to record an examination

The doctor in line 25 in the bid to have a better understanding of the patient's problems asks a question. The next two turns are taken by the nurse and patient

and the patient's answer is summarised by the nurse in line 30. The doctor's comments in lines 32 and receive no responses and the nurse starts a conversation with the patient on the issue earlier discussed in lines 25. The conversation discussing the patient's personal problems or what is termed the "lifeworld" runs from the lines 34 to 42.This exchange is not translated for the foreign doctor perhaps with the belief that the "lifeworld" was not necessary or needed by the doctor to make a diagnosis. Hence, in line 44, the doctor makes a diagnosis without considering the issue of stress he had earlier raised and which may have being a significant factor in the treatment of the patient.

5.2.2.5 Ignored turns

The nurses also act as gatekeepers and determiners of the information received by the patient and doctor. The nurse for reasons unknown may decide to ignore a turn by either the patient or the doctor. An example is given below in excerpt 9

Before the exchange below, the doctor had informed the patient through the nurse that he was prescribing an additional medication. The patient's outburst in line 113 was not taken into consideration by either the nurse or the doctor. The fact that the patient shouted should have alerted the doctor that something was wrong even if he did not understand the language spoken by the patient. However, no question was asked by the doctor. The patient's complaint in line 120 was also ignored as well as the declaration that she was going to throw the pills away in line 122.

EXCERPT 5.2 9: JFH001 CONSULTATION

113 Patient: ↑GONA GORA GORE KE SA ILE GO TSEA TSE DINGWE DIPILISI↑
Patient: ↑THIS MEANS I AM GOING TO TAKE ANOTHER PILLS↑
114 Doctor: = Ok bring me your file over and let write [the (collected pills)]
115 Nurse: [ba re tlisa faele]
Nurse: [He is saying bring your file]
116 Doctor: = But you nee:d to give them a copy of this ok(.) that side you have to give them copy of this
117 Nurse: o ba nee (.) copy ye khwe aker
Nurse: You must give them (.) THis copy ok
118 Patient: ↑ee↑
Patient: ↑Yes::↑
119 Nurse: ee
Nurse: Yes
120 Patient: (0.4) akere ke tshaba go hlwa ke phaka dipilisi (.) o hwetsa di tletse kua gae kua
Patient: (0.4) Isn't that I'm afraid of taking others sort of pills (.) you'll find [my home full of them]
121 Doctor: [So you just go there]
122 Patient: [ketlo di lahla nna]
Patient: [I'm going to throw them away]
123 Doctor: [You just go there] And tell [them that you took pills::: last week]
125 Nurse: [bare o ya ko dihlareng]

Nurse: *[He is saying you going to the pharmacy section]*

In order to guard against or reduce cases of un-interpreted and ignored turns, the doctor asks the nurse for an interpretation what the patient said. In the extract below, the doctor asks for a translation of the patient's reply to the question he asked in line 8. In this way, it is ensured that answers are obtained to questions. This requires that a doctor take note when a lot has been said and no interpretation has been given. Requests for interpretation must, however, be made periodically to ensure that vital information is not lost.

EXCERPT 5.2.10: JFH002F CONSULTATION

08 Doctor: let me ask, the headache which side or all over ((point))
09 Nurse: e go swara ka side efe hlogo ye
09 Nurse: which side is the head ache
10 Patient: mo: ((point)) Ya theoga ya tla ka mo o kereya ebile e tswaletse maahlo a a etswa meokgo
10 Patient: here: ((point)) here then it comes down here You will even find my eyes closed and teary
11 Doctor: (.) what is she saying? All over
12 Nurse: ((laughs))
13 Doctor: it comes to the face
14 Patient: yaa
14 Patient: yes

5.3 THE USE OF PAUSES AND HESITATIONS

Pauses or hesitations were found to be used by the doctors for linguistic and non-linguistic purposes.

5.3.1 Non-linguistic pauses

This is when the doctor pauses as he /she speaks without a linguistic reason. For example, the doctors were noted to pause when writing in the case files during consultations. The pauses occur because they are engaged in two activities at the same time, as in the excerpt below where the doctor after examining the patient had to make some notes in the case file as well as give a feed back to the patient at the same time.

EXCERPT 5.6.1: LTC001P2 CONSULTATION

98 Doctor: er::: chest x-ray ()(2.0) i' ll write you medication for another six months so you can come fetch it every:: month
99. Patient: ok

5.3.2 Linguistic uses of pauses/hesitation

To show a lack of understanding leading to a question for clarification

Pauses in this case are used to convey to the listener that more information is needed as in the excerpt below where the patient understood the doctor's pause to mean a request for information concerning the year of birth.

EXCERPT 5.6.2: LTC001FP2 CONSULTATION

90. *Doctor: oh eighty: ok ay born in (.)*
91. *Patient: °1928*

Also, in the excerpt below, the doctor's hesitation in line 45 led to a question about the driver of the tractor from which the patient fell.

EXCERPT 5.6.3: CNP002MP2 CONSULTATION

45. *Doctor: okay(0.5) where is er::: where is the driver of the tractor*
46. *Patient: ()*
47. *Nurse: where is the driver*
48. *Doctor: (is he your::)*
49. *Patient: ↓ (delivery) ↓*

Pause/hesitation when giving directives to the patient

Doctors are noticed to pause and hesitate when giving directives to patients. In the example below, the doctor in line 59 pauses before stating emphatically the consequences of the patient not taking her pills. In lines 61 and 125, the information is emphasised by the use of pauses so as to allow each part to register with the patient. Hence, pauses are used to place emphasis on information.

EXCERPT 5.6.4: LTC001P1 CONSULTATION

55. *Doctor: so it means you are in a daN:Ger*
56. *Patient: woo*
57. *Doctor: and if it continues like tha::t=*
58. *Patient: mm*
59. *Doctor: = for long TI:me (.) you gonna HAVE HEArt disease you gonna have a STRoke you gonna have BLindNess=*
60. *Patient: mm*
61. *Doctor: = you gonna:: ha::ve:: er::: >kidney< problem*
62. *Patient: kidney problem*
63. *Doctor: >and THIS is not a JOke<*
64. *Patient: mm*

125. Doctor: i have seen many patients come with a stroke (.) and half of the body is paralyzed it's just because i'm not sure:: (.) they are not taking their medication properly (0.3) it's because of high blood pressure(.) is very very important

To search for the appropriate or correct word

Pauses were also used when doctors try to find the right word to use either in English or the local language. In excerpt 5.6.3, the doctor hesitates as he searches for the local word for wound.

EXCERPT 5.6.5: LTC002P2 CONSULTATION

25. Doctor: but I can see that there is a wound there you don't say about the wound ah:: what is aH:: t shilonda
Doctor: but I can see that there is a wound there you don't say about the wound ah:: what is aH:: your wound

The fact that English is a second language for the doctors and that some of them struggle to speak it fluently is also evident in their communication during consultations. In the excerpt below, the doctor struggles for the words at various times. In line 44, he struggled to find the right word which was supplied by the patient and repeated by the doctor in line 46; however, line 48 indicates that he had not yet learned the new word. This process may be used to learn new words in both English and local languages.

EXCERPT 5.6.6: SH001MP1 CONSULTATION

24 Doctor: chest you feel (.) heavy to:: (.) you cannot breath::
25 Patient: it was very very……..to……
26 Doctor: O::::K::: when you walk (.) you cannot breath well::

42 Doctor: because the:::(.)job situation or job environment is not healthy::
43 Patient: [yes::
44 Doctor: and did they:: give you MUsk::to put on your face::?
45 Patient: respirators::
46 Doctor: Respirators::
47 Patient: ye::s
48 Doctor: are you using it did you:::I was use to
49 Patient: [ye::s I was:: I was using it before
50 Doctor: ok::but eh:: mean while you are using or eh::(.) Although you are using this respirator you have got difficulty in problem::

5.4 QUESTIONING AS A COMMUNICATION STRATEGY

A doctor's work is often achieved mainly through the questioning of patients to have an understanding of the problems, make subsequent diagnosis and proffer appropriate treatment.

The doctors' questions were designed to achieve the following:

a. Questioning for clarification
b. Questioning for confirmation
c. Questioning for patient's expectations

These are explained below.

Questioning for information/clarification

This is the most basic of the questioning forms where the doctor asks basic direct questions to obtain information from the patients. The questions are usually short; often eliciting monosyllabic answers from the patients.

EXCERPT 5. 3.1: LTC002 M CONSULTATION

27. Doctor: are you vomiting
28. Patient: no
29. Doctor: do you have diarrhoea
Doctor: do you have back pain
30. Patient: yes
31. Doctor: where exactly?
Doctor: which part of the back?
32. Patient: ((pointing))
33. Doctor: ok and this back pain did it start with the same pain you are feeling at both side of the stomach
34. Patient: yes
35. Doctor: do you have pain when you are passing urine:: urinating
36. Patient: no
37. Doctor: (0.3) what else can you tell me?
38. Patient: eeh it's I don't know if you did ever together: I don't feel the pain on my spine
39. Doctor: and how long have you been feeling this pain, for how long now
40. Patient: ahh no sometimes it just come because=
41. Doctor: it comes and it goes
42. Patient: jah because this thing of having problem on my kidneys is about:: it started in 2012
43. Doctor: mmh
44. Patient: so I went to see a general practitioner so there was nothing they can do
45. Doctor: when you are passing urine do you see something like blood or has the colour is changed
46. Patient: no, right now because am taking morphine the urine is pale

Questioning for confirmation

In some cases, the doctor asks questions to confirm some information. This happens when the doctor reads from the case files. While reading through the notes, the doctor asks questions to confirm the information contained in it.

EXCERPT 5.3. 2: LTC002 M CONSULTATION

15. Doctor: so::: you have kidney stones
16. Patient:, am not sure
17. Doctor: you are not sure it is what the doctor told you the last time
18. Patient: jah
19. Doctor: and:: how did he come up to tell you that is kidney stones
20. Patient: ohh it is because the way how I told her how I felt because:: the last pass out they were some white particles
21. Doctor: an::d umm you say he told you is kidney stones
22. Patient: yes
23. Doctor: and when he gave you the medicine you went home and after a week there is no change
24. Patient: yes
25. Doctor: that's why you are coming back

In the excerpt above the doctor queries the patient about a diagnosis made by another doctor during an earlier visit to the hospital. His questions were directed at confirming the information in the case note.

EXCERPT 5.3.3: CNP001 F CONSULTATION`

11. Doctor: so:: you can:: FREEly so start the (.) er the treatmen:t
12.Patient: the treatment
13.Doctor: and you KNOW all about the treatment
14.Patient: ye:s they told me £
15. Doctor: everyda:y (.) same time
16. Patient: same time ye:s

The doctor questions the patient about a treatment option to ensure that it was well understood. The questioning started with "so" indicating that this was the conclusion of any earlier discussion which also turns out to be the beginning of another segment about treatment. In line 12 the patient's response to the doctor's statement suggested that she did not understand the doctor's statement. The doctor began questioning to confirm that the patient clearly understood the treatment. The question started with "and" indicating a link to the earlier statement necessitating the questions. The doctor waits after each question to get a confirmation from the patient that each fact about the treatment is fully understood.

Questioning for patient's expectations

This type of questioning usually occurs at the beginning of the consultation or immediately after the patient has told the doctor the symptoms and is aimed at understanding the expectations of the patient. It is important for the doctor to understand the patient's expectation as there may be cultural or religious factors that may need to be considered in treatment. The doctor in the excerpt also asked the patient what he believes the problem is. This is also done for cultural and religious beliefs of the patients.

EXCERPT 5.3.4: LTC002 M CONSULTATION

51. Doctor: and what do you expect from me
52. Patient: eh I just want you to help me out
53. Doctor: Ahh to help you out in which way
54. Patient: in any way that you can
55. Doctor: ok and (.) what do you think can be the problem if you:::
56. Patient: (.) ah I really don't know because this thing = you know used to exercise so this thing is giving me a problem I did go to see a doctor but there was nothing they can do so am just asking myself what's really going on.

5.5 COMMUNICATION STRATEGIES USED BY ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS

The strategies used by the English-speaking foreign medical doctors as they consulted with patients with or without interpreters were analysed. In most cases, the nurse interpreted, in some the relatives of the patients did the interpretation, while in others, the consultation was in English language requiring no interpretation. The identified communication strategies are similar to those highlighted by participants during the interviews. They are discussed below.

1. Clarification strategies
2. Continuation strategies
3. Complimentary strategies
4. Avoidance strategies

5.5.1: Clarification strategies

As mentioned in chapter four, these are strategies used by the doctors to gather information from the patients.

a. Asking patients for choice of language to be used in consultation: At the beginning the consultations, some doctors asked the patients if they understood English and if they were comfortable conversing in it. In the first excerpt below, the consultation began in English language but the patient's response was incomprehensible. The doctor's invitation for a repetition yielded the same result leading to the doctor's request that the patient repeat what was said in English. The patient's response confirmed that she was not willing to converse in English and a validation of her situation by the doctor led to the disclosure of the reason for her unwillingness in line 8.

EXCERPT 5.4.1 CNP002MP2 CONSULTATION

1. *Doctor: >hello< (1.0) what can i do for you today*
2. *Patient: ()*
3. *Doctor: say it again*
4. *Patient: ()*
5. *Doctor: can you try and say it in english*
6. *Patient: ↓ (english haa no:) ↓*
7. *Doctor: it is difficult*
8. *Patient: ↓(some of the things I understand mara ())↓*
9. *Doctor: please:* (.) sister will help us okay
10. Patient: yes

EXCERPT 5.4.2: LTC002 P1 CONSULTATION

1. *Doctor: ARE YOU COMFORTABLE USING ENGLISH for us to communicate*
2. *Patient: >yes<*
3. *Doctor: you speak English very well*
4. *Patient: yes*

In the excerpt above, the doctor confirmed that the patient was comfortable conversing in English before he commenced the consultation. This, all things being equal, would ensure a more productive consultation session.

Excerpt 5.4.1 was extracted from a consultation in a rural hospital while excerpt 5.4.2 was from a consultation in an urban area. This suggests that the doctors need to ask this fundamental question in both rural and urban areas to ensure that patients use a

language they are comfortable with.

b. Asking the patient or nurse for confirmation

EXCERPT 5.4.3: ELM001F CONSULTATION

1. *Patient: hai (.) nda kho toda utou vhudzisa uri muthu are na 43 zwia itea uri nowa yawe iime asi tshaya deithini naa*

Patient no(.) I just wanted to ask if it's possible for a 43 year old to stop menstruating

2. *Nurse: she is asking if can more than 43 you can menopause*
3. *Doctor: she want to know if menstruation stops=if it is possible the menstruation stopped::: is it normal for a 43 years old*

The doctor in the excerpt above due to his knowledge of the local language understood the patient but needed a confirmation to rule out mistakes and therefore repeated what the patient said as a question for confirmation in line 4.

c. Asking patients for expectations

Often at the beginning of a consultation, the doctor asks the patient reason for the visit to the hospital and what assistance may be offered by the doctor. From the interviews with the doctors, it is possible that the doctors do this to have a cultural understanding of the patient's condition.

EXCERPT 5.4.4: LTC002MP1 CONSULTATION

1. *Doctor: yes:: baloyi we are to help you*
2. *Patient: yes*
3. *Doctor: how do you think we can help you, what is the problem?*
4. *Patient: the problem here is i'm feeling cold*
5. *Doctor: and what do you expect from me*
6. *Patient: eh I just want you to help me out*
7. *Doctor: Ahh to help you out in which way*
8. *Patient: in any way that you can*
9. *Doctor: ok and (.) what do you think can be the problem if you:::*
10. *Patient: (.) ah I really don't know because this thing = you know used to exercise so this thing is giving me a problem I did go to see a doctor but there was nothing they can do so am just asking myself what's really going on.*

In the excerpt above, the doctor reassures the patient that the medical team was there to help and wanted to know how they could be of assistance. The patient's reply in line 4 which is a statement of the problem leads to a follow-up question by the doctor, asking what the patient expected the doctor to do about his problem. The patient's reply, "Eh I just want you to help me out" did not satisfy the doctor as he probed further for the patient to state the specific type of help he wanted. The

patient's reply in line 8 places him at the mercy of the doctor. This introduces a form of power-play by the doctor as he pushes the patient to a point when he admits that he would appreciate any form of help from the doctor.

d. Explaining

Doctors try to improve communication with patients by giving them detailed explanation of the problems and treatment options as indicated in the excerpt below.

EXCERPT 5.4.5: LTC002MP1 CONSULTATION

112. Doctor: am going to put you in a treatment for 7 days then if there is no improvement then we will think of::we will think about booking you for an urologist you understand
113. Patient: yes
114. Doctor: (0.6) hoping that you will be fine
115. Patient: mmh
116. Doctor: (0.6) you must drink a lot of water or fluid (0.3) do you have anything else you want to ask
117. Patient: no ahhh what's going on: what's the cause of this problem?
118. Doctor : the cause is: um saying is quite difficult to say for now but ahh we did investigate your urine the last time it just show that you have slight infection okay and when we talk about urinary tract is from the kidney bladder from kidney bladder urethra ok oh right , then now because right now because the pain is not going away is from last week ,we are going to give you again antibiotics for this week= for the next seven week, if there is no change then say we will book you to go and see the specialist for urology that is the person that can tell you what is really going on, we can speculate to say that it is kidney stones but we can't say for sure that is kidney stones that's the man who will tell you that is kidney stones
119. Patient ok
120. Doctor: oh right

The doctor took some time to explain to the patient the treatment he was prescribing for him and plans for further intervention if there was no improvement in his condition. This is followed by the doctor's instructions and an open-ended question leading to a question from the patient about the cause of his problem. The explanation given in from line 118 is devoid of medical jargons and takes a deviation from the usual one or two short sentences used by the doctors in communicating with the patient. Here, the doctor spoke for longer time than usual in a bid to ensure clear understanding by the patient.

5.5.2 Continuation strategies

a. Asking nurses for interpretation

In some cases, the doctor requests an interpretation from the nurse in a bid to continue the consultation as well as to ensure that vital information is not lost and that he remains in control of the consultation.

EXCERPT 5.4.6: JFH002F CONSULTATION

08 Doctor: let me ask, the headache which side or all over ((point))
09 Nurse: e go swara ka side efe hlogo ye
09 Nurse: which side is the head ache
10 Patient: mo: ((point)) Ya theoga ya tla ka mo o kereya ebile e tswaletse maahlo a a etswa meokgo
10 Patient: here: ((point)) here then it comes down here you will even find my eyes closed and teary
11 Doctor: (.) what is she saying? All over

In the excerpt above, the doctor asked the nurse what the patient's answer was to the question in line 8. Failure to make such requests may lead to ignored turns or un-interpreted turns during the consultation.

b. Assuring the patient

Communication may become difficult if the patient becomes agitated and the doctor tries to reassure the patient during consultation.

EXCERPT 5.4.7: CNP001F CONSULTATION

5 Doctor: like the:: lab resulTS to see whether you: (.) your kidney is still working well
6 Patient: okay::
7. Doctor: it is [still working!-] it is fine
8. Patient: [it is fine] (0.3) oka:y
9. Doctor: an:d your:: blood results(.) the (hp) is still acceptable
10. Patient: okay

In the excerpt above, the doctor allayed the patient's fear by informing her that her kidney was in good working condition. The reaction of the patient in lines 6 and 8 indicate the relief felt by the patient with the doctor's verdict on the state of her kidney. She asks in line 8, "it is fine" as if in unbelief, pauses and says, "Okay" acknowledging the doctor's statement.

c. Repetition

In some cases, the doctor needs to repeat instructions or questions in order to continue the consultation. For example, in the excerpt below, the doctor's question in line 5 does not receive a direct answer from the patient who understood the doctor and answered him directly by saying he was there the week before. The question

received no answer until the doctor repeated it in line12, after which the nurse interpreted and an answer is finally received.

EXCERPT 5.4.8: JFH001P2M CONSULTATION

05 Doctor: (0.2) Today [(any problem)]
06 Patient: [eeeee, aker beke ya go feta ke tlile mo
Patient: [Er::: (.)] isn't that I came here last week
07 Nurse: [((Laughs))] ↓last week he was here↓
08 Patient: ee last we::ek (.)
Patient: Yes last we:::ek (.)
09 Doctor: Ya::neh
10 Patient: = E:: gabotse ke tlo renewa (.) lengwalo la ↓dipilisi↓
Patient: = E:: well I came to renew: (.) referral ↓form↓
11 Nurse: ↓He came to renew the↓ referral form
12 Doctor: But does he have a problem today
13 Nurse: are ga le na bothata lehono
Nurse: Don't you have a problem today
14 Patient: akere ke sa nwa dipilisi tsela, ke kwele okare pain tsela di eme nyana
Patient: I am still taking those pills right, I felt like those pains have: stopped a little
15 Nurse: ↓No he is fine↓[he said that!-]
16 Doctor: [No pain,] nothing, everything (IS) right, no problem
17 Nurse: yaa
Nurse: Yes
18 Patient: mmm
Patient: Yes
19 Doctor: Ok
((clicking of a pen))

5.5.3: Convergence strategies

These are strategies used by doctors to forge an identity with the local patients who consult them. During the interviews reported in chapter four, the doctors identified these strategies as being used to understand the patient better but a look at the use during the consultation suggest that they are used to bond with the local patients.

a. Local way of speaking

The doctor uses words like "gonna" and "wanna" which are words usually used by Black South Africans for "going to" and "want to".

EXCERPT 5.4.9: ELM001F CONSULTATION

56. Doctor: she is ::: I think [she don't ah do] maybe she don't wanna speak

b. Speaking the local language

As noted in the interview, learning and speaking the local language was the most common strategy identified by the participants. Having learnt some local language,

the doctors speak directly with the patients. The strategy presents the doctor as willing to identify with the local people.

EXCERPT 5.4.10: ELM002F CONSULTATION

Doctor: minjhani?
Doctor: how are you?
Patient: hi kona
Patient: I am fine
Doctor: pfukile minjhan? (hhh) okay what is the problem (hhh) today
Doctor: I am fine and you? (hhh) okay what is the problem (hhh) today

Being able to converse directly with the patient, introduces a personal touch to the consultation as there was no need for an interpreter when the doctor is able to speak the local language. Below, the doctor is able to give directions to the patient in the local language.

EXCERPT 5.4.11: JFH001P2M CONSULTATION

103 Nurse: wa isa […]!- [o fo ba nea]
103 Nurse: Take it there!-[just give it to them]
104 Doctor: [[…](tše tharo neh) wa tsea [dithare] neh
104 Doctor: [[…](Three ok)]then you go collect [medicine]ok
105 Patient: [ka gorealo] ke sa ile go dula ntshe ka kua
105 tient: [By saying so] I am still going to sit that side

5.5.4 Avoidance strategies

These strategies are used by doctors to avoid topics they do not wish to discuss or avoid speaking directly to a patient. In the excerpt below, the doctor dismissed the information given by the nurse in line 14 as a “family problem” and moved on to medical issues. Hence, the doctor avoided conversations outside the medical domain.

.EXCERPT 5.4.12: ELM001F CONSULTATION

1. *Doctor(0.2) any problems like stress*
2. *Nurse: vhana stress kana zwinwe zwithu zwine zwa khou vha remisa thoho*
3. *Nurse: do you have stress or anything which you think of which can contribute to this headache*
4. *Patient: ndo tou vha na problem ya nwana mara nda da nda fhiwa philisi zwa di nga zwi a tuwa nga zwituku nga zwituku*
5. *Patient: I had a problem with my child but they give me some pills it getting better*

6. *Nurse: u khou ita mini nwana*
7. *Nurse : what was the child doing*
8. *Patient: u tou vha na problem a tshi shuma a sa nthumeli tshelede*
9. *Patient: he had problems so whenever he worked he didn't send any money to me*
10. *Nurse: the problem is the child when he is working give he don't give her anything at home*
11. *Doctor: oh the problem is family problem*

5.6 POLITENESS STRATEGIES USED BY ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS

In examining the politeness strategies used by English-speaking foreign medical doctors, the broad division of positive and negative politeness strategies were considered.

5.6.1 Positive politeness

Positive strategies are those designed to show people that they are similar, that they are liked, to show sympathy or use of humour in conversations. The observed positive strategies are discussed below. A major politeness strategy found used by English-speaking foreign medical doctors is claiming common ground with both patients and interpreters. Using the positive strategy of claiming common ground may be an attempt by the doctors to reduce uneasiness with the patients during consultations as Enfield (2006) argued that communication becomes less constrained when interlocutors share a lot in common. It may, however, be argued that the doctors employ these strategies because they see themselves in a position of low power and find it necessary to identify with and please the local people. Further investigation may be required to compare the strategies used by the foreign and locally trained medical doctors.

The identified strategies are discussed below:

Reference to prior meeting outside or within the hospital

The doctor in the excerpt below realised that the patient had attended a lecture he gave in a church on high blood pressure. This became a common ground for them to relate and the doctor referred to this as a basis to educate the patient. The doctor made direct references to the lecture in lines 1,3,7,11,13 and 27.

EXCERPT 5.5.1: LTC001P1 CONSULTATION

1. *Doctor: i'm happy: (.) that you were in the church that we had a speech about high blood pressure about sugar and you are coming that you know ME because of that speech and that speech assisted you with er: how to control your: blood pressures(.) you have high blood pressure isn't that*
2. *Patient: yes*
3. *Doctor: oka:y ok i'm happy that i see some voice coming back now giving me feedback saying that it was useful for you*
4. *Patient: mm*
5. *Doctor: ok so:: now you know what is the limit for your: blood pressure=*
6. *Patient: mm*
7. *Doctor: = after that speech isn't it=*
8. *Patient: ye::s*
9. *Doctor: = so: can you tell me what is that limit*
10. *Patient: that limit was er::!-*
11. *Doctor: what is the!- should it be:: less than(.) 1 er:: 140(.) over >190<(.) you remember i gave you [i gave you some] papers huh*
12. *Patient:*
    [you give] that paper
13. *Doctor: you can go and check that paper again huh ? <u>your</u> blood pressure? the reason i'm explaining to you because <u>see</u> (.) your blood pressure is!- just give me a draft (.) please(.) <u>your</u> blood pressure as i explain:ned that da[y]should be less than one: [for:]::TY over 90 see*
14. *Patient: [yes] [140](0.4) mm*
15. *Doctor: we hav::: we record it like that every person has two: blood pressure*
16. *Patient: mm*
17. *Doctor: NO matter what is we don't want to go through the (days) it doesn't matter but just to know that you have two blood pressure all of us (.) and if you look here they write it like that 140 [over 90]*
18. *Patient:*
    [over 90]
19. *Doctor: or 140 slash 90*
20. *Patient: 90 mm*
21. *Doctor: ok S::O YOur blood pressure must be less than this (.) it means the top one mus:::tn't reach 140*
22. *Patient: ok*
23. *Doctor: and the loWER one rea[ch 9]0*
24. *Patient: [90]*
25. *Doctor: must be leSS*
26. *Patient: oh i see*
27. *Doctor: is exactly what they have written in th[at](.) paper that we distributed to the audience that day*
28. *Patient: [in that] paper*

Also, in the excerpt below, the doctor claims a common ground by saying the patient was well known to him as he had consulted with him before. The doctor's claim is supported by the patient in line 57.

EXCERPT 5.5.2: JFH002M CONSULTATION

52 Doctor: He was using Paulos Masha before
53 Nurse: [Paulos Masha]!-
54 Doctor:[I'm (sensing)] [Paulos Masha]
55 Nurse: [PAULOS MASHA] ok
56 Patient: Yes:: > ↑Paulos Masha↑ <
((they all laugh))
57 Patient: e::: Paulos Masha yaa wa e tseba
57 Patient: Yes::: he knows it Paulos Masha
58 Doctor: akere you are my friend, so I know you very well
58 Doctor: You are my friend right (.) so I know you very well

Local way of speaking and speaking the local language

Examples of doctors speaking the English language like the locals and learning the local language has already been given in the section on the communication strategies and comments will only be made here in reference to their use as positive politeness strategy. Claiming common ground in conversation may be achieved by using the native dialect which according to Enfield (2006:401), is judged to be a "reliable indicator of long years of common social and cultural experience." Hence, when doctors use such words as "gonna", "wanna" and "neh" or speak the local language they are making a statement that they belong or are willing to integrate into the community they serve.

Humour

Humour when used appropriately during consultations can help to build a cordial relationship between the doctor and patient, (Squier, 1995). The doctor through the use of humour reinforces the instruction that the patient was to avoid certain types of drinks.

EXCERPT 5.5.3: JFH002M CONSULTATION

60 Doctor: good (.) no cold drink, no beer, no whiskey neh
Doctor: good (.) no cold drink, no beer, no whiskey ok
61 Patient: no nna ga ke dire dilo tseo
Patient: no I don't do those things
62 Doctor: ((laughs)) papa are you a pastor or are you priest
63 Interpreter: bare le moruti
Interpreter: he is saying are you a priest
64 Patient: aowa ga se nna moruti

Patient: no I am not a priest
65 Doctor: ((laughs))

The use of “we”

During consultations involving the use of an interpreter, the doctors often use the inclusive pronoun, “we” to refer to himself and the nurse interpreting as a team. The use of the inclusive pronoun gives the nurse a sense of belonging to the team and creates the need to contribute positively to the success of the consultation. A breakdown of communication is not considered a failure of the foreign doctor but also of the nurse who does the interpreting.

5.6.2 Negative politeness

The use of hedges

The doctor used hedges in communicating information and directives to the patients. These are used often by the doctors as an attempt to reduce the seriousness of a procedure or ailment. For example, in the excerpt below, the doctor informed the patient in line 3 that he was looking for “just” a few things and noted that the kidney was “still working well” in line 5. Also in line 8, he said the blood result was still acceptable without informing the patient what constituted an acceptable level.

EXCERPT 5.5.4: CNP001F CONSULTATION

01 Doctor: now have you got the results
02 Patient: the results yes (they’re fine)
03 Doctor: (0.9) () it’s jus:t (.) few things we are looking at hey
04 Patient: okay
05 Doctor: like the:: lab resulTS to see whether you: (.) your kidney is still working well
06 Doctor: it is [still working!-] it is fine
07 Patient: [it is fine] (0.3) oka:y
08 Doctor: an:d your:: blood results(.) the (hp) is still acceptable
08 Patient: okay

The excerpt below shows the doctor allaying the fear expressed by the patient in line 71 by down-playing the medical test as “just a screening”

EXCERPT 5.5.5: LTC 001P2 CONSULTATION

71. *Patient: ((laugh)) what i' m scared of is this operations i don't want to [hear about it]*
72. *Doctor: [no no no] operation it's just a screening the x-ray shows your heart is fine or not that's all we want to know okay*
73. *Patient: yes*

5.6 FORMS OF ADDRESS

Forms of address, as noted in chapter two, play an integral part in communication and set the tone for the rest of the consultation. The form of address is usually introduced at the beginning of interaction and creates a sense of rapport (Brown, Crawford and Carter, 2006). A patient may respond negatively or positively to a doctor based on form of address. A wrong form of address is considered disrespectful and rude. In the consultations analysed, majority of the doctors tried to use appropriate forms of address for both nurses and patients. This is an indication of convergence on the part of the doctors as they used culturally appropriate addresses.

The nurses were never at any time during the consultations addressed by their first names. They were referred to as "Sister" or "Nurse" on rare occasions irrespective of their professional rankings signifying a respect for gender and professionals. The doctor used forms of address that showed a willingness to integrate culturally by using appropriate cultural address for the patient. For example, the elderly patients were often addressed as "Mama" or "Papa", according to the gender.

EXCERPT 5.7.1:JFH001F CONSULTATION

02 Doctor: What is the problem today mama

EXCERPT 5.7.2: SH002 (M1) CONSULTATION

32 Doctor: re gona PApa↓
32 Doctor: we are fine PApa↓
33 Patient: okay↓
34 Doctor: no complain Baba::

Middle aged female patients were addressed by their marital status that is “Mrs” and their male counterparts “Mr”, while the younger ones were addressed by their first names or “Sesi” (Sister) or “Buti” (Brother).

EXCERPT 5.7.3: LTC001F CONSULTATION

1. *Doctor: okay:: er:::: mrs:: moDOU.*
2. *Patient: modau*
3. *Doctor moDOU*
4. *Patient: mm*

EXCERPT 5.7.4: JFH002M CONSULTATION

10 Doctor: let me ask papa what is wrong with him
11 Interpreter: bare bothata ba lena ke eng papa
11 Interpreter: he is asking what is your problem papa

EXCERPT 5.7.5: CNP002M1 CONSULTATION

5. Doctor: you are rodney
6. Patient: yes:

EXCERPT 5.7.6: VVH001F2 CONSULTATION

1. *Doctor: SE:si WHat’s wrong*
   Doctor: SI:ster WHat’s wrong.

In some cases, the doctors did not use any of the forms of address discussed above but simply called “patient” and referred to her in the third person “she” as shown in the excerpt below.

EXCERPT 5.7.7: ELM001F CONSULTATION

1. *Doctor: ok are just gonna() how are you*
2. *Patient: ndi hone ndi humbela upfa haningeo*
3. *Patient: I am fine thank you how are you*
4. *Doctor: [eeeh] sister what is wrong with the patient*
5. *Nurse: vhari: vha khou vhavhudzisa uri hu khou itea mini vho dokotela*
6. *Nurse: the doctor is asking what is wrong*
7. *Patient: oh right ndi khou di dela zwezwi zwa maduvha thoho ndi yone ino ita I tshi pina pina*
8. *Patient: oh right am here for the usual, the headache is the one which troubles me*
9. *Nurse: headache and she is asking for(.)*
10. *Doctor: ok: she is is taking treatment for hypertension every month and today she is complaining about the headache and then is there any other complaint*

The doctor greeted the patient in the English language as she enters the consulting room. The patient replied in the local language indicating to the doctor that an interpreter was needed. In line 4, the doctor offered no reply to the patient's greetings but spoke to the nurse to find out what was wrong with the patient. This type of address was found in cases where the patient was young or middle aged and spoke the local language thus requiring an interpreter. This suggests that consultations were likely to become impersonal as the doctor spoke to the nurses and not the patients. It also suggests that the doctors were not favourably disposed to the use of the local language by younger patients.

5.8 INFLUENCE OF GENDER ON COMMUNICATION

The question sought to explore if gender had a bearing on the use of communication strategies during consultations between English-speaking foreign medical doctors, patients and interpreters. The time used in consultations was measured for all analysed consultations and examined according to the gender of the patients.

The tables below show the length of time used for each consultation.

Table 5.1: Table showing time used by males during consultations

Number	Time used	Type of consultation	Location	Gender of doctor
EH001M	1.14	Monolingual	Urban	Male
SH001M	1.48	Monolingual	Urban	Male
MGH001M	1.49	Interpreted	Rural	Male
ELM001M	3.10	Interpreted	Rural	
CNP002P2 (Accompanied by male relative)	3.22	Semi-interpreted	Rural	Male
JFH001M	3.56	Semi-interpreted	Rural	Male
RC003M (Accompanied by male relative)	4.31	Monolingual	Urban	Female
JFH002M	5.26	Interpreted	Rural	Male

CNP002M	6.08	Monolingual	Rural	Male
RC002M	7.02	Semi-interpreted	Urban	Male
VVH002M	9.9	Interpreted	Urban	Male
MKH002M (Accompanied by female relative)	30.1	Semi-interpreted	Urban	Female

Table 5.2: Table showing time used by females during consultations

Number	Number of minutes	Type of consultation	Location	Gender of doctor
ELM001F	1.38	Interpreted	Rural	Male
SH002F	2.26	Interpreted	Urban	Male
RC001F	2.56	Interpreted	Urban	Male
MGH001F	2.58	Interpreted	Rural	Male
SH002F	3.12	Interpreted	Urban	Male
MKP001F2	3.23	Monolingual	Urban	Female
JFH002F	3.25	Interpreted	Rural	Male
ELM002F	3.42	Interpreted	Urban	Male
MGH001F	4.01	Interpreted	Urban	Male
MKP001F	4.25	Interpreted	Urban	Male
VVH001F	5.07	Interpreted	Urban	Male
SH001F	6.48	Monolingual	Urban	Male
EH001F	6.55	Monolingual	Urban	Male
LTC002F2	7.3	Monolingual	Urban	Male
VVH002F	7.35	Semi-interpreted	Urban	Male
LTC001F	9.45	Monolingual	Urban	Male
LTC002F	9.59	Interpreted	Urban	Male
CNP001F	10	Monolingual	Rural	Male
VVH001F	10.02	Interpreted	Urban	Male
JFH001F	12.13	Interpreted	Rural	Male
JFH001F	13.31	Monolingual	Urban	Male
RC002F	15.50	Monolingual	Urban	Male
RC003F	28.50	Semi-interpreted	Urban	Female

The following points were noted based on the use of time during consultation.

The shortest time spent by a male patient in consultation was 1.14 minutes, while it was 1.38 minutes for the female. Both patients consulted with male doctors. The longest time spent by a male patient was 30.01 minutes while it was 28.50 minutes for the female patient. Both patients were attended to by female doctors. The male patient was accompanied by a female, that is, his daughter. Thus, it is concluded that females spend more time with doctors than males. The time is extended if the doctor is a female and the patient is accompanied by a female relative.

A number of reasons may be as to why females spend more time in consultation than men:

a. Females ask more questions than males and subsequently the doctors often have to the use the communication strategy of explanation more with them.
b. Female patients were also noted to engage more in side conversations with the nurses resulting in more time spent in the consultation rooms.
c. It may also be argued that the female doctors are more detailed in speaking with and examining the patients, resulting in more time spent with each patient.

From tables 5.1 and 5.2, it was also noted that more women than men needed to have the consultation fully translated. 13 women accounting for 57% of the women spoke the local language and had fully translated consultations. This is in contrast to the 4 men (34%) who had fully translated consultations.

5.9 OBSERVATION

The observation table presented below speaks for itself. However, a few points are highlighted below.

a. None of the three female doctors observed had nurses to interpret for them. In two instances when they called for nurses, the nurses responded reluctantly and in one case held on to the door suggesting she was in a hurry to leave. While this phenomenon may be attributed to shortage of nursing

staff, it may also be considered a gender issue as such was not observed happening with the male doctors.

b. The role of the nurses in the communication process during consultation is also seen in their physical positioning in the consulting rooms. They were often positioned between the doctor and the patients and act as a link between the two by interpreting what one party says to the other.

c. Some doctors exhibited signs of physical fatigue during the consultations and appeared detached from the patient and interpreter as they concentrated more on note taking than the patient. However, most doctors tried to focus on the patient by maintaining eye contact with them.

d. The body language of the patients who spoke the local languages showed that they felt more comfortable with the nurses. They often leaned towards and looked more often at the nurse. The doctors tried to keep eye contact with the patient. It was, however, noticed that most concentrated on the case notes and often left the nurses and patients conversing while they read and wrote in the case notes and asked occasional questions. This was, however different when the doctor understood a little of the local language or the consultation was in English language.

Table 5.3 Observation of participants during consultations

CODE	DOCTOR	PATIENT	NURSE	COMMENTS
ELM001 F (P1) **1**	The doctor made eye contact with patient once in a while, more with the nurse Very expressive face. His face showed confusion and deep thought.	Patient came along with a younger person possibly her daughter who did most of the talking. The patients nods and gives sounds of affirmations as the younger person speaks. The patient sits while the daughter stands behind her.	The nurse sat between the doctor and the patient and her daughter. She leaned towards and faced the patient often	The patient seemed more comfortable with the nurse perhaps due to the fact that they spoke the same language
LTH001 (P1) **2**	The doctor was relaxed. He examined the patient's legs and chest	Nodded, kept eye contact with doctor, smiled when greeting and when doctor explains x-ray, sat relaxed with hands on doctor's table, points to areas of pain	No need for an interpreter as the consultation was in English	Both patient and doctor were relaxed as they conversed.
LTH 001 (P2) **3**	He maintains eye contact and smiled when speaking with patient. Makes sounds of affirmation, touched patient to examine chest	Listened intently, used hand gesticulations, frowns when given unpleasant report, Repeats doctor's instructions, completes the doctors sentences	No need for an interpreter as the consultation was in English	The doctor was relaxed and appeared confident during the consultation
LTH002 **4**	Greeted the patient, educates the patient about the illness. The doctor was relaxed and tried to focus on the patient	Completed sentences for doctor. She looked down when the doctor explained the dangers of not taking her medication.	No need for an interpreter as the consultation was in English	There is no need for interpretation as patient speaks English. The doctor is able to educate the patient when patient speaks English
LTH002 P2 **5**	Doctor did a lot of writing, Nonverbal signs to indicate bad smell. Hand gesticulations Relaxed sitting position, smiles	The patient appeared uneasy as she was questioned by the nurse and doctor. She fidgeted and looked down a lot.	The nurse appeared agitated at a point when questioning the patient.	More eye contact between nurse and patient.

CNP001 (P1) **6**	Maintained eye contact with patient, speaks more with the nurse.	Tried to keep eye contact with doctor, fidgeting-touching her stomach and left underarm	Did not maintain eye contact. Moved a lot, rocked back and forth playing with her hands, looked down a lot and answered most questions	Nurse asks patient questions to ensure understanding
CNP002 (P1)**7**	Maintained eye contact, relaxed sitting posture	A shy smile, laughed at jokes. Uncle did most of the talking.	The nurse turned when speaking to patient to make eye contact.	Patient was there with uncle. Consultation took place in the emergency room
CNP 002 (P2) **8**	Mostly maintained eye contact, made jokes and examined the patient	Shy, unstable eye contact, laughed at jokes. Touched himself a lot to demonstrate where the pain was, ridged sitting position, looked away a lot, placed hand on face as if to hide	The nurse stood beside the doctor's table and was relaxed as she interpreted	Consultation was in the emergence room
RH001 (P1) **9**	Mostly maintained eye contact with patient. Closed door to ensure privacy, helped patient get on the bed for examination	Patient appear confused about how to lie on examination couch, does not speak English at all. The son was relaxed	No nurse to interpret due to staff shortage (as explained by doctor)	Patient was there with son. There was no nurse to interpret, the son did, but this caused a struggle in communication between him and the doctor.
RH003 (P1) **10**	Maintained eye contact, kept a smile on his face and joked with patient	Touch the site of pain, frowned as she struggled to understand what the doctor was saying. Sat quite stiffly and move only to show doctor the area of pain	No nurse to interpret due to staff shortage (as explained by doctor)	The doctor was not disturbed by lack of effective communication with the patient.
RH002 (P1) **11**	Did not maintain eye contact, but looked more at his notes even when asking the patient questions	Fidgeted a little, asked the doctor a lot of questions about the accident claim and asked the observer to help interpret as he struggled to	No nurse to interpret	The doctor did not seem disturbed that communication with the patient was

		understand the doctor. Patient needed letter to SASSA		difficult.
RH002 (P2) **12**	Maintained eye contact and nods as he listened to patient. A lot of hand gesticulations. Moves close to the patient as if to reassure her that she is alright, moves back to the table to write notes and prescription thumbs-up as she explains medication to patient. Examined patient on couch. She leaves consultation room to call a nurse to interpret as patient could not understand her.	Rigid sitting position, sometimes nodded as doctor spoke. A look of confusion and anxiety.	The nurse acted like she did not want to be there, she was in a hurry to leave and left before the end of the consultation. She interpreted holding on to the door.	A nurse was called by the doctor to help interpret when it became impossible to communicate with patient
RH003 (P1) **13**	Maintained eye contact with patient as they struggled to communicate	The patient struggled to understand the doctor. He making sounds which indicated he did not understand what the doctor was saying. He looked confused.	No nurse to interpret due to staff shortage (as explained by doctor)	The observer had to intervene by helping to interpret as the patient and doctor could not communicate and there was no interpreter
MKH001 (P1) **14**	Tried to maintain eye contact wherever she speaks with the patient; off and on at the beginning of consultation but stable towards the end	Fidgeted a bit; played with earrings and folded arms and legs	No nurse interpret	The patient did not appear to fully understand what the doctor said but she kept on making sounds to express agreement. The consultation was very brief.

MKH001 (P2) **15**	The doctor appeared to be in a hurry but was relaxed as she made the rounds	Frowned in confusion as she could not understand what the doctor was saying, another patient helped to explain to the patient in the local language. Seemed more relaxed when the nurse came to interpret	The nurse was called to interpret. She stood next to the doctor but seemed in a hurry to go back to the nurses' station	Observation took place in the ward as the doctor did the rounds
MKH002 M **16**	The doctor did not appear to be in a hurry as she asked a lot of questions and educated the patient	The patient was accompanied by his daughter who did most of the talking	There was no need for an interpreter.	This was the longest consultation recorded
VVH001 (P1) **17**	Had hand on his face, looked down as he spoke	Touched the area of pain	Nurse with broken legs, using clutches. Made eye contact with doctor and patient, relaxed	There was smiles and laughter
VV001 (P2) **18**	Talked sometimes with fingers in the mouth, changed sitting positions a lot, joked with patient and nurse	Quiet, often nodded to answer questions, sat still	Frowned sometimes perhaps when she does not understand what the doctor said.	Nurse continues speaking even when the doctor did not say anything.
VVH002 (P1) **19**	Infrequent eye contact, concentration more on notes Doctor looks visibly tired. He was called to the emergency room and quickly rounds up with patient.	Nodded as she answered the doctor's questions, smiled, relaxed, a lot of body and hand gesticulations	No need for interpreter as consultation was in English	Patient speaks English, but spoke the local language with the nurse until the doctor spoke English.
VVH002 (P2) **20**	Mostly focused on writing notes and lifted up his head only to ask questions.	Fidgety, touched the areas of pain.	Maintained eye contact with patient.	It appears the doctors were more verbally active with females than males
SH001 (P1) **21**	Maintained eye contact,	Often appeared confused as she listened to the doctor	No need for interpretation as consultation was in English language	The consultation would have been easier if there had been an

				interpreter.
SH001 (P2) **22**	Frowned as he tried to communicate with patient. He used gesticulations	Frowned as he struggled to speak English and understand what the doctor was saying. Gesticulations	No need for interpretation as consultation was in English language	The consultation would have been easier if there had been an interpreter.
SH002 (P1) **23**	The doctor tried to speak the local language. He appeared relaxed as he consulted the patient	The patient was relaxed as he answered questions	The nurse maintained eye contact with whoever she was speaking with	The doctor's effort to speak the local language seemed to put the patient at ease.
SH002 (P2) **24**	Relaxed, a lot of hand gesticulations maintained eye contact	Maintained eye contact with the doctor and appeared at ease.	No interpretation needed	Patient spoke English so there was no need for an interpreter.
ELM001 (P1) **25**	No eye contact. Busy with notes, very business-like; no similes or jokes. Little eye contact Nods as nurse interprets	A lot of frowning as he struggled to communicate in English language. Sat rigidly and fidgets. The patient spoke little English and sought clarification from the nurse when he does not understand	A lot of conversation between the nurse and the patient	Sitting arrangement does not facilitate effective communication. The doctor appeared detached from the nurse and patient as he sat at the farthest part of the room and rarely looked up.
MH001 (P2) **26**	The doctor seemed remote from the patient and nurse. There was no eye contact, smiles or jokes. His concentration was on note taking.	The patient was either very old or very sick and was accompanied by the daughter. The Patient's escort speaks for the patient. Bends towards the nurse, speaks very quietly sometimes, leans, bends down to speak with the nurse. Cries	The nurse spoke more with the patient. The nurse stood between the doctor and the patient's daughter.	Patient (in a wheelchair) came with his daughter. The wheelchair could not be moved into the consulting room as there was no space. Only the daughter came into the consulting room while

				the patient's wheel chair was positioned at the door.
MH002 (P1) **27**	Focused on papers, glances once in a while at the patient. The doctor hardly moved in his seat. He occasionally lifted his head from his notes to look at	Confused look as doctor spoke, looked to the nurse for help	The nurse was ill at ease. She was fidgety; playing with hand and legs.	The doctor showed signs of tiredness. There seemed to be no rapport between the nurse and the doctor.
MH002 (P2) **28**	Stern business-like face, little eye contact	Appeared confused by some of the questions, relaxed when the topic was unrelated to medical issues.	Seem not to concentrate on interpreting, struggled with getting the right words in English	There was lack of rapport between the doctor and the nurse
EH001 (P1) **29**	Maintained eye contact, relaxed	Eye contact	No need for an interpreter as the consultation was in English language	The patient was white and spoke English
ELM001 (P2) **30**	Started off with eye contact but improved as time went on, relaxed and ensured that he understood what the patient was saying and was understood as well.	Patient was relaxed and alternated focus on doctor and nurse.	The nurse was seated such that she could see both the doctor and patient. She was relaxed and cheerful.	The conversation became easier as the doctor relaxed.
EH001 (3) **31**	Maintained eye contact, smiles, touched knee to examine it. Joked with the patient.	Relaxed, joked with the doctor	No interpreter	The doctor appeared more relaxed than doctors who used interpreters.
JFH001 (P1) **32**	Focused on the patient as he spoke	Nodded when questioned by nurse, smiles when the doctor was explaining, and also maintained eye contact.	Stood between the doctor and the patient. She tried to face whoever she was addressing	The doctor understood a little Sepedi and tried to understand the patient even before the nurse interpreted.
JFH001	Looked more at the nurse	Smiled when doctor said	The nurse engaged in	Most conversation was

(P2) **33**	and not the patient, eye contacts were few and far apart, Frowned as patient lists symptoms in Sepedi	something he understood, relaxed and gesticulated, maintained eye contact, frowned when he did not understand	conversation with the patient while the doctor made notes in the case file.	between nurse and patient. It appeared as if the doctor was not in charge of the consultation
JFH002 (P1) **34**	Starts with good eye contact but later concentrates on note taking. Relaxed writing posture, jokes and laughs	More eye contact with the nurse, smiles, gesticulates does not seem to understand when the doctor speaks Sepedi, nod to indicate understanding	The nurse interacted a lot with the patient while the doctor wrote in the case file.	The doctor directs his questions to the nurse
JFH002 (P2) **35**	Mostly concentrated on note taking, sounds of affirmations when asking if patient understands instructions, relaxed	The patient was relaxed but looked more to the nurse even when the doctor tried to speak the local language.	The nurse was relaxed and conversed a lot with the patient while doctor made notes in the case file	The doctor communicated directly with the patient as he speaks some Sepedi and only called on the nurse to help when he encounters problem – when the patient did not seem to understand him.

CHAPTER SIX

SUMMARY, DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents the summary and discussions of findings based on the results of the analysis of data from the three tools used in data collection as presented in the last two chapters. The study adopted a qualitative approach using a triangulation of tools as well as participants. The tools of semi-structured interviews, observation and recording of actual consultations were used to collect data from doctors, patients and nurses. Ten hospitals; two from each of the five districts in the Limpopo province were visited. In total, thirty-five consultations were analysed, 18 doctors, 13 nurses and 35 patients were interviewed.

The summary and discussions of the findings are presented below in a tabular form with each summary followed by a discussion. Recommendations are made based on the findings from the study.

6.2 SUMMARY AND DISCUSSION OF FINDINGS

Table 6.1: Summary and discussion of turn-taking and pauses

Focus	Summary of findings
Turn-taking and use of pauses in consultations between English-speaking foreign medical doctors, patients and interpreters	a. Monolingual consultations Monolingual consultations in English language Monolingual consultations in local languages b. Interpreted consultations Fully interpreted consultations Semi-interpreted consultations Un-interpreted bilingual consultations Extended turns Un-interpreted turns Ignored turns c. Pauses
Discussions	

Monolingual consultations occur either in the local languages or English. This study did not find any consultation that was totally monolingual in any local language rather, there were monolingual exchanges usually at the beginning, helping to set the tone for the consultation and creating a rapport between the patient and the doctor. Monolingual turn-taking in English is, however, not very productive as the doctor is all too pleased to have the consultation in English language and ignoring the signs of limited comprehension by the patient. In such cases, the doctor does most of the talking and accepts the monosyllabic answers of the patient as sufficient for the interaction.

Interpreted consultations involve three participants with the interpreter acting as a link between the doctors and patients. In this study there were cases where the interpreter was bypassed and there was direct communication between the doctor and the nurse. This type of semi-interpreted consultation was also identified by Li (2011). This occured under two circumstances namely, when the patient understood English or when the doctor understood the local language. In both cases, as observed in chapter five, the patient for examples responds directly to the doctor because he/she understood English but still requires the interpreter to translate for him/her as the local language was spoken. The semi-interpreted consultation has the following advantages:

a. It gives the patients the opportunity to express themselves in the language in which they are comfortable.
b. Since the patient understands the English language, it ensures that she fully understands the doctor without distortions from the interpreter.
c. It gives both the doctor and patient the opportunity to initiate repairs if there is a wrong translation by the interpreter.

The role of the nurses as interpreters needs to be properly harnessed in interpreted consultations. It is suggested that interpreting courses be included in the curriculum of the nursing schools.

Table 6.2: summary and discussion of clarification strategies Focus	Summary of findings
Communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters	Clarification strategies a. Asking patients for choice of language. b. Asking for confirmation c. Asking for patient's expectations d. Explanation e. Asking more questions f. Using examples g. Repetition
Discussion	
The fact that the doctors, nurses and patients were able to identify the strategies employed during consultations lends credence to the definition of communication strategies by Faerch and Kasper (1983) as plans that are consciously made by people to solve problems they encounter when communicating with others. The English-speaking foreign doctors are aware of the problems they encounter in consulting with patients from different linguistic backgrounds when an interpreter is used or even when the consultation is in a common second language and they consciously take steps to communicate more effectively. The focus of the interlocutors was not on speaking grammatically correct sentences in English or the local language but to ensure that the hearer understood what was said.	

Rosenberg, Kirmayer, Xenocostas, Dao and Loignoo (2007) found that the doctors they interviewed had no framework for addressing cultural differences between them and their patients; however, this study found that the doctors relied on the nurses who interpreted for them as cultural brokers to explain the cultural beliefs of the patients to them supporting the view that the role of the interpreter is not only language related but also as mediators of " historical, cultural, linguistic disease barriers" (Penn & Watermeyer, 2012:397).

They also explored navigating the different cultural and linguistic terrain they work in by learning the local language. As indicated in chapter four, the doctors believe that this made it easier for them to communicate better with the patients. However, a framework needs to be developed centrally at the national and provincial levels to prepare the foreign doctors for the cultural and linguistic differences they will encounter. Learning a language does not automatically make you aware of the cultural implication of words spoken. It is suggested that the doctors on initial assumption of duty in the South African health sector and in cases of relocation from one linguistic and cultural area to another, be given at least a week of cultural and linguistic orientation. Luddicoat (2004), stressed that it is necessary to engage with the culture when learning a language to understand its cultural context.

Doctors using clarification strategies allow patients to state their preference of language, understanding of illness or disease and their expectations from the doctor. Giving patients the opportunity to vocalise their understanding of their problems and expectations gives the doctor an opportunity to establish what the patient actually wants. Macdonald (2004), cautioned that doctors should be aware that they do not fully understand their patient's conceptualization of their problems and should therefore provide patients with the opportunity to tell their own stories in their own words.

The need to explain, repeat, ask more questions and using examples cannot be over emphasised in medical communications, more so in an intercultural setting. Doctors, due to differences in pronunciation of some words, often need to repeat or ask patients and interpreters to repeat what they said. These strategies ensure that the patients do understand the doctor's questions and treatment plan. Labhardt, Schiess, Manga and Langewitz (2009) reported that patients remember their diagnosis when they are clearly stated during consultation.

An impetus to follow a treatment plan is an understanding of the illness, thus patients are more likely to comply with treatment and medication when they are clearly explained to them. These strategies move the consultations from a purely paternalistic pattern towards a more patient-oriented consultation. Giving the patient a voice in the consultation room by allowing them to tell their story in their language of choice instead of dishing out “medical treatment without communication” (Deumert, 2010) by concentrating on case files, is indeed a step in the right direction.

Table 6.3: Summary and discussions of continuation strategies

Focus	Summary of findings
Communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters	Continuation Strategies a. Asking nurses for interpretation b. Assuring the patient c. Repetition d. Asking for help e. Nonverbal communication
Discussion	

These strategies are used to ensure that a total breakdown does not occur during consultations. The main strategy used here is calling for an interpreter. The strategy has many problems as has been investigated by several researchers. However, this study moves beyond identifying the problem inherent in the communication process to identifying ways of solving the problems encountered in both monolingual and interpreted consultations. The doctor asks the nurse to interpret when he notices that a lot of un-interpreted conversation had occurred between the interpreting nurse and patient, assures the patient that they are there to help.

The patients were not worried that the doctor did not speak the local language provided there was a nurse to interpret. This emphasises the vital role nurses play in the communication process. However, these nurses do not receive any form of training in interpretation; a fact that could possibly account for the problems they encounter in interpretation. There are major concerns about the interpretations done by the nurses especially in the cases of extended turns, un-interpreted and ignored turns during consultations as well as trying to prescribe medication for the patient. The turns that are either ignored or not interpreted may be crucial in aiding the doctor make a diagnosis and recommend appropriate treatment. Mishler (1984) is of the view that discussions about the “lifeworld” during consultations may increase the patient’s level of satisfaction with the consultation.

The study found that most doctors tried to maintain eye contact with patients as a means of achieving better communication with them. Eid and Diener (2001) also reported the use of eye contact by foreign doctors as a means of compensating for linguistic inadequacies. The patients perceived the doctors to be more attentive to them when they maintained eye contact.

Repetition was also found to be used by doctors with both patients and interpreters. This was also identified by Ellis (2004) and Jain and Keiger (2011) by doctors in South Africa and the United States respectively. The use of repetition requires patience from both the speaker and the hearer. The doctor needs to be patient and persist along a line of questioning until the answer sought is received indicating that it was understood; and the patient and interpreter must not see the repetition from the doctor as a negative sign of inattentiveness.

Table 6.4: Summary and discussion of convergence strategies

Focus	Summary of findings
Communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters	Convergence strategies a. Learning and speaking the local language b. Local way of speaking c. Use of time d. Doctor's behaviour
Discussion	

The doctors were found to use convergence strategies by learning and speaking the local language, being friendly with the patients and giving the patients enough time to express themselves during consultations. Most of the doctors took pride in learning and speaking the local language of where they practiced and noted that it made consultation easier for them and the patients. However, the success of this strategy is questionable from reports of mistakes made by doctors in the contextual use of local words, (Mandla.2009).

The patients identify these strategies of friendliness and patience as reasons why they like the doctors despite the linguistic problems inherent in communication. This is akin to the submissions made by Gile, Coupland and Coupland (1991) that speakers who converge are considered competent and cooperative. The foreign doctors make efforts to present themselves as likable people. This is highly commendable as reported in Chapter four; the patients highlighted the doctor's effort to pay attention to them as individuals by listening to their medical concerns instead of prescribing without listening to their complaints.

There were no cases of complementarity on the part of the patients as doctors reported that some patients who could speak English refused to use it as the medium of communication during consultations. A patient also noted that the doctors should learn the local language as they are foreigners. This tends towards a display of power by the patient and requires further investigation on its effect on the communication during consultation. However, most patients were appreciative of the services rendered by the foreign doctors. The fact that there were only cases of convergence on the part of the foreign doctors and not complementarity strategies suggested that a third culture may not be easily developed in South Africa as its development requires active participation of all involved.

The patients identified the fact that the doctors' use of time with them in consultation was a crucial factor for their sense of satisfaction with the foreign doctors. They noted that the doctors spent time to explain their sickness and treatment to them. Findings from research on use of time and patients' satisfaction have changed over the years. Morrell, Evans, Morris and Roland (1986) reported no difference in the levels of satisfaction between patients who spent five minutes and above in consultation with doctor and those whose spent less, while Puri, Gupta, Aggarwal and Kaushal (2012) report that patients who spent 12.4 minutes and above in consultation with the doctor were

more satisfied than patients who spent 8.5 minutes or less. Although the patients in this study indicated that the doctor's use of time was a factor for satisfaction, the time used in consultation did not indicate this. Patients who spent little time as well as those who spent a long time indicated their satisfaction with consultation. This study therefore concludes that the communication between the doctor and patient is responsible for the sense of satisfaction. This is consistent with the findings by Gross, Zyzanski and Borawski (1998) that patients feel a sense of satisfaction and feel that enough time has been spent with them if the doctor engages them in conversations about everyday topics like the weather or jokes with them. These strategies were used by the foreign doctors and may account for the sense of satisfaction felt by the patients despite the short time spent in consultation. More research is needed in this area of the use of time, communication and patients' satisfactions.

Table 6.5: Summary and discussion of knowledge strategy

Focus	Summary of findings
Communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters	Knowledge strategy a. Display of medical knowledge and expertise
Discussion	
Patients identified the display of medical knowledge as a factor facilitating communication with the foreign doctors. The doctors achieved this despite the fact that they did not use difficult medical terminology during consultations with the patients. Patients' symptoms and treatment plans were explained in such a way that the patients understood. The fact that the doctor was able to identify the patient's illness, prescribe treatment that proved effective ensured that the patient was more willing to listen to the doctor and comply with future treatment. A study by Wang, Adams, Pasick, Gomez, Allen, Ma, Lee and Huang (2013) among Chinese-Americans and non-Hispanic white women substantiated this fact by showing that the medical knowledge that the doctors had about their condition and treatment proved more important than other factors.	

Table 6.6: Summary and discussion of avoidance strategy

Focus	Summary of findings
Communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters	Avoidance strategies a. Patient selection b. Refer patient to colleague c. Ask patient to bring an interpreter d. Avoid conversations about the “lifeworld”
Discussion	
The English-speaking foreign medical doctors employed avoidance strategies in various ways when it became obvious to them that communication with the patients could not continue at that present time. Thus, they selected patients based on their ability to communicate with them in the English language, refer patients to colleagues who speak the local language or ask the patient to bring an interpreter. These three strategies are used when there is no interpreter available. These strategies pose as barriers to access for patients who are unable to speak English. A fact also noted by Deumert (2010) when she noted that patients unable or uncomfortable when using the doctor’s language are likely to access healthcare irregularly and only come to the hospitals at an advanced stage of their illness. One of the tasks in the seven key communication tasks advocated by Makoul (2001) is listening and exploring the patient’s views about family, gender and spirituality. Thus, when the doctor avoids listening or interacting with the patient on this level, a major communication task is left uncompleted. It is possible for the doctor to communicate with patients with minimal response from the patient when close ended questions are asked. Communication becomes more difficult when the discussion necessitates sentences and may be a reason why the doctors avoid such discussions with the patients.	

Table 6.7: Summary and discussions of politeness strategies

Focus	Summary of findings
The politeness strategies used in medical interactions between English-speaking foreign medical doctors, patients and interpreters	Politeness strategies a. Bald on record b. Positive strategies Reference to prior meeting Local way of speaking Use of humour Use of “we” c. Negative strategies Use of hedges Forms of address
Discussion	

The study identified that the doctors used three main types of politeness strategies during consultations namely bald on record, positive and negative strategies. They used bald on record strategy when drawing the attention of their patients to the dangers of their lifestyles and non-compliance with treatments. Agledahl, Gulbransen, Forde and Wifstad (2011), noted that the doctors cannot be accused of being impolite but that they use their courteous behaviour towards patients as a cover-up for their indifference and lack of interest in the patients. This fact was also found in this study as some doctors though very polite with the patient were not interested in discussing issues beyond the medical realm. Hence, doctors were quite professional in their dealings with the patients.

Sometimes, speakers of a second language adopt the culture of the language. This did not happen with the foreign medical doctors as they used appropriate forms of address for their patients. Elderly patients were not called by their names; rather all patients were given suitable forms of address. The doctors were aware of the cultural values of the communities where they worked and reflected this in the politeness strategies they employed. This, according to Iragiliati (2006), was crucial to the success of consultations.

The study noted that the doctors were very polite in their dealings with patients and interpreters using mainly positive and negative strategies. They were quick to claim common grounds with patients, agree and smile and offer encouragements. In cases where the bald on record strategy was used, this was often softened by the use of hedges, pauses and hesitations. This is in contrast to findings by Yin, Hsu, Kuo and Huang (2012) and Zibande and Pamukoglu (2013) who reported that doctors used mainly bald on record strategies in communicating with patients. The reason for the difference is likely to be the fact that the doctors in this study are foreign medical doctors. It would be worthwhile to investigate the use of politeness strategies by foreign and native born doctors as well as the strategies used by patients in consultations with each group. Politeness theory proposes that the issues of power, social distance and degree of imposition will determine how polite a speaker is (Brown and Levinson, 1987). It is possible that the doctors used very polite strategies more often because they are foreigners, usually economic migrants who despite the high level of training feel powerless in a different country.

Table 6.8: Summary and discussion of influence of gender on communication

Focus	Summary of findings
Gender influence on the use of communication strategies in medical interactions between English-speaking foreign medical doctors, patients and interpreters	Gender does influence the choice of strategies used by doctors in some cases

Discussion

During the interviews with the doctors, most were of the opinion that gender was not a factor in their communication with patients. However, some highlighted communication differences they had noticed between male and female patients. The study found that though gender was not actively considered by doctors as a factor to be considered in the choice of strategies used during consultations, it, however, impacted on the communication during consultation. This is consistent with findings from Gabbard-Alley (1995), Bischoff, Hudelson, and Bovier (2008) and Sandhu, Adams, Singleton, Clark-Carter and Kidd (2009).

Examining the time spent with each patient, it was found that doctors spent more time in consultation with women and with men when accompanied by a female relative. Female doctors also spent more time with patients and were more detailed in the communication with and examination of patients. Jefferson, Bloor, Birks, Hewitt and Bland (2013), substantiating this finding found that female doctors do spend more time than with patients showing a more patient-centred consultation. They, however, raised a valid concern that the time spent by female doctors may affect the number of patients they are able to attend to. This factor is important to consider in relation with the high number of patients doctors have to see every day.

The study did not find evidence that male patients received more medical information than women or that simpler language was used with

female contrary to findings from Gabbard-Alley (1995). On the contrary, females received more information as they spent more time with the doctors and asked more questions. It was, however, found that more women spoke the local languages during consultation and used interpreters, suggesting that males were better educated than females.

Hence, gender affected the choice of language used in consultation, the length of the consultation and the amount of information given by the doctors.

Table 6.9: Summary and discussion of lapses and improvement needed in the Language practice policy Focus	Summary of findings
Improving the language policy on Health to facilitate the use of appropriate communication strategies by English-speaking foreign medical doctors and interpreters	Lapses in the policy a. Lack of focus on issue of communication between doctors and patients b. Lack of funding for interpreting services c. No specification for the training of interpreters Suggested solutions to the problems encountered in consultations a. Provision of interpreters b. Doctors to learn the local language c. Doctors to learn English language before commencing practice d. Provision of a bilingual medical dictionary/glossary e. Train nurses to interpret f. Community integration of doctors g. Linguistic posting of doctors

Discussion

A policy cannot address a problem it does not recognise. The National Department of Health language Policy as discussed in chapter two recognises the importance of providing professional interpreters in the public health sector but fails to articulate the modalities of achieving this; with its focus being on printed health messages. A major step in improving the policy is to give the provision of interpreters in hospital the needed attention it deserves.

Even though the policy acknowledges the need for people to speak in a language they are most comfortable speaking, there was no professional interpreter in any of the hospitals visited. In most cases, the nurses interpreted, in some cases relatives of the patients and yet in others, there was no one to interpret, making consultations impossible and the doctors resorting to avoidances strategies.

6.3 RECOMMENDATIONS

As a consequence of the outcome of this study, the following recommendations are made.

6.3.1 Recommendations for the English-speaking foreign medical doctors

The study concluded that doctors used many converging strategies in communicating with the patients. It is recommended that foreign medical doctors continue to use strategies that converge with the patients as they help to create a rapport with both the patient and nurses. However, it is also important for the doctors to remain in charge of the consultations and use strategies that will ensure they get the complete information from the nurses to reduce un-interpreted and ignored turns during consultations. This requires sensitivity from the doctors to recognise which should be used at different points in time. The vast use of convergence strategies suggests that the doctors feel powerless in the consultation room despite the knowledge strategy.

The qualifying examinations organised by the Health Professional Council of South Africa (HPSCA) does not include an assessment of proficiency in the English language as a separate paper or require a certificate of proficiency from other examining bodies like the United States of America, Canada and Australia. It is recommended that the doctors write an English language proficiency test before they commence practice. This will reduce the number of doctors who begin work without the needed proficiency in the English language and remove the need for the doctors to learn the English language on the job.

It is recommended that due to the diverse linguistic and cultural nature of South Africa that orientation programmes be organised for doctors employed in different provinces in relation to the language and culture of the province. This should be done alongside the provision of bilingual medical dictionaries for the doctors.

6.3.2 Recommendations for nurses as interpreters

Interpretation in medical consultation is better done by professional interpreters. However, it is evident that professional interpreters are not available in the hospitals and nurses often do the interpretation. In order to reduce the problems inherent in using ad-hoc or untrained interpreters, it is recommended that nurses are trained to interpret preferably in the Nursing school and not on the job. Language practitioners should be consulted to develop a curriculum for interpreting as part of the basic nursing training. For nurses already working, it will be beneficial to organise courses on interpreting. Nurses need to be aware that they do more than interpret but also act as cultural brokers for the doctors. Proper training will provide interpretation close to a professional level at a reduced cost. A major problem noticed is the insufficient number of nurses to help doctors interpret hence, the need to employ more nurses.

6.3.3 Recommendations for patients

The patients need to be, through the use of pamphlets and health talks by medical personnel who speak the local languages, about what to expect from the doctors. Most patients are used to the situations where interpreters are used. They, however, need to be taught strategies to use to ensure that the interpreters relate to them what the doctor says and what they say to the doctor. Strategies to be taught are those that are assertive without being offensive. Patients who understand and can speak English should be encouraged to communicate with the doctor in English.

6.3.4 Recommendations for future research

With regards to the limitations of this study, it is recommended that video recording be used as a data collecting tool for the recording of the consultations. The use of an unobstructive high-tech video camera will reduce the affectations of the participants as the presence of the researcher is removed.

This study presented a descriptive overview of the strategies employed during consultations by English-speaking foreign medical doctors with regards to the communication strategies, politeness strategies, influence of gender and the

language policy. It is recommended that each aspect be researched separately in future studies to ensure a more in-depth study.

6.4 CONCLUSION

This study aimed at identifying and describing the strategies used during consultations between English-speaking foreign medical doctors, patients and interpreters. Thus, it focused on identifying the communication strategies, politeness strategies, gender issues and the policy affecting the communication in the hospitals.

Chapter One presented the introduction and background to the study. It put the problems inherent in intercultural consultations in context and introduced issues that were discussed in the study. In Chapter Two, literatures relevant to the germane issues of this study were reviewed. The review revealed a lack of emphasis on the strategies used by foreign doctors to resolve the problems they encounter in the discharge of their duties. The review of the Language Practice Policy of the Department of Health showed a lack of commitment to the provision of interpreters in the hospitals. The theoretical and conceptual framework was also presented.

The research methodology was discussed in Chapter Three. This study adopted the qualitative research design using the research tools of audio recordings, interviews and observation to collect data from 19 doctors, 13 nurses and 35 patients in 10 hospitals in the Limpopo province. Analysis was done using the SPSS software for the participants' background information and the Nvivo to code the interviews and consultations.

The findings from the interviews were presented in Chapter Four. The participants' background information was presented in graphs and tables. Themes from the interviews showing the strategies used by the doctors as identified by the participants as well as the ways by which the communication during consultations may be improved were also presented. Chapter Five presented the findings from the analysis of the recorded consultations. The turn-taking system and use of pauses by the doctors discussed. The communication strategies, politeness strategies, gender issues and policy issues were identified.

In this last chapter, the findings were summarised and discussed. In summary the study examined the communication between English-speaking foreign medical doctors in the Limpopo province with a focus on the communication, politeness strategies, and the influence of gender on the communication process as well as the national language practice policy and concludes that the communication during consultation will be improved through the joint effort of the government, doctors, nurses as interpreters and patients.

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ANNEXURE 1

CONSENT FORM FOR PARTICIPANTS

THE COMMUNICATION STRATEGIES OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS IN THE LIMPOPO PROVINCE

Please tick the boxes if you agree

I have heard the information on the proposed study and was provided the opportunity to ask questions and was given adequate time to rethink the issue. ☐

I understand that participation in the study is completely voluntary and that I may withdraw from it at any time without supplying reasons. ☐

I agree to take part in the one-to-one interview for the study of the communication strategies of English-speaking foreign medical doctors in the Limpopo province ☐

I agree to the interviews being audio recorded and transcribed for use in the study of the communication strategies of English-speaking foreign medical doctors in the Limpopo province. I am aware that my conversation will be audio recorded. ☐

I agree to the discussions being audio recorded and transcribed for use in the study of the communication strategies of English-speaking foreign medical doctors in the Limpopo province. ☐

I understand that all information received from me with be treated with confidentiality and anonymity and cannot be traced back to me. ☐

Name: ----------

Signature: ----------

Date: ----------

Place:……

ANNEXURE 2

FOROMO YA TUMELELANO YA BAKGATHATEMA

MEKGWA YA DIPOLEDIŠANO YEO E ŠOMIŠWAGO KE DINGAKA TŠA GO TŠWA DINAGENG TŠA NTLE TŠEO DI BOLELAGO SEISIMANE PROFENSENG YA LIMPOPO.

Swaya mapokisana ge o dumela

Ke sedimošitšwe ka thuto ye go šišinywago go e dira , ke filwe le sebaka sa go botšiša dipotšišo gape ke filwe le nako yeo e lekanego go naganišiša taba ye.

Ke kwešiša gabotse gore go tšea karolo mo diphatišišong tše ke ka go ithaopa le gore nka tlogela nako efe goba efe ntle le go fa mabaka.

Ke dumela go kgatha tema mo dipoledišanong tše tša diphatišišo tša malebana le mekgwa ya dipoledišano yeo e šomišwago ke dingaka tša go tšwa dinageng tša ntle tšeo di bolelago Seisimane profenseng ya Limpopo.

Ke dumela gore dipoledišano di ka gatišwa ka segatišamantšu le go ngwalollwa gore di šomišwe diphatišišong tša malebana le mekgwa ya dipoledišano ya dingaka tša go tšwa dinageng tša ntle tšeo di bolelago Seisimane profenseng ya Limpopo. Ke a lemoga gore poledišano yaka e tlo gatišwa ka segatišamantšu.

Ke dumela gore dipoledišano di ka gatišwa ka segatišamantšu le go ngwalollwa gore di šomišwe diphatišišong tša malebana le mekgwa ya dipoledišano ya dingaka tša go tšwa dinageng tša ntle tšeo di bolelago Seisimane profenseng ya Limpopo.

Ke a kwešiša gore tshedimošo yeo e hwetšwago go nna e tla ba sephiri le gore ke tla ba hlokaina gomme e ka se amanywe le nna.

Leina: ----------

Mosaeno: ----------

Tšatšikgwedi: ----------

Lefelo: ----------

ANNEXURE 3

FOMO YO NYIKA MPFUMELELO YA LAVA VA NGA NA XIAVE

MATIRHISELO YA MBULAVULO EKA MADOKODELA YA VUTSHUNGURI LAWA YA HUMAKA EKA MATIKO MAMBE LAWA YA VULAVULAKA XINGHEZI EPHUROVHINSINI YA LIMPOPO

Vekela gwaju endzeni ka xibokisana loko u pfumela

Ndzi ya twile mahungu eka dyondzo leyi yi gangisiweka na kona ndzi nyikiwe nkarhi lowu eneleke wa ku ehleketa hi mhaka leyi. ☐

Ndzi twisisa leswaku ku va ndzi teka xiave eka dyondzo leyi i ku va ndzi hoxa xandla ntsena na kona ndzi nga ha yima ku va na xiave ndzi nga nyikanga swivangelo. ☐

Ndzi pfumela ku va ndzi teka xiave eka ku vulavurisana eka dyondzo leyi ya matirhisele ya mbulavulo eka ririmi ra Xinghezi ra madokodela ya swa vutshunguri ePhurovhinsi ya Limpopo. ☐

Ndzi pfumela leswaku ku vulavurisaniwa loku ku kandziyisiwa na ku tsariwa ehansi leswaku swi ta tirhisiwa eka dyondzo ya mbulavulo eka ririmi ra Xinghezi ra madokodela ya swa vutshunguri eka Phurovhinsi ya Limpopo. ☐

Ndzi pfumela leswaku hinkwaswo leswi swi nga ta vulavuriwa swi kandziyisiwa na ku tsariwa ehansi leswaku swi ta tirhisiwa eka dyondzo ya mbulavulo eka ririmi ra Xinghezi ra madokodela ya swa vutshunguri eka Phurovhinsi ya Limpopo. ☐

Ndza swi twisisa leswaku hinkwawo mahungu lawa ya nga ta amukeriwa ku suka eka mina ya khomiwa na ku tirhisiwa tani hi xihundla, na kona vito ra mina a ri nge tirhisiwi na leswaku mhaka leyi a yi nge vuyi eka mina. ☐

Vito: ----------

Nsayino: ----------

Siku: ----------

Ndhawu:……

Tshipida tsha 4

Ndila dza kuambele kwa madokotela a vhabvannda vha ambaho luisimane vunduni la Limpopo

Vha humbelwa uri vha ṅwale tshibogisini arali vha tshi tenda

Ndo pfa ngaha mafhungo a nḓivho ya ngudo iyi nda fhiwa na tshikhkala tsha u vhudzisa mbudziso nahone nda fhiwa tshikhala tsha u humbula nga ha mafhungo aya. ☐

Ndi a pfesesa uri ushela mulenzhe kha ngudo iyi ndi ha u tou ḓi ṋekedzela nahone ndi nga ḓi bvisa tshifhinga tshiṅwe na tshiṅwe hu sina u ṋea mbuno. ☐

Ndi a tenda u vha tshipiḓa tsha nyambedzano ri vhavhili kha ngudo ya nḓila dza kuambele kwa madokotela a vhabvannḓa vha ambaho luisimane vunduni ḽa Limpopo. ☐

Ndi a tenda uri nyambedzano i rekhodiwe na u ṅwaliwa fhasi nga murahu u itela u shumiswa kha ngudo ya nḓila dza kuambele kwa madokotela a vhabvannḓa vha ambaho luisimane vunduni ḽa Limpopo. Ndi a zwi ḓivha uri nyambedzano yanga i khou rekhodiwa. ☐

Ndi a tenda u fara nyambedzano i tshi khou rekhodiwa na u ṅwalwa fhasi ngamurahu kha ngudo ya n̰dila dza kuambele kwa madokotela a vhabvannda vha ambaho luisimane vunduni l̰a Limpopo.

Ndi a pfesesa uri mafhungo o̰the o wanalaho kha nn̰e a d̰o shumiswa lwa tshiphiri nahone ndi sa d̰ivhei hu si vhe na vhṵtumani u vhuya murahu kha nn̰e.

Dzina ……

Tshaino……..

Datumu……

Fhethu ……

ANNEXURE 5 (interview for the doctors)

COMMUNICATION STRATEGIES OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS IN LIMPOPO

The questions are designed to collect information about communication between English-speaking foreign medical doctors, nurses and the patients they attend to in the hospitals in Limpopo. The data collected will be used for research purposes only and none of the responses will be traced back to you. The confidentiality of your responses is guaranteed. Your honest answers to the questions are appreciated.

Thank you.

SECTION A

Please tick or fill in the appropriate responses as needed.

1. Gender:

Male	
Female	

2. Qualifications:----------

3. Year of graduation:----------
4. Specialization:----------
5. Country of birth:----------
6. Country of training:----------
7. Home language:----------
8. What other languages do you speak? ----------
9. How long have you been registered as a medical doctor in South Africa? ----------
10. How long have you worked in this hospital? ----------

SECTION B

1. What is your preferred way of communicating with your patients?
   (a) English language
   (b) Use an interpreter
   (c) Others (please specify)
   Please state reason for preference ----------
2. Who usually initiates the use of English language during consultation? ----------
   ----
3. Do you encounter problems in communicating with patients during consultations?----------
   ----
4. Please highlight 3 of these problems.----------

   ----
5. Have you been able to overcome some of these problems? ----------
   _____
6. How were you able to overcome the problems? ----------

   _____
7. Please describe your experience with interpreters.----------
   ----
8. Please describe your experience with male patients. ----------
   ----
9. Please describe your experience with female patients----------

10. Any other issue you may want to discuss in relation to miscommunication you encounter in consultation using the English language.----------
---

Thank you for your time.

ANNEXURE 6 (interview for the nurses as interpreters)

COMMUNICATION STRATEGIES OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS IN LIMPOPO

The questions are designed to collect information about communication between English-speaking foreign medical doctors, nurses and the patients they attend to in the hospitals in Limpopo. The data collected will be used for research purposes only and none of the responses will be traced back to you. Your honest answers to the questions are appreciated.

Thank you.

Section A

Please tick or fill in the appropriate responses as needed.

1. Gender:

Male	
Female	

3. Qualifications: ----------

4. Home language: ----------

5. Other languages spoken: ----------

6. How long have you worked in the hospital? ----------

SECTION B

1. How often are you called to perform the role of an interpreter in a day? ----------
   ----
2. Do you have any training as an interpreter? ----------
3. How proficient are you in the English language?

Very good	Good	Basic

4. Do you always understand the doctor when she/he speaks? ----------
   ----
5. If not, mention 3 problems you encounter? ----------
   ----
6. Do patients convey a dislike of being treated by foreign doctors? ----------
7. If the answer to question 6 is 'yes', please mention 3 reasons given for the dislike----
   ----

   ----
8. Are there times you find it difficult to interpret for the doctor or the patients? -------
9. If the answer to question 8 is 'yes', mention 3 of the difficulties you experienced ------
   ----

   ----
10. Please give 3 reasons for the difficulties you experienced

Thank you for your time.

ANNEXURE 7 (interview for the patients)

COMMUNICATION STRATEGIES OF ENGLISH-SPEAKING FOREIGN MEDICAL DOCTORS IN LIMPOPO

The questions are designed to collect information about communication between English-speaking foreign medical doctors, nurses and the patients they attend to in the hospitals in Limpopo. The data collected will be used for research purposes only and none of the responses will be traced back to you. Your honest answers to the questions are appreciated.

Thank you.

Section A

Please tick or fill in the appropriate responses as needed.

1. Gender:

Male	
Female	

2. Age: ----------

3. Home language: ----------

4. Other languages spoken: ----------

5. Level of proficiency in English language

Very good	Good	Basic	None

6. Level of formal education

Primary	
Grade 12	
Tertiary	

SECTION B

1. Are you satisfied with the discussion you just had with the doctor? ----------
2. Did the fact that he is foreign affect the discussion in any way?
3. If yes, mention 2 ways it affected the discussion? ----------
4. Did you speak English during the discussion or did someone interpret for you? --------
5. Did you understand everything the doctor said? ----------
6. If you spoke English do you think the doctor understood and has knowledge about your illness? ----------
7. Did you feel comfortable discussing with the doctor? ----------
8. Please give 2 reasons for your answer. ----------
9. Mention 2 ways you think discussions with the doctor can be improved----------

Thank you for your time.

ANNEXURE 8

SEKGOMARETŠWA SA 8 (poledišano le balwetši)

MAANO A DIKGOKAGANO A DINGAKA TŠA GO TŠWA NTLE TŠA GO BOLELA SEISIMANE KA LIMPOPO

Dipotšišišo tše di hlaketšwe go kgoboketša tshedimošo mabapi le dikgokagano magareng ga dingaka tša go tšwa ntle tsa go bolela Seisimane, baoki le balwetši bao di ba hlahlobago ka dipetleleng tša ka Limpopo.Tatha ye e tlogo kgoboketšwa e tla dirišetšwa mabaka a dinyakišišo feela mme ga go sengwe sa dikarabelo se se tlogo amangwa le wena. Re tla thabela dikarabo tša botshepegi go tšwa go lena.

Re a leboga.

Seripa sa A

Swaya goba o tlatše dikarabelo tša maleba ka fao go nyakegago.

1. Bong:

Monna	
Mosadi	

2. Mengwaga: ----------

3. Leleme la gae: ----------

4. Maleme a mangwe:----------

5. Legato la botsebi bja leleme la Seisimane

Go kgona kudu	Go kgona	Go leka	Go hloka tsebo

6. Legato la thuto ya semolao

Phoraemari	
Kereiti ya 12	
Thuto ya godimo	

Seripa sa B

1. Na o kgotsofaditšwe ke poledisano ye o sa tšogo e swara le ngaka? ----------
2. Na gore ke motšwantle go amile poledisano ya lena ka mokgwa o mongwe?.....
3. Ge go le bjalo, bolela mekgwa ye mebedi ka fao go amilego poledišano ya lena? -----
4. Na o be o bolela Seisemane mo poledisanong goba mongwe o be a go tolokela? -----
5. Na o kwešišitše tšohle tše ngaka a di boletšego? ----------
6. Ge eba o be o bolela seisemane o gopola gore ngaka o go kwešišitše mme o na le tsebo mabapi le bolwetši bja gago? ----------
7. Na o kwele o lokologile ge o bolela le ngaka? ----------
8. Efa mabaka a mabedi a karabo ya gago. ----------
9. Efa mekgwa ye mebedi yeo ka yona o gopolago gore dipoledisano le dingaka di ka kaonafatšwa----------

Ke leboga nako ya lena.

ANNEXURE 9

ANEKSCHARA 9 (N'wangulano lowu kongomisiweke eka vavabyi)

TINDLELA TA VUHLANGANISI LETI TIRHISIWAKA HI MADOKODELA YA RIHANYO YA VAHLAPFA LAVA VULAVULAKA RIRIMI RA XINGHEZI ELIMPOPO

Swivutiso leswi swi kongomisiwile ku hlengeleta timhaka ta vuhlanganisi exikarhi ka madokodela ya rihanyo ya vahlapfa lava vulavulaka ririmi ra Xinghezi, vaongori na vavabyi va vona. Timhaka leti nga ta hlengeletiwa laha ti ta tirhisiwa ku endla vulavisisi ntsena naswona tinhlamulo hinkwato leti u ti nyikika a ti nge tirhisiwa ku salasala wena muhlamuli endzhaku. Hi ta amukela ku nyikiwa tinhlamulo hi ntiyiso no tshembheka eka swivutiso leswi landzelaka.

Ha nkhesa.

XIYENGE A

Hi kombela leswaku u fungha tinhlamulo ta wena kumbe u tata hi gweju exibokisani.

1. Rimbewu

Wanuna	
Wansati	

2. Malembe:----------

3. Ririmi ra le kaya:----------

4. Tindzimi tin'wana leti u ti vulavulaka:----------

5. Vuswikoti bya wena byo vulavula/twisisa ririmi ra Xinghezi:

Swinene ngopfu	Swinene	Swintsanana	A ndzi ri tivi na swintsanana

6. Vuxokoxoko bya dyondzo ya le xikolweni

Dyondzo ya le hansi	
Giredi 12	
Dyondzo ya le henhla-henhla	

XIYENGE B

1. Xana wa enerisiwa hi mburisano lowu u veke na wona na dokodela? ----------
   ----
2. Xana mhaka ya leswaku dokodela i muhlapfa swi nga va swi ve ni nkucetelo eka mburisano wa n'wina hi ndlela yini kumbe yini? ----------
3. Loko nhlamulo ya wena yi ri ina, boxa tindlela timbirhi hilaha mhaka leyi yi veke na nkucetelo eka mburisano wa n'wina: ----------
   ----
4. Xana a wu vulavula Xinghezi kumbe a ku ri na muhundzuluxi eka mburisano wa n'wina?----------
   ----
5. Xana a wu twisisa hinkwaswo leswi a swi vuriwa hi dokodela?----------
   ----
6. Loko ku ri leswaku a wu vulavula Xinghezi eka mburisano wa n'wina, xana u vona leswaku dokodela a twisisa hinkwaswo leswi a wu swi vula naswona a nga va a kotile ku twisisa vavabyi bya wena?----------
   ----
7. Xana a wu titwa u tshuxekile ku burisana na dokodela?----------
   ----
8. Nyika swivangelo swimbirhi leswi seketelaka nhlamulo ya wena.----------
   ----
9. Boxa tindlela timbirhi leti u vonaka leswaku ti nga antswisa mburisano wa wena na dokodela:-----
   ----

Hi nkhesile nkarhi wa wena.

ANNEXURE 10

Tshipia tsha 10 (nyambedzano na vhalwadze)

Nila dza kuambele kwa madokotela a vhabvanna vha ambaho luisimane Limpopo

Mbudziso dzo dzudzanyelwa u wana mafhungo nga ha kuambele vhukati ha madokotela a vhabvanna vha ambaho luisimane, manese na vhalwadze vha vha ongaho zwibadela zwa limpopo. Mafhungo a kuvhanganywaho a o shumiswa kha hoisiso fhedzi nahone a hu ngavhi na vhutevheleli kha muvhudziswa. Ri o takalela phindulo dzavho nga u fhulufhedzea.

Ro livhuwa.

Lua lwa A

Kha vha wale phindulo yone kha zwi oeaho afho fhasi.

1. Mbeu:

Munna	
Mufumakadzi	

2. Miwaha: ----------

3. Luambo lwa amuni: ----------

4. Dziwe nyambo dzine vha dzi amba ----------

5. Vhukoni ha u amba luisimane

Nga maana	zwavhui	hukhu hukhu	ahuna

6. Pfunzo ine vha vha nayo

Phuraimari	
Murole wa fumi	
Gudedzi	

Luṱa lwa B

1. Vho fushea nga nyambedzano yavho na dokotela? ----------
2. Fhungo a uri ndi mubvanna lo kwama nyambedzano yavho?
3. Arali phindulo i ee! Kha vha ee nila mbili dze nyambedzano ya kwamea ngadzo? -----
4. Vho amba nga luisimane nga tshifhinga tsha nyambedzano kana ho vha hu na ologi? ----------
5. Vho pfesesa zwohe zwe dokotela a amba? ----------
6. Arali vho amba luisimane, vha pfesesa uri dokotela o vha pfa, nahone u na ndivho ya vhulwadze havho? ----------
7. Vho pfa vho dzulisea kha nyambedzano yavho na dokotela? ----------
8. Kha vha ee mbuno mbili u tikedza phindulo yavho. ----------

9. Kha vha ee nila mbili dzine vha vhona uri dzi nga khwinifhadza nyambedzano na dokotela----------
---

Ro livhuwa tshifhinga tshavho.

ANNEXURE 11

OBSERVATION SHEET FOR NONVERBAL COMMUNICATION BETWEEN DOCTORS, PATIENTS AND NURSES AS INTERPRETERS

DATE----------HOSPITAL----------
DOCTOR'S CODE----------

BEHAVIOUR	DOCTOR	PATIENT	NURSE	COMMENTS
Head nods				
Eye contacts				
Smile				
Affirmations e.g. un hun…, hmm etc				
Touch				
Frown				
Rigid sitting posture				

Relaxed sitting posture				
Fidgeting				

ANNEXURE 12

Transcription symbols

[	C2: quite a [while Mo: [yeah	Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk.
]	C2: and i thought] Mo: you said]	Right brackets indicate the point at which two overlapping utterances end.
=	W: that I'm aware of = C: =Yes. Would you confirm that?	Equal signs, one at the end of a line and one at the beginning, indicate no gap between the two lines.
(0.4)	Yes (0.2) yeah	Numbers in parentheses indicate elapsed time in silence in tenths of a second.
(.)	to get (.) treatment	A dot in parentheses indicates a tiny gap, probably no more than one-tenth of a second.
_____	What's <u>up</u>?	Underscoring indicates some form of stress via pitch and/or amplitude.
::	O:kay?	Colons indicate prolongation of the immediately-prior sound. The length of the row

		of colons indicates the length of the prolongation.
WORD	I've got ENOUGH TO WORRY ABOUT	Capitals, except at the beginnings of lines, indicate especially loud sounds relative to the surrounding talk.
.hhhh	I feel that (0.2) .hhh	A row of h's prefixed by a dot indicates an inbreath; without a dot, an outbreath. The length of the row of h's indicates the length of the in- or outbreath.
( )	future risks and ( ) and life ( )	Empty parentheses indicate the transcriber's inability to hear what was said.
(word)	Would you see (there) anything positive	Parenthesized words are possible hearings.
(( ))	confirm that ((continues))	Double parentheses contain author's descriptions rather than transcriptions.
-	talking about- uh	A hyphen after a word or part of a word indicates a cutoff or self interruption, often done with a glottal or dental stop.

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°	C2: and then° I remember	The degree sign indicates that the talk following it was markedly quiet or soft.
_: or :	C2: In the gy:m?	If the letter(s) preceeding a colon is underlined, it indicates the pitch turning downwards.
><	>we were just<	"Greater than" and "less than" carrots in this order indicate that the talk between them is rushed or compressed.
<>	>	"Less than" and "greater than" carrots in this order indicate that the talk between them is markedly slow.
↓ or ↑	↓are you↓	The up and down arrows mark sharp rises or falls in pitch or may mark a whole shift or resetting of the pitch.
#	# it was in the	Indicates a rasping or 'creaky' voice quality.
£	£ it was so	Indicates the speaker is smiling while speaking.