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PROVIDING HEALTH CARE INTERPRETING IN THE DEPARTMENT OF RADIATION ONCOLOGY, CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

By

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in partial fulfilment for the requirements for the award of

MASTER OF ARTS IN (TRANSLATION) (OPTION: INTERPRETING)

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MARCH 2014

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I declare that “Providing Health Care Interpreting in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital” 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.

_____ _____

Signature Date

(Ms Mbwéli Ndachi)

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ABSTRACT

South African public hospitals face communication barriers between medical staff (more specifically doctors) and patients as a result of cultural and linguistic diversity. Consequently, medical staff and patients experience frustrations, errors in diagnosis have been recorded and multiple tests need to be run to determine patients' conditions, all these at the expense of patients. The services of *ad hoc* untrained interpreters such as relatives (including children), other medical staff (including fellow doctors, nurses, cleaners and porters), and other patients are used to bridge communication barriers, since there is no statutory interpreting service. However, the use of *ad hoc* untrained interpreters has been shown to lead to more complications, including breach of patient confidentiality, distortion and/or omission of information, and patients turning to *sangomas* (traditional witchdoctors), only to return to the hospital when their conditions have worsened. In the first part of this study, conducted at the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital in Johannesburg, semi-structured interviews were conducted with patients and medical staff members in order to obtain a clear picture of their linguistic profiles. Thereafter, in order to determine whether *ad hoc* interpreters such as nurses interpret better than trained interpreters, the interpreting performance of a professionally trained interpreter is contrasted with that of an *ad hoc* nurse interpreter, both interpreting in an oncology setting; and a thorough analysis of both performances is provided through the use of Conversation Analysis (CA). The present research report is therefore a first attempt to determine possible solutions to miscommunication in the South African health care setting in general and an oncology setting in particular, from the perspective of Interpreting Studies.

TRANSCRIPTION SYMBOLS (Adapted from Dr Koole's hand-outs, 2013)

Wor[d overlap
[word

[word] overlapping words or sentences
[word]

<u>Word</u> stressed

Wo-Word hesitation and false start (except indigenised English words e.g.: e-gastro, i-patient, e-GI clinic, u-cream, i-gel, nge-English, ku-radiation, i-Chemo etc.)

(long silence)

[short pause]

Word/ pause or [pause]

Word// long pause or [long pause]

(inaudible) word or sentence not understood

{word} softly spoken

Word English loan word when Zulu is spoken and indigenised loan word

Word… interruption of the sentence

…Word

(Word?) uncertain word or sentence

Word (in black) original dialogue in English

Word (in blue) original dialogue in isiZulu

Word (in red) back translation from isiZulu into English

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CHAPTER 1: INTRODUCTION

"In many settings in South Africa, patients and providers may differ from each other not merely in these 'usual' ways but also in terms of coming from different backgrounds and speaking different languages. Thus difficulty with communication and cultural incompatibility between patients and health care providers become even more important barriers to quality care in this setting." (Levin, 2007:54)

1.1 Introduction

This chapter explores the communication problems experienced by medical staff and patients alike in the health care sector globally and in South Africa, as well as the need for professionally trained interpreters to bridge language barriers. The research questions and the research methodology are then discussed, and an outline for each chapter is given.

1.2 Background to the research problem

In South Africa, while private hospitals cater for the financial elite, public hospitals provide services for 80% of the population (southafricainfo.com, 2012). The country's cultural diversity makes it difficult for public hospitals to cater for patients in their mother tongues. In this regard, Herselman (2007:64) indicates that in South Africa, "generally, the physician-patient encounter operates smoothly and patients recover after treatment regardless of whether sociocultural differences are acknowledged or not. But in such cases we may question the quality of the encounter". In the field of health care interpreting, researchers' findings all consistently point out that communication barriers between patients and health care providers open the door to numerous problems. Leanza (2007:11-12) enumerates the problems of "inappropriate diagnostic investigation, lower adherence to treatment, lower rates of following up (appointment proposed and kept), poor referrals, incomplete investigations and lower rates of preventive interventions by physicians." South African researchers have also contributed to these findings by stressing the problems resulting from language, cultural and social barriers that are specific to the country and that are encountered in the local health care settings. Herselman (2007:64) for instance states that:

> Often problems including miscommunication, delayed consultation, fear, distrust, disregard of doctors' instructions, treatment interruption, and excessive submissiveness among patients might occur, all of which have an implication for patients' well-being and recovery.

Schlemmer and Mash (2006:1076-1079) also point out that South African public hospitals face the following problems: very poor and even inexistent communication between the medical staff and patients, tensions arising between members of the medical staff, breaching of patients' confidentiality, cross-cultural misunderstandings and ethical dilemmas. They also add that these problems lead to the fact that hospitals tend to lose patients; many of these patients then prefer to turn to traditional witchdoctors or *sangomas* with whom they can better relate at a linguistic and sociocultural level; medical staff may become depressed as a result of dissatisfaction with their ability to care for their patients adequately; the quality of service delivery may decrease and patients' satisfaction regarding the services obviously decreases as well. Along with these statements, raising the problem of how communication, contextual and cultural barriers affect patient adherence to taking drugs and to following up visits in South Africa, Penn, Watermeyer and Evans (2011:315) state that: "health professionals seemed sensitive to these barriers to adherence in their narratives and expressed frustration with service delivery problems which included difficulties with referral to other sites, inadequate follow up systems, cramped office space, as well as the impact of political unrest and hospital strikes on the treatment process". Discussing in-depth the problems resulting from communication barriers between patients and health care practitioners, Deumert (2010:54) enumerates three consequences of communication barriers between these two parties: firstly, patients become unwilling to consult with doctors, and would only meet with doctors when they are at an advanced stage of their illness. Secondly, "errors in diagnosis and treatment" result from the miscommunication and often the non-communication between patients and doctors, which means that doctors have to "request more tests, hospitalise patients more often and frequently delay initiation of treatment". Finally, language barriers result in non-compliance and treatment default due to the fact that patients do not understand doctors and therefore neither understand their conditions, nor their treatment options. Furthermore, Herselman (2007:64) adds that barriers to providing effective heath care

> could be the result of patients' experiences with poverty, unemployment, political issues, ignorance about available health-care facilities and their services, distance from health-care facilities and lack of transport, they could also be the result of doctors' lack of awareness and understanding of their patients' beliefs and behaviour, as well as language difficulties. For instance many physicians are only aware of some of the more exotic aspects of their patients' health beliefs and behaviour, such as ritual scarification and ideas about witchcraft and sorcery, which moreover, seldom feature in the clinical encounter. If a doctor's diagnosis and the patient's understanding of a condition are at variance, communication is likely to break down.

In order to bridge communication barriers, it is common practice for the medical staff to make use of interpreters. (Leanza, 2007:12) states that, in general, "studies suggest that interpreters employed in medical settings tend to be *ad hoc* or proxy interpreters, that is untrained people drawn from the patient's family or the (non-medical) staff of the institution where the consultation takes place". This is also the most common strategy employed in the South African health care sector. It is important to stress in this context that a trained interpreter refers to an individual who has undergone some type of general interpreting training through a tertiary institution. There is currently no formalised health care interpreting training for South African interpreters, and there is no funding in this regard. Certain liaison interpreting programmes, such as the Diploma in Legal Interpreting at the University of the Witwatersrand, include a small health care interpreting component. Penn (2007:66) therefore points out that "while existing language legislation promotes the use of interpreters in all health-care sectors, common practice indicated that in most cases, a trained interpreter is usually not available and at best, interpreting is performed in an *ad hoc* way using nurses, family members or fellow patients". In fact, owing to financial constraints, in order to overcome the language barrier challenge, public hospitals use *ad hoc* untrained interpreters. As Deumert (2010:58-59) points out, public hospitals do not only use nurses, fellow patients and adult family members as interpreters. They also use staff members, security guards, cleaners and their use of family members includes children.

Leanza (2007:12) states that though the use of *ad hoc* untrained interpreters aims at addressing language issues, it also opens the doors to several problems: the remaining risks of misdiagnosis of patients, breach of confidentiality, the likelihood that consultations will not help patients to express difficult feelings and the evidence that untrained interpreters feel significant stress and discomfort. When using *ad hoc* untrained interpreters, it has been identified that South African public hospitals expose themselves to two main problems: the problem of breach of confidentiality and the problem of quality and veracity of the interpretation. In this regard, Penn (2007:69) states that:

> When nurses are not available and other patients are used as interpreters, both patients and doctors have concerns about confidentiality […] In general it has been found that the *ad hoc* interpreting procedures often result in omission, substitutions, condensations and distortion of information resulting in reduced understanding and awareness of patient diagnosis, as well as increased patient dissatisfaction. In some contexts up to 40% of the utterances within a medical interview contain translation errors, many of which have negative implications in terms of accuracy and efficacy of medical service.

In addition, the cases during which children are used as interpreters constitute a violation of children's rights, especially when these children have to be bearers of bad news. Using children as *ad hoc* interpreters not only affects the dynamic of the family, but also exposes children to psychological sequels (Leanza, 2007:12). For these reasons, researchers, language practitioners, medical staff and patients alike are of the opinion that trained interpreters are needed in order to overcome this communication handicap. This statement is substantiated by Ntshona (1997:1143) from the former National Language Project in Cape Town who in an attempt to answer the question of whether or not professional interpreters are needed in the South African health care services concludes that: "the findings of the study strongly indicate that the introduction of (professional) interpreters is desirable to both the health care providers and patients". Kilian, Swartz and Joska (2010:309) also come to the conclusion that "the lack of formally trained interpreters in South Africa's public health services could lead to misdiagnosis and could compromise interventions".

1.3 Research questions

Schlemmer and Mash (2006:1084) state that public hospitals in South Africa lack the funds to hire trained interpreters. However, in public hospitals the consequences of not using trained interpreters are as legion, as they are serious. It goes without saying that errors in diagnosis and wrong treatments can be fatal to patients. The *Batho Pele* (People First) principles which are used in the South African public service to encourage public servants to provide excellent service are then placed under threat when patients' lives are at stake because of the absence of trained interpreters. In the National Department of Health (2007:4), it is stated that: "community participation and the adoption of the *Batho Pele* principles are key to empower users of services to take control of their own health care and that of their families". In order to increase patients' participation and the dignity afforded to them, the National Department of Health provides (2007:4) that:

- Patients must be informed and involved in decision-making since their active participation can improve the effectiveness of care as well as their satisfaction. If patients are well informed, able to participate in decision-making and treated with dignity, they will be more likely to adhere to treatment plans.

- Patients must be enabled to care for themselves. If patients are able to assess their health, practice preventive health care and self-care, their health will improve and unnecessary health care service and costs will be reduced.
- Community must be involved in health care since they can have a positive impact on fighting again diseases as it was the case with regard to AIDS.

However, at a practical level the provisions made by the National Department of Health seem to be idealistic and almost impossible to realise. Quoting a patient, Deumert (2010: 58) states that patients feel "robbed" by doctors. They feel robbed because they have to continuously come back to the doctors and continuously pay for consultations whereas it is proven that these patients are not wealthy. Herselman (2007:64) goes along with this statement, when he claims that "the decision to consult a practitioner is also influenced by other factors, most importantly economic issues and proximity to and accessibility of treatment facilities. Consulting a doctor entails expenses". Deumert (2010: 58) therefore goes further supporting that "[patients] are 'robbed' of the doctor's help and support, and of their participation in any decision-making concerning their own bodies (i.e. their autonomy)". Thus, my overarching presupposition is that by weighing the cost of using *ad hoc* untrained interpreters against using professional interpreting services, public hospitals may realise that their expenses will be reduced as a result of more efficient communication with patients: they will need to run fewer tests on patients thanks to better diagnosis, and they will conduct better consultations which will result in having more satisfied patients and medical staff. The more patients are satisfied and are aware that their satisfaction matters to the hospital, the more people will go to the hospital for services. However, given the constraints of the present study, it will not be possible to provide a clear answer to this overarching presupposition. I will therefore test aspects of the presupposition at one Department in one public hospital.
The first research question that I will therefore be analysing is the following:

- Would providing trained interpreters to the Department of Radiation Oncology improve the quality of consultations compared to consultations where *ad hoc* untrained interpreters are used - will patients be more satisfied?

Public hospitals already face a serious shortage of health care providers. It is therefore unrealistic to ask nurses to interpret as they already have a significant workload. In addition, nurses' attitudes towards interpreting are not always positive. In this regard, Levin (2006:

1077) reports that in the course of his research, he found that "forty per cent of nurses said that they were not willing to help doctors with interpreting and 35% of patients said nurses do not want to speak African languages other than their own". Nonetheless, although nurses are not trained interpreters, some nurses claim to be the best interpreters due to the fact that on the one hand, they can culturally relate to patients and on the other hand, as medical staff, they know the jargon, they are familiar with patients' conditions and treatments therefore they can interpret better. Thus, our second research question aims at verifying this presupposition:

- How does the interpreting performance of nurses compare to that of trained interpreters? In the specific case of this study, trained interpreters refer to individuals who have undergone general interpreting training.

In the previous paragraph, quoting Schlemmer and Mash (2006), I mention the consequences of the absence of a professionally trained interpreter to break the language and cultural barriers between doctors and patients: tensions between the medical staff and dissatisfaction of the medical staff towards their own service delivery, patients avoiding doctors until they reach a critical stage of illness, "errors in diagnosis and treatment" and the "non-compliance and defaulting of medication" from patients (Deumert, 2010:54). All these factors result in very poor service delivery. My third set of research questions is therefore the following:

- Would the provision of trained interpreters to the Department of Radiation Oncology improve doctors' satisfaction with their service delivery?
- Would the provision of trained interpreters to the Department of Radiation Oncology improve nurses' work satisfaction?

Consequently, my presupposition is that if medical practitioners are assisted by trained interpreters, if both parties work together as a team, medical practitioners will feel more satisfied regarding their service delivery; they will feel more enthusiastic and there will be a new positive dynamic in their way of working.

1.4 Rationale for the research

Research has been undertaken in communication in the health care setting in South Africa. However, the little literature available that focuses on how interpreting is used to bridge

language barriers between health care providers and patients in South Africa is hardly provided by interpreting scholars. As a result, these research papers do not shed light on the complexity of the interpreting practice and procedure. Hence, this research will fill the gap by providing an exploratory and descriptive analysis of the interaction between doctors, patients and interpreters in the Department of Radiation Oncology at Charlotte Maxeke Johannesburg Academic Hospital; the goal being to identify where language breakdown occur and understand why they occur. The interpreting service provided by a professionally trained interpreter will be contrasted to the one of an *ad hoc* untrained nurse to determine whose performance is more likely to lead to a successful consultation and to increase doctors' and patients' satisfaction. This research report will therefore provide the first pragmatic recommendations as per how to improve interpreted doctor-patient communication in South African public hospitals.

1.5 Brief literature overview

In this study, the type of interpreting discussed is liaison interpreting, with a specific focus on health care interpreting. The setting is health care and the specific field is radiation oncology. In the next sections I provide a brief overview of the existing literature in the field of interpreting in general and of health care interpreting in particular, which are explored in more detail in Chapter 2. The next aspect of my literature overview explores how language management can be used in order to overcome language barriers in the health care setting.

1.5.1 Existing studies in interpreting and in health care interpreting

View from the medical profession

Historically, clinical competence included only three aspects – medical technical knowledge, physical examination and medical problem solving. Until the mid-1970s, communication was not even considered to be an issue (Kurtz, 2002:23). This has changed – it is now rare to find any health care professional who would not agree that communication is a basic clinical skill, and medical educators world-wide agree that formal communication skills training is key. It is worth mentioning that enhancing physician-patient communication skills improves physician as well as patient satisfaction (Kurtz, 2002:26). However, awareness of the

importance of communication does not always mean that health care professionals implement good communication strategies in practice. Levin (2006), Herselman (2007), Deumert (2010) etc. have all raised awareness of the language barriers in health care.

Liaison interpreting and health care interpreting

In the last two decades, mainly in developed countries such as Australia, Canada, Belgium, Switzerland, Sweden and the United States, to name only a few, there has been a shift in perception of the interpreter's role from a language conduit to an active co-participant in the interpreting process (Cf. Bot (2001), Roy (1993), Tebble (2001), Wadensjö (1993) etc.). As Roy (1993:348) puts it, "academicians and practitioners alike struggle to adequately characterize the role (of the interpreter)". Historically, interpreters have been perceived as devices that would automatically change from one language to another. It is expected of them to be invisible, impartial and to keep all communication confidential, as Roy (1993:347) highlights:

> [i]nterpreters are required to reproduce a message from one speaker to another faithfully, accurately, and without emotional or personal bias entering into interpretation […] interpreters may not introduce topics, change topics, ask questions of their own, interject their opinion or give advice, and most importantly, must keep the entire transaction confidential. The performance of this role has been compared to a machine, a window, a bridge, and a telephone line among other metaphors in trying to compress the complexity of the role to a simple singular analogy.

Angelelli (2000:580) states that the goal of interpreting is to ensure that the target audience receives an interpreted source message with the same impact as it would have had on the receivers of the source language:

> More often than not, the task of the interpreter is portrayed as one of 'transcoding' a simple changing of one code (e.g. French, or ASL) to another (e.g. Spanish or American English). Is that enough to meet the goal of interpretation stated above?

In Angelelli's (2003:16) view, the expectation that the interpreter should be neutral, invisible and a mere 'language switching operator', is unrealistic. This is supported by Bot (2001:29), drawing on Wadensjö (1997), who introduces the term "three-person psychology" within the mental health care setting. This term indicates that in the course of a consultation, there are three interlocutors involved. Wadensjö (1997) therefore describes interpreter-mediated conversation as a "kind of three-party communication in its own right, which cannot be simply described as a two-party conversation with a technical handicap" (Bot, 2001:29).

Some researchers, such as Berk-Seligson (in Jacobsen, 2009:160) warn about the "intrusiveness" of interpreters, but the majority of researchers agree that interpreters need a degree of latitude in order to convey the speaker's meaning (Cf. Angelelli (2000), Davidson (2000), Jacobsen (2009), Wadensjö (1993) etc.) In this regard, Jacobsen (2009:160) states that:

> The key element inherent in an interpreter's performance, i.e. the very fact that her presence is meant to ensure successful interaction, which necessarily entails that the primary participants understand each other as if they spoke the same language, inevitably provides her with a more active role than prescribed by official guidelines.

Leanza (2007:14) thus suggests that in order to achieve successful communication, interpreters can hardly fully comply with the normative role of translation device that is commonly expected of them. He describes five different roles that interpreters may adopt to bridge communication barriers in health care interpreting:

1. The *translator* in which the interpreter minimises his/her presence as much as possible in order to simply facilitate the communication process without interfering with the speaker's messages
2. The *cultural informant* in which the interpreter helps the health care practitioner to better understand patients. In this role, the interpreter uses his/her knowledge of cultural norms and values
3. The *cultural broker* or *cultural mediator* in which the interpreter is not only a cultural informant but also a negotiator between two conflicting value systems. In this role, the interpreter provides explanations or synthetizes both parties' messages so as to arrive to a meaningful share model of care or behaviour
4. The *advocate* in which in case of value-conflict situation, the interpreter may choose to defend the patient against the institution (e.g.: doctor, nurse, hospital) and
5. The *bilingual professional* in which the interpreter becomes a health care professional by leading the interview in the patient's language and then reports to the health care provider. The interpreter can assume this role thanks to a prior training in health care or thanks to his/her knowledge of institutional practices and routine.

In South Africa, language surveys conducted in the health care sector have shown that "fewer than 5% of the doctors at the institutions studied were able to conduct interviews in the first language of their patients" (Penn and Evans, 2009:285). Penn and Evans (2009:285) thus state that:

> Even when healthcare professionals are culturally and linguistically matched to their location, their interactions may take place in a language other than the first language of their patients or clients. Thus, the nature of the setting, power relations, the materials, and the task often lead to the use of English.

Thus, following the research conducted by Penn (2007) on factors affecting the success of triadic consultations, it was found that the South African context is so complex that interpreters are expected to adopt all of the above roles suggested by Leanza (2007). In the South African health care setting, interpreters seem to be expected to assume at the same time the role of *translator*, *cultural informant*, *cultural mediator*, *advocate* (of either the patient or the institution) as well as *bilingual professional*. This argument is substantiated by Penn (2007:69) who asserts: "depending on the context, the mediator [interpreter] in such clinical interactions is often expected to assume multiple roles including those of linguist, cultural broker, research assistant, counsellor, patient advocate and institutional gatekeeper". Watermeyer (2011:72) adds the role of "co-diagnostician, manager, coordinator of communication between patient and health professional, clarifier and/or conduit" to Penn's list. Nevertheless, owing to the fact that patients attending the same institution want interpreters to assume a role that suits their individual needs, Watermeyer (2011:78) argues that in South Africa, "there is a necessity for an interpreting style that is tailored towards each individual patient's communication needs and preferences". Leanza (2005) and Hale (2008) have addressed this claim and they both argue that different role perceptions and expectations of users of interpreting services still complicate interpreting situations irrespective of the setting" (in (Jacobsen, 2009:163)). According to Jacobsen (2009: 163), the problem may be solved by "professionalising interpreters and granting them proper working conditions", a view with which the researcher is in agreement. In other words, this problem may be alleviated by stating the rights and duties of patients, institutions as well as interpreters. Some countries have adopted this solution, whereas some others have organised a different system of language service provision. Chapter 2 provides a more in-depth review of literature in the field of liaison interpreting and health care interpreting. The next section provides a brief overview of how language management is tackled in some developed countries facing the challenge of cultural diversity in the health care setting. These case studies are explored in more detail in Chapter 3.

1.5.2 Case studies of health care interpreting models in other countries

In Australia, there are bodies that regulate health care interpreting services. According to the Australian Health directory (SA), translators and interpreters are accredited by the National Accreditation Authority for Translators and Interpreters Ltd (NAATI), which is an independent body responsible for maintaining standards. Interpreters and translators are therefore bound by a professional Code of Ethics set by the Australian Institute of Interpreters and Translators (AUSIT). The AUSIT Board of Professional Conduct deals with complaints about interpreters. The Australian Health Directory (SA) also indicates that health care interpreters work on site as well as over the telephone. Interpreters are available 24 hours a day, 7 days a week; and that as part of their services, interpreters can translate health related documents and help health professionals to understand clients' cultural and religious backgrounds. In order to achieve optimal service delivery, training courses have been implemented for doctors and interpreters to work together at providing good service delivery. In Tebble's (2001:88) view: "It was acknowledged that to treat all patients equally and to perform their work satisfactorily and legally, all new doctors were required to undertake skills training in learning how to communicate with non-English-speaking patients via the services of medical interpreters". Thus, as Tebble (2001:95) states, "the interpreter is an important member of the health care team".

The case study of health care interpreting in Belgium is to be discussed in depth in chapter 3 of the dissertation. It covers the historical background of health care interpreting in the country up to the current regulations.

In Switzerland, the state acknowledges that there are approximately 200.000 people residing in the country who speak none of the four national languages namely: English, French, German and Italian (Federal Office of Public Health (FOPH), SA). Community interpreters are therefore regarded as being essential for successful communication between migrants and health care providers since besides interpreting, interpreters are expected among others to "point out different perceptions, values or significances to the participants" (Federal Office of Public Health (FOPH), SA). As stipulated on the website of the Federal Office of Public Health of Switzerland (SA), Community Interpreting is the cornerstone of the National Programme of Migration and Public Health. The National Programme regulates Community Interpreting Services, promoting:

> education and certification of community interpreters, a national centre of competence in charge of quality assurance and public relations, and the establishment of a national telephone interpreting service. Numerous studies furthermore examine qualitative, legal and financial aspects of intercultural translation" (Federal Office of Public Health (FOPH), SA).

Since 1 April 2011, the National Telephone Interpreting Service has been operating in Switzerland, more specifically in Zurich (Slater, 2011). The service is provided by AOZ Medios and works specifically in health care settings such as hospitals, outpatient clinics, general practitioner surgeries, nursing homes etc. (Federal Office of Public Health (FOPH), SA). The information provided on the Federal Office of Public Health of Switzerland stipulates that:

> The national telephone interpreting service accepts calls from throughout Switzerland round the clock seven days a week and provides appropriate telephone interpreters. The interpreting service is offered in the official languages German, French and Italian and provides the following languages for interpretation: Albanian, Arabic, Italian, Kurdish, Portuguese, Russian, Serbian-Croat-Bosnian, Somali, Spanish, Tamil, Tigrinya, Turkish. Depending on how demand develops, the range of languages offered will be supplemented regionally or nationally. (Federal Office of Public Health (FOPH), SA)

In the online article published by Julia Slater (2011), some readers raised the complaint that English is not offered as an operating language. Ms Slater's answer is that English is a language well known by doctors. They therefore do not need any interpreting service into English. However, a reader by the name of "Dr Mo" mentioned that he was almost killed by a doctor whose English was not good:

> I am shocked that English is not on the list. I have had doctors refuse to speak English I've had doctors who couldn't speak Englihs (sic) and I've had doctors who thought they could speak English (ie. one told me to take some 'poison' if I have another allergy attack thanks dr. I think I'll skip that!) Since large numbers of immigrants have English as either a first or second language, it would be prudent to offer this language as well. I've even had a doctor refuse to speak High German to me and would only speak Schweizerdeutsch to explain to me a procedure that could paralyze me, but that I had to have in an emergency situation. This is a slap in the face to those of us who live in areas where the doctors are not multilingual. (Dr Mo, Switzerland 02.04.2011)

Nonetheless, the National Telephone Interpreting Service aims at supplementing the existing community interpreting service on site programme (Federal Office of Public Health of Switzerland (FOPH), SA). The Federal Office of Public Health of Switzerland (FOPH) will

finance this service until end 2013, time that has been set for its full implementation. Afterwards, each hospital or heath care provider would have to support itself (Slater, 2011). Slater adds that it has been proven that for diverse reasons (including language barriers) migrants have a poorer health condition than the native population. However, the Swiss Constitution states that "everyone has access to the health care that they require" and communication problems between health care providers and patients undermine that provision. She goes further in informing readers that on the Federal Health Office's website, it is stated that: "Inadequate medical care can in the long term have "a negative effect on the course of diseases, which, in turn, generates higher costs". It is emphasised that the cost of the use of community interpreters as well as the cost involved in making use of the National Telephone Interpreting Service has to be covered by health care institutions (Slater, 2011). In their article depicting the state of health care interpreting in Switzerland, Bischoff and Hudelson (2010) suggest that the integration agenda of immigrant communities should be "pushed". They add that: "professional interpreters are an essential component in the quality care for diverse patient populations" (Bischoff and Hudelson, 2010:2842). They also mention that clinicians have to be aware of the risks they face when using *ad hoc* interpreters. They recommend that the use of professional interpreters' services be increased through information and training.

In the United States, Spolsky (2009:127)) states that "in September 2006, the New York Department of Health adopted regulations setting standards for hospitals and requiring them to provide skilled interpreters, translate important forms into common languages, and make sure that patients are treated rapidly in spite of language issues". This is an indication that some countries have implemented measures to break the language barriers in their health care system and to insure the best service delivery possible. Nevertheless, in South Africa, there is a necessity to find and apply the solutions that will work efficiently within the local context.
Still in the USA, but more specifically in the Radiation Oncology field, Lubrano di Ciccone et al. (2009:27) affirm that in the oncology setting, "effective medical interpretation is necessary not only for the clinical encounters but also for the other health related activities such as registration, appointments and pharmacy". According to their module: the communication skill training (CST), in order to achieve an "optimal interaction with the patient", the doctor and the interpreter have to achieve some important tasks: "(i) [privileging] the doctor-patient dialogue, (ii) [promoting] shared understanding and (iii) [being] sensitive to cultural differences" (Lubrano di Ciccone et al., 2009:28). They use

some strategies that involve "introducing the content and expectations of the consultation with the interpreter and eliciting interpreter's knowledge about the patient that is relevant for a successful visit" (Lubrano di Ciccone et al., 2009:29). They also point out that some extra skills are relevant such as: breaking bad news, sharing decision making about treatment options including clinical trials, responding to patient anger, conducting family meeting, discussing prognosis, discussing the transition from curative to palliative care and sharing decision making about Daunorubicin Orders (Lubrano di Ciccone et al., 2009:29).

1.6 Theoretical framework and methodology

1.6.1 Data

The data will be collected through questionnaires, interviews and audio as well as video recordings. Audio recordings of consultations are needed in order to perform adequate conversational analyses of the interactions between doctors, patients and interpreters. Video recordings are highly desirable to record the positioning of the interpreters in relation to the other participants and determining the power dynamics at play. In the case of video recordings, participants' faces are blurred so as to keep participants' identities confidential. Informed consent of the parties involved in the recordings has been requested. The target population is the medical staff and the patients of the Department of Radiology Oncology, Charlotte Maxeke Johannesburg Academic Hospital. Additionally, it will be important to profile the patients in terms of gender, language and occupation. This latter information will help in knowing who the patients are and what register of language would be appropriate for them. All information obtained from patients will be subject to their consent and will be used anonymously and confidentially. The questionnaires, interviews and recordings are used to understand the challenges the Department may face within this multilingual and multicultural context. It is also used to understand the department's needs and evaluate the solutions that can be provided.

The data collected from the video recordings are analysed from the perspective of conversation analysis (CA) which is a methodology that finds its roots in sociology, in anthropology as well as in linguistics. Friedland and Penn (2003:96) describe conversation

analysis as a descriptive approach that "adopts a detailed and intricate analysis of turns, topics and patterns of an interactive collaborative language. Its focus is on naturally occurring data and analysis is driven by data rather than preconceived checklists". Since conversational analysis does not focus on the context that is external to the data collected, but rather on context emerging from the interactions between participants, it makes it an ideal approach as the researcher's analysis, suggestions and conclusions can only be drawn from the analysis of the data collected. In line with ten Have (1999) and Sacks (1992), de Kok (2008:888) points out that "CA's ultimate goal is to explicate the organisation of conversations in terms of mechanisms which are the same across varying contexts, abstracted from the contents of interaction, and thus context free". The principles described by Friedland and Penn (2003) as well as de Kok (2008) further contribute in making CA a suitable approach since the researcher can retract from the data collected factors that either facilitate or inhibit good communication in the course of a consultation in the health care setting; whether that consultation takes places between doctor and patient or doctor, patient and interpreter.

The application of CA in the course of this research cannot be done without making transcriptions of the audio data. As an attempt to define transcription, Bezemer and Jewitt (2010:186) state that: "Linguistic notions of transcription refer to the "translation" of speech into writing. In this tradition, transcription conventions are used to express features of speech, such as intonation, hesitation or pauses, which are not normally expressed in writing". Thus, these conventions make transcription a central method of data analysis in qualitative research (Hennink and Weber, 2013).

Video recording is crucial to this study as interpreting is also a visual activity. It is therefore important for the researcher to see where each participant physically stands, what body language they have and what they do during the consultation. These data are to be collected on interpreters, medical staff and patients who were willing to be videotaped: three patients and three doctors, and two interpreters: an *ad hoc* nurse interpreter and a professionally trained interpreter. The videotaping was carried out using a video camera that was installed in the consultation room. The arrangements and furniture in the consultation rooms could not be altered. Hence, whenever possible, the camera was installed behind the patients so as to keep their identity confidential. The doctor was able to switch the camera off whenever the patient was no longer feeling comfortable being videotaped. Data collection took place in October and November 2013. The researcher asked the Medical Research Committee for special

permission to videotape consultations. Certainly videotaping presents advantages, such as the possibility to capture the kinesic elements of the consultation. However, it also has drawbacks, such as the fact that participants might not act naturally and might feel discomfort due to the presence of the camera. These aspects are taken into consideration in the course of this study.

The analysis of the video recordings will assist in examining at the interaction between doctor, patient and between doctor, patient and interpreter. The goal of using this method is:

- to see how the communication between participants takes place,
- to evaluate the quality of the communication between participants,
- to find, if applicable, the causes of the problem in their communication, and
- to suggest some solutions to improve interactions between participants.

Using this method will also assist in ascertaining how the interpreter handles her/his task and whether s/he succeeds in rendering the cultural connotations as well as both parties' intentions during the course of the communication.

1.7 Outline of the study

Chapter 1: Introduction

In this part of the dissertation, the reasons and purposes of the research topic are explained. The rationale and well as the research problem are stated; and the outline of the dissertation is provided.

Chapter 2: Theoretical framework

This part of the dissertation contains a review of literature in the field of liaison interpreting in general, as well as a review of theory in the field of health care interpreting in the radiation oncology setting. It will also present a review of theory in the field of communication in oncology.

Chapter 3: Case studies of health care interpreting models

In this chapter, the researcher provides a description of health care interpreting models and training and accreditation models implemented elsewhere in the world, notably in Australia, Belgium, Switzerland and the United States. The interpreting training and accreditation applied in South Africa are then examined.

Chapter 4: Methodology

This part of the thesis presents the methodology used in the course of this study. The pilot study aims at evaluating the linguistic landscape as well as assessing the necessity of providing health care interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital, the methodology of the pilot study includes on-site observation and the collection of data through patient interviews and distributing questionnaires to the Department's medical personnel. The pilot study conducted forms part of the methodology for the main study as it informed the main study.

Chapter 5: Analysis

In this chapter, the main study aims to analyse the communication dynamic in interpreted doctor- patient consultations in the Department and to elucidate the researcher's objective, which was to compare nurses' interpreting performance to that of trained interpreters. The methodology used comprises the audio and video recording of the interpreted doctor-patient consultations, the transcription of recordings of the interpreted doctor-patient consultations, the analysis of the transcribed data through conversation analysis (CA), and the processing of the data collected from the questionnaires and the video recordings.

Chapter 6: Findings and recommendations

This part of the dissertation will present the findings and recommendations from the data collected for the purpose of this study. A comparison with the researcher's presuppositions will be provided.

1.5.7 Chapter 7: Conclusion

In this part of the dissertation, the results of all the previous chapters are drawn together, and the limitations of the study and possibilities for further research are discussed.

CHAPTER 2: THEORETICAL FRAMEWORK

"Serious illness inevitably affects all aspects of personhood and threatens the integrity of relationships on many levels. Responding compassionately requires an acknowledgement of the individual's uniqueness and respect for his or her life. Without language, we lose our most effective tool for establishing a meaningful relationship with patients and the opportunity to address individual worries and fears." (Schapira et al. 2008)

2.1 Introduction

This chapter contains a review of literature in the field of liaison interpreting in general, as well as a review of theory in the field of health care interpreting in the radiation oncology setting. It will also present a review of theory in the field of communication in oncology. A discussion on conversation analysis as well as its existing application in liaison interpreting is also provided.

2.2 Review of literature in liaison interpreting

2.2.1. Liaison interpreting, community interpreting, cultural interpreting or dialogue interpreting?

There are two modes of interpreting: consecutive interpreting and simultaneous interpreting. Just as described by the International Association for Conference Interpreter (AIIC) (2013), consecutive interpreting is the mode of interpreting during which the interpreter sits with the participants usually around a table, listens to a source message, takes notes and then renders the meaning of the speaker's message in a target language. Simultaneous interpreting is rather the mode during which the interpreter is usually in a sound-proof booth with a view on the conference venue. The interpreter listens to a source message through earphones and simultaneously renders the meaning of the speaker's message in a target language through a microphone for the target audience present in the venue. That target audience receives the interpreter's rendition through earphones.

It is partly due to diverse expectations towards the role of interpreters as well as towards the interpreting activity that various types of interpreting have stemmed from consecutive interpreting. Just as these various types of interpreting have materialised, various names are used to qualify them and to attempt to mark out their scope. However, the scope and the

definition of these different types tend to be unclear. Thus the following statement from Roberts (1997:8):

> The fact that the scope of community interpreting is ill-defined is clearly illustrated by the numerous designations used to describe this still nebulous concept: community interpreting, public service interpreting, cultural interpreting, dialogue interpreting, *ad hoc* interpreting, liaison interpreting, escort interpreting, and medical or legal interpreting, to name just a few. What all these terms have in common is the fact that they are all used for interpreting in a setting other than a conference. However, they are by no means exact synonyms.

Smirnov (1997:211) equally supports that there is no clear demarcation of the area covered by "liaison" or "community" interpreting; which is why he uses the term "liaison interpreting". He highlights that the controversy in the nomenclature and the scope of the interpreting activity might be due to several predicaments. Firstly, the practice awaits institutionalisation in most places; in other the words, the difficulty in providing a nomenclature and defining the scope of each type of consecutive interpreting might be due on the one hand to the fact that the activity lacks formal recognition in some countries in general and in the settings where they are undertaken in particular. On the other hand, as Smirnov (1997) recalls, "liaison and particularly community interpreting have developed as a result of anti-assimilationist and globalization policies later on and even today" (1997:212). Secondly, the contrastive definitions might also derive from the unpopularity of liaison interpreting in the field of interpreting studies. In this regard, Choi (2007:5) states that: "Despite the impact that community interpreters have on societies, unfortunately, so far, interpreting studies have not given enough attention to this area of interpreting". Thus, Choi's recommendation is that: "Efforts […] be made to achieve a real understanding of what community interpreting entails and to come up with specific measures that can support the substantial development of its many dimensions" (2007:5). Lastly, numerous interpreting scholars are of the opinion that the lack of formal interpreting training by *ad hoc* untrained interpreters working in statutory services; that is to say: health, legal, education, local government and social services is an impediment to the institutionalisation of the profession (Cf. Angelelli (2005), Roberts (1997), Smirnov (1997), Ozolins (1995) to name just a few); therefore, of its denomination.

However, referring to Gentile (1996) in order to provide a nomenclature, Smirnov (1997:212) defines liaison interpreting as:

> a growing area of interpreting throughout the word: in business settings, where executives from different countries meet each other; in meetings between a society's legal, medical, educational and welfare institution and its immigrants who speak a

> different language; in relations between a dominant society and indigenous people speaking different languages; in a whole host of less formal situations in tourism, educational and cultural contacts.

Smirnov (1997) however suggests to make a distinction between "liaison interpreting" as the umbrella term that regroups all types of consecutive interpreting and "liaison interpreting" as "business liaison", that is to say the type of consecutive interpreting that is undertaken in business settings in "both the context of 'Language for a specific purpose' (business, trade and technical terminology) and of 'intercultural communication' (from 'wining and dining' to broader cross-cultural aspects of modern business)" (1997:213). He then contrasts his definition of liaison interpreting to community interpreting by stating that the latter is "inferior to business liaison interpreting in status and remuneration, but superior in 'humanitarian' (social) significance, demands that its practitioners possess the same specialised terminology and *bicultural competence* as business interpreters" (1997:213).

Roberts (1997) brings a slightly different perspective when it comes to defining liaison interpreting and contrasting it with community interpreting. Roberts (1997:8) first defines "*ad hoc* interpreting" as the generic type of interpreting that can be broadly divided into business and community-oriented according to the nature of the dialogue to be interpreted or the interpreting setting. She is in agreement with Harris (1983) in stating that "liaison interpreting" just like "escort interpreting" are generally used to refer to business-oriented *ad hoc* interpreting that is to say the type of interpreting that is done when accompanying visitors, diplomats and businessmen to meetings and negotiations. In contrast, quoting Collard-Abbas (1989), "community interpreting" which is to her synonym for "cultural interpreting", "dialogue interpreting", "public service interpreting", "medical interpreting" and "legal interpreting" is restricted to community-oriented *ad hoc* interpreting; that is to say the type of interpreting that is undertaken to assist non-native speakers immigrants to gain full and equal access to statutory services.

Besides these different definitions attached to each type of consecutive interpreting provided by scholars, it happens that in countries where interpreting in statutory services is institutionalised, there is a specific denomination attached to the interpreting activity and to the interpreters. In Belgium for instance interpreting in a hospital setting is called "intercultural mediation" and an interpreter working in such a setting is called "intercultural mediator" or "mediator" (Federal Public Service Health, Food Chain Safety and Environment of Belgium, 2013). As stated by Ozolins (2010), in the United Kingdom, the activity is rather

called “public service interpreting” (2010:200). An interpreter working in the UK is either referred to as “public service interpreter” or “interpreter”. Furthermore, contrary to the practice in North America where interpreters need to be accredited in order to work in court, in the UK a public service interpreter may work both in a courtroom setting and in a health care setting (Roberts, 1997:9). In South Africa, as stated by Erasmus (1999:50), the Unit for Language facilitation and Empowerment has adopted the nomenclature “liaison interpreting” since it is viewed as a generic concept. Furthermore, in the South African context, the term “community interpreting” would be very problematic since as Erasmus (1999) highlights:

> The task, position and status of ‘interpreters in the community are controversial within the arena of discursive dominance – particularly in South Africa, but also in most countries where interpreters are employed to facilitate communication between service providers and their clients. (1999:50)

Thus, in this study the interpreting activity undertaken in statutory services is referred to as “liaison interpreting”. With regard to the nomenclature of interpreters working in statutory services, in South African public services, the role of interpreters is unsettled since whereas interpreters are often mistakenly referred to as “translators” by those using their services, scholars do not seem to commonly agree on the nomenclature as they call interpreters: “cultural broker”, “cultural mediator”, “mediator”, “liaison interpreter” or “interpreter” depending on their expectations of interpreters (Cf. Penn, Watermeyer and Evans (2011), Watermeyer (2011), Kilian, Swartz and Joska (2010), Penn (2007), Penn and Evans (2007)). However, in this study, the interpreter working in statutory services is referred to as the “liaison interpreter” or the “interpreter”.

As mentioned above, the issue in defining the interpreting activity as well as the interpreter finds its roots among others in the different expectations towards the role of interpreters as well as the interpreting activity and the lack of institutionalisation of the profession. Thus, the following question is raised: What are the factors that may hinder the institutionalisation of the profession? The next paragraph attempts to provide some answers.

2.2.2 Issues relating to the institutionalisation of the interpreting profession

As per Merriam-Webster (2013) institutionalising the interpreting activity would mean to incorporate interpreting not as a mere activity but as a formal profession into a structured and often highly formalized system. In other words, by institutionalising interpreting, it would

become recognised as a profession by the state, and would therefore be attributed conventions, rules and norms as a profession. Such a change of status would mean that the interpreter's role and status would to be clearly defined and respected (Cf. Angelelli (2005), Roberts (1997), Ozolins (1995) etc.) Nevertheless, the institutionalisation of the interpreting profession might be mainly influenced by five factors namely: the perception that participants and institutions have towards the interpreter with regard to his/her social status, the status of interpreters with regard to whether they are trained or not, the standard and the quality expectation of the interpreting service, the expectations with regard to the role of interpreters as well as the role of the institution they work in and of course the political will to institutionalise the profession. Nevertheless, most literature focuses on the provision of liaison interpreting for immigrants and linguistic minorities. There is not much literature on the provision of language services in multilingual countries such as South Africa.

Concerning the perception that participants and institutions have towards the interpreter, liaison interpreting is described by Niska (2002) as a thousand year old activity which, at best, is carried out for only modest remuneration. Since it is regarded as a "linguistic assistance for communication between members of different ethnic communities", the perception that is associated with it is that liaison interpreting is a trivial, everyday activity that can be undertaken for free by any willing bilingual who cares to help fellow community members (Niska, 2002:136). Thus, owing to the fact that liaison interpreting is regarded as an activity aiming to help, to assist different ethnic communities, liaison interpreters are consequently perceived as helpers and not as professionals. This assertion is supported by Roberts (1997) who states that: "Many if not most definitions of community interpreting explicitly include the concept of 'assistance' or 'service'" (1997:11). Furthermore, Gentile (1997:112) asserts that: "The vast majority of practitioners belong ethnically and linguistically to the minority group. Again, this should in theory make no difference to the interpreting *per se*, but the perception of the interpreter by both clients is affected by this." Smirnov (1997: 216) brings more clarity to Gentile's statement as he bluntly states that: "[liaison] interpreters are commonly assigned positions as low as those of their lower-status clients". In other words, those who do not speak the language used in the statutory services and who thus need an interpreter to have access to the services are perceived as lacking the necessary level of literacy to have access to these services independently. They are usually perceived as either immigrants or as pertaining to the working class and although *ad hoc* interpreters are bilingual, they are regarded as pertaining to the same social class with the

difference that they managed to integrate themselves (Cf. Cherbonnier (2002), Ozolins (1995)).

Besides being perceived as low-status helpers, liaison interpreters are also regarded as tools. Wadensjö (1997:36) affirms that: "Interpreters are seldom depicted as *providers of service* and *agents of control*. A more common image is that of *producers of text*. Even more common perhaps is the image of interpreters not as actors but as passive *tools*, to be used and handled by the primary interactants". The perception of liaison interpreters as low-status helpers and tools thus raises an interrogation: Why is there a derogatory perception upon liaison interpreters although they occupy a vital position in bridging communication barriers and without them, the parties receiving interpreting services might be exposed to substantial problems such as: misunderstandings, misdiagnosis, noncompliance and impossibility to receive or to provide statutory services? The answer to this question may lie in the status of the interpreters with regard to whether or not they are trained.

The literature shows that in most countries where interpreting has not yet been institutionalised, those interpreting in statutory institutions are predominantly *ad hoc* untrained interpreters (Cf. Deumert (2010), Kilian, Swartz and Joska (2010), Penn (2007), Pöchhacker (2000), Meyer (2001)). The repercussions of such practice affect not only the service provider but the quality of the service provided. Meyer (2001:87) for instance reveals that in German medical institutions, those working as *ad hoc* interpreters have limited or no experience in interpreting. Nonetheless, they are exposed to

> a type of discourse which is guided by institutional purposes and professional knowledge structures. These in turn lead to the use of a certain vocabulary, formulaic structures and a certain organization of discourse. All this can affect the process of understanding – especially when lay persons are drafted in to work as interpreters.

It is to say that without proper interpreting training, *ad hoc* untrained interpreters might be exposed to a jargon and a discourse they are unfamiliar with; they might also be exposed to situations they might not know how to tackle. On this subject, in conducting a research in Vienna hospitals, Pöchhacker (2000:116) finds that: "When asked about problems with the use of various types of untrained *ad hoc* interpreters […] 90% agreed with the observation that 'accompanying persons do not know or understand medical terms' and 'do not have sufficient knowledge of medical subject matter'". This lack of knowledge can lead to problems such as misinterpretations and omissions. Raising the fact that *ad hoc* untrained interpreters are often security guards, cleaners, relatives, friends, other fellow patients or

colleagues, Kilian, Swatz and Joska (2010:310) raise the issue of the level of literacy of *ad hoc* untrained interpreters, and the repercussions when using untrained interpreters on service provisions:

> Even before the translation exercise began, it became clear that not all interpreters were bilingual–particularly the security guards, both of whom were involved in interpreting on a daily basis at the hospital. They repeated questions and remained quiet until the interviewer explained questions in very basic terms. These two participants, unlike the clerks and nurses, appeared not to understand the questions.

The issue of the lack of proper literacy from *ad hoc* untrained interpreters leads to facing the lack of standards and quality control in institutions where their services are used. Scholars agree that interpreters whether working in statutory services on an *ad hoc* basis or not should be trained (Cf. Deumert (2010), Bischoff and Hudelson (2010), Lubrano di Ciccone (2009), Jacobsen (2009), Angelelli (2005), Pöchhacker (2002), Tebble (2001) etc.). In this regard, Angelelli (2005:37) states that: "The laws of economics are quite clear: it is difficult to imagine professional recognition (and, thus, adequate monetary rewards) without formal education. A profession cannot be characterized as such without an education". Thus, setting the standard to be met by professional interpreters, Pöchhacker (2002:96-97) mentions that:

> There is considerable agreement in the literature on a number of criteria which come into play when assessing the quality of interpreting. While the terminology may vary from one author or text to the other, concepts such as accuracy, clarity or fidelity are invariably deemed essential. […] the interpreter is essentially expected to "represent fully" the original speaker in his/her interests and intentions (Cf. Gile 1991:198) […] quality essentially means "successful communication" among the interacting parties in a particular context of interaction.

When it comes to the standard that should be met with regard to health care interpreting, Angelelli (2005:36) claims that:

> Regardless of whether the student crosses over to healthcare interpreting from a related field or if this is the starting point of his or her education, an individual characterized as a professional in this field needs to have been educated in at least six different areas: 1) information processing; 2) interpersonal; 3) linguistics; 4) professional; 5) setting-specific; and 6) socio-cultural.

In countries where the profession is institutionalised, there are offices in charge of the accreditation of interpreters as well as offices in charge of insuring quality control. In Australia, the National Accreditation Authority for Translators and Interpreters Ltd (NAATI) deals with maintaining standards whereas the Australian Institute of Interpreters and Translators (AUSIT) deals with complaints. In England, the National Register of Public

Service Interpreters (NRPSI) works at promoting professional public service interpreters as well as maintaining standards and doing quality control. Clients and institutions can approach these offices to issue their concerns about an interpreting service. However, in the UK there are some independent bodies that work at promoting standards such as the Chartered Institute for Linguists, Universities and other numerous institutions that offer training in order for aspiring public service interpreters to pass the National accreditations they need to start working in statutory services (Praxis Interpreting, SA).

One other issue that is associated with the institutionalisation of interpreting is the recurrent question of the role of the interpreter. The literature shows that there is a dichotomy between what is expected of the interpreter ethically and what is expected of the interpreter when he or she is at work. Ethically, it is expected that the interpreter remains impartial, that he or she interprets everything, faithfully, that he or she remains emotionless and voiceless and that he or she keeps the communication event confidential (Cf. Angelelli (2003), Roberts (1997), Roy (1993), Bot (2001), Wadensjö (1993)). However, in practice it is proven that the interpreter is an active participant in the triadic exchange (Cf. Angelelli (2003), Bot (2001), Jacobsen (2009), Leanza (2007), Roberts (1997), Roy (1993), Tebble (2001), Wadensjö (1993)). In fact, in agreement with Giovannini (1992), Roberts (1997:15) explains that much more is usually expected from the interpreter than just interpreting:

> Before the communication event, the [interpreter] speaks to the client, "establishes a positive connection", attempts to clarify the client's problem, and "explains the role of the professional or institutional worker" they are about to see (Giovannini, 1992a). This reflects the "assistance" approach […]. He may also, at this stage, integrate the advocacy approach by advising the clients "about rights and options in this situation" (Giovannini, 1992a). During the communication event, in addition to acting as "chair" to ensure that each party has his turn to speak, he may be required to act as an impartial mediator if the conciliation approach is adopted, or as an advocate for the rights of the minority language speaker if the advocacy approach is embraced. Following the interpreted event, the [interpreter's] tasks are often not over. He may, at this point, resume his role of helper and advocate […] In any case, he needs to ensure that the client has all the relevant information for any follow-up. Often a busy doctor will give last-minute instructions to the patient and then rush off, telling the interpreter to "convey the information" to the client.

The doctors' attitude as described above by Roberts (1997) can often be a source of tension since some doctors would claim that interpreters take over their role as medical practitioners, whereas some others would expect interpreters to work as if they were doctors' personal assistants (Cherbonnier, 2002). In South Africa, the ill-defined expectations from interpreters are described by Penn (2007:69) and Watermeyer (2011:72) who equally support that South

African liaison interpreters are expected conjointly to bear the role of linguist, cultural broker, research assistant, counsellor, patient advocate, institutional gatekeeper, co-diagnostician, manager, coordinator of communication between patient and health professional, clarifier and/or conduit. Thus, in order to avoid tensions between medical practitioners and interpreters and to allow interpreters to work at their best, countries where liaison interpreting is institutionalised such as Belgium have set clear rules and regulations describing the duties of the interpreter towards the institution he or she is working at and towards clients. In Belgium, the ministry of health has defined interpreters' scope of duty. In Belgium, "mediators" take on the role of translators, interpreters, patients' advocates, cultural mediators and to a certain extent the role of social workers (Federal Public Service Health, Food Chain Safety and Environment of Belgium, 2013). Nonetheless, Angelelli (2005) reminds us that the onus does not lie on the interpreter alone to ensure successful communication. Users of interpreting services should also be educated about not only the scope of the interpreter's work, but also how to work with an interpreter. Referring to medical practitioners, Angelelli (2005:36-37) highlights that: "Since [healthcare providers (HCPs)] practice in a multicultural environment, it is essential that they be educated about cross-cultural issues, including how to work effectively with an interpreter. Therefore the education of HCPs should include aspects of speaking with, to, and through an interpreter". Although it has not proven to be successful yet, determined efforts have been made to deal with this issue in Australia, which has started including such programmes in medical practitioners' curriculums (Cf. Tebble (2001)).

The last factor that might hinder the institutionalisation of the interpreting profession is the political will of each individual country. Ozolins (2010:196) affirms that there are some factors that "reflect the different priorities that may arise from specific political, social and administrative disposition". Among these factors, he cites "the overall political/social attitudes to immigration (attitudes to indigenous populations are also important in some cases, or attitudes to the Deaf)" (2010:196). Thus, concurring with Hertog et al. (2007) Ozolins (2010) emphasises the reluctance of governments and people in almost every country to address the practical needs of those who do not speak their language" (2010:197) and further he points out that:

> Yet, two caveats are in order: some traditional non-immigrant countries such as Sweden have developed quite comprehensive approaches to language service needs; while even among immigration countries (say USA, Canada and Australia) quite

> significant differences exist in how language services have developed and how governments have responded. (Ozolins, 2010:197)

Another important point is that if interpreters are not trained and reciprocally if there are no institutions to train them, there would be very few organisations that would lobby for their rights and issues and therefore influence political decision-making in order to institutionalise the profession. However, not all countries need lobbyists' pressure to force politicians to address the issue of language provision. Norway for instance is one of very few countries where the state has especially undertaken to tackle language provisions: It is the Norwegian state that regulates interpreter training, certification and employment in the public services (Praxis Interpreting, SA).

2.3 Health care interpreting in the oncology setting

2.3.1. Communication in oncology

Researchers in the field of communication in the oncology setting concur that successful communication is crucial to obtain good cancer care (Cf. Eggly et al. (2006), Fallowfield and Jenkins (1999), Kissane et al. (2012), Lubrano di Ciccone et al. (2009), Nayak et al. (2005), Owen and Jeffrey (2008), Schapira et al. (2008), Surbone (2009)). Kissane et al. (2012) for instance state that: "Effective communication is central to the clinician patient encounter. When the patient's needs and concerns are well understood through biopsychosocial formulation, then a comprehensive care plan can be mutually agreed on" (2012:1242). However, it appears that oncologists' communication skills constitute a challenge to effective cancer care as Fallowfield and Jenkins (1999) support that: "Not surprisingly, many cancer patients are dissatisfied with much of the communication that takes place within hospitals. The Omission of adequate prognosis and potential therapeutic options can increase anxiety and uncertainty and can lead to dissatisfaction with healthcare in general" (1999:1593). Nayak et al. (2005) corroborate with this statement. After conducting a survey on patients' satisfaction, they have found that: "Physician communication is one of the areas that cancer patients have expressed their lowest level of satisfaction" (2005:4771). This could be justified by the fact that most oncologists and nurses in that setting do not receive adequate training in communication. Fallowfield and Jenkins (1999) raise this argument as they emphasise that: "Communication should be viewed as a core clinical skill that merits a considerable investments of time and resources in training. Unfortunately few oncologists or nurses have

received adequate formal education in communication skills using methods likely to promote change, confidence and competence" (1999:1592). Oncologists' low communication skills constitute an even bigger issue because as stressed by Surbone (2010), cancer care is filled with "profound experiences of suffering, resilience, loss and grief regardless of patient's race, ethnicity, socioeconomic status or culture" (2010:3). Good communication is thus at the centre of how to disclose bad news to patients and successfully handle the draining emotions as well as the deep suffering. Communication is also important to appropriately suggest the options available to patients and receive their consent for clinical trials. In this regard, Owen and Jeffrey (2008) assert that: "beyond its pure informational content, communication is […] at the core of emotional support during this stressful disease" (2008:1163). Thus, diverse goals must be achieved through communication in cancer care in order to help patients to:

> receive bad news; handle the emotional impact of a life-threatening illness; understand and remember complex information; communicate with multiple health professionals; understand statistics related to prognosis; deal with uncertainty while maintaining hope; build trust that will sustain long-term clinical relationships; make decisions about treatment, possibly including participation in clinical trials; and adopt health-promoting behaviours. (Owen and Jeffrey, 2008:1163)

Discussing further the importance of communication in the oncology setting, Fallowfield and Jenkins (1999) argue that: "Good communication had many positive effects on the patient's adjustment to cancer and its treatment, whereas poor communication has negative consequences for both healthcare professionals and patients" (1999:1592). Explaining the benefits of effective communication on both health care professionals and patients, Fallowfield and Jenkins (1999:1592) contend that:

> Effective communication during a consultation is probably the major determinant of the accuracy and completeness of the data collected. It influences the range and number of symptoms elicited, permits a more precise assessment of the efficacy of therapy, affects adherence to treatment recommendations, impacts on emotional and physical well-being and contributes to both patient and healthcare satisfaction.

Researchers in communication in the oncology setting such as: Butow et al (2010), Surbone (2009), Nayek et al. (2005), Kissane et al. (2012) and Owen and Jeffrey (2008), to name just a few, stress that having cultural competence, being aware of the importance of trust between doctor and patient as well as between doctor-patient and interpreter, receiving communication skills trainings and being considerate of patients' privacy during consultations are altogether major steps towards improving communication in the oncology setting.

Concerning cultural competence, Surbone (2009:3) explains that it refers to a set of knowledge and practical skills that are needed to efficiently care for cancer patients and families belonging to different cultures. Explaining how cultural competence has evolved, Surbone (2009:3) states that:

> Its initial focus was on providing clinical tools for the necessary negotiation of different health beliefs and values in discordant medical encounters, and its main goal was to reduce the conflicts that arise from cultural differences among patients, families and health care professionals. Today, cultural competence is increasingly considered a key factor, both at individual and system levels, that may contribute to our efforts to eliminate disparities in health care and reduce the burden of unequal cancer treatment.

There are various issues that can be observed in the oncology setting and that are directly related to culture. In their study about bridging cultural barriers in the oncology setting, Butow et al. (2010) state that: "interpreters noted that some cultures have a tradition of passivity in medical encounters and/or deep respect for the doctor which stops patients from asking the questions they need to ask in order to fully understand their situation" (2010:238). Thus as an attempt to address this difficulty:

> Interpreters sometimes felt the need to act as a cultural advocate, by intervening to encourage patients to ask questions on their behalf. They also felt that migrant patients sometimes became confused when asked to make treatment decisions, as they expected to be told by the doctor what to do, and may be disadvantaged by the "Western approach" to decision making imposed upon them. Sometimes, [the interpreters] were put into a difficult position when patients turned to them for advice, which they felt unable to give. (Butow et al., 2010:238)

Although the above example only describes an attempt to address a cultural challenge, Surbone (2009:3-4), lists five issues that remain unresolved in the practice of oncology:

> First the notion of culture is extremely complex and we still lack a good definition for it since confusion persists about race, ethnicity and culture, and there is a tendency to reduce cultural issues to socioeconomic issues. […] Secondly, the relationship of culture to health and illness is complex, multifaceted and still poorly understood. For example, most medical literature evaluates the impact of cultural factors using Western standards for comparison, while knowledge and appreciation of non-Western cultural traditions and beliefs in promoting the health of their members are largely overlooked. […] Thirdly, many unfortunate instances of racism still exist in the practice of medicine. […] Most often, it results from the institutional and system attitudes and choices that create a 'culture of discrimination' by which health care workers are influenced. […] Fourthly, effective communication in medical encounters is a bidirectional process that enables us to gather information and clarify it during the course of our patients' illness, with the aim of establishing a correct diagnosis, prognosis and treatment plan and of involving patients in the decision-making

> process, so that they may receive not only the best care but also the one most respectful to their values and beliefs, according to their individual wishes and culture. […] Fifthly, inadequate communication, whether verbal or nonverbal, engenders frustration and reciprocal mistrust.

Trust is thus mentioned as an important issue that should be addressed in order to improve communication in the oncology setting. In this regard, Surbone (2009) adds that: "Mistrust […] negatively affects the quality of the care received by cancer patients, which on large part depends on an open, effective, ongoing relationship with their oncologists" (2009:4). Trust is as important in a consultation involving doctor and patient as it is in a consultation involving doctor, patient and interpreter. Schapira et al. (2008) support that: "In order to work smoothly, physicians need to be able to trust that the interpreter will deliver a precise rendition of the physician's assessment and plan for treatment, clarify possible misunderstanding, and facilitate rapport among all participants in a meeting or conference" (2008:588). Trust is also an important factor in communication in a multidisciplinary team in the oncology setting. Fallowfield and Jenkins (1999:1594) thus affirm that:

> Important information for the patient is often omitted, based on the assumption that someone else must have relayed the relevant facts at the appropriate times. This can be confusing and cause a loss of confidence in the team and provoke needless anxiety for patients; it is also frustrating for clinicians who may have to spend extra time communicating bad news or even quite basic information to an unprepared patient.

The lack of trust may therefore originate from a lack of communication or an ill communication either between parties involved in receiving and providing health care or between professionals providing health care in the oncology setting. Fallowfield and Jenkins (1999:1594) thus assert that: "Some doctors acknowledge that their own communication skills are limited and consequently abrogate much of the responsibility for information-giving to specialist nurses. There is, however, no evidence that nurses' skills are any better than those doctors". They also add that:

> The context and content of communication in oncology can often generate challenging and highly charged emotions and some doctors exhibit a cold, professional detachment as a means of preserving their own emotional survival. Unfortunately, such distancing tactics are unhelpful and damaging to patients and their families. Furthermore, strategies such as these do not allow doctors to establish the kinds of satisfying therapeutic relationships that can make medicine so worthwhile. (Fallowfield and Jenkins, 1999:1594)

This is why researchers such as Kissane et al. (2012), Eggly et al. (2006) and Owen and Jeffrey (2008) for instance concur on the importance of communication skills training for

oncologists as well as all professionals working in the oncology setting. Kissane et al. (2012:1244) suggest a communication skill training curriculum at two levels: a basic core curriculum for oncology that covers the basic communication skills that professionals working in the oncology setting should master to successfully tackle daily consultation, and an advanced curriculum for oncology that covers the communication skills professionals should master to successfully deal with selections for clinical trials.

Table 1. **Communication Skills Training Curriculum for Oncology**

Basic Core Curriculum for Oncology	**Advanced Curriculum for Oncology**
1. Breaking bad news	**1. Clinical trial enrollment (sic)**
2. Discuss prognosis and risk	**2. Cancer genetics**
3. Shared decision making	**3. Survivorship**
4. Responding to emotions	**4. Treatment adherence**
5. Deal with recurrence	**5. Discuss Internet and unproven therapies**
6. Transition to palliative care	**6. Culturally determined beliefs**
7. Run a family meeting	**7. Working as multidisciplinary team**

Table 2.1 Communication Skills Training Curriculum for Oncology. Kissane et al. (2012:1244)

In addition to these verbal communication skills, Nayak et al. (2005) as well as Fallowfield and Jenkins (1999) stress the importance of nonverbal communication skills. Nayak et al. (2005:4772) declare that:

> Common problems of communication include simple errors like faults in common courtesy or failure to listen and to acknowledge patients' needs. Many clinicians feel uncomfortable communicating sensitive news to cancer patients because of a lack of basic skills in nonverbal communication. Good training for physicians in verbal and nonverbal communication skills facilitates patient compliance and overall satisfaction.

Besides stressing the importance of verbal and nonverbal communication skills, Nayak et al. (2005) also raise the importance of the respect of patients' privacy and confidentiality. Owen and Jeffrey (2008) insist on the fact that: "Healthcare professional owe patients a duty of confidentiality but in practice this duty is often compromised by a variety of circumstances" (2008:1167). In the course of their research, Nayak et al. (2005) have found that: "The main source of interruptions/disturbance during the interview process was found to be the telephone, other patients or relatives, and other hospital staff" (2005:4773). They also raise the financial constraints that developing countries face as they affirm that:

> Our faculty and administration were particularly concerned about the great level of discomfort expressed by patients regarding privacy. […] However, due to limited resources in Developing countries, apparently simple changes such as the rearrangement of clinic layout, avoidance of interruptions, or instituting appropriate time for communication can be complex or overwhelming. Therefore, a major

> concerted effort between clinicians and administrators is required for successful implementation of these changes. (Nayak et al., 2005:4774)

Giving a warning regarding the consequences of not respecting patients' privacy and confidentiality, Owen and Jeffrey (2008:1167) claim that:

> In a poorly constructed outpatient department, or on a ward, the patient may fell inhibited about asking questions when other patients can overhear the conversation and he/she may feel unable to express emotions such as anger or distress. Other patients in the ward may also be traumatised by hearing this difficult consultation. This situation can be avoided by arranging for some private space to be available.

Having discussed the state, challenges and stakes of communication in the oncology setting, it is worth examining how interpreting services may play a role in improving communication by bridging language and cultural barriers in the oncology setting. It is however crucial to highlight that researchers in that field have stressed the difficulty in recruiting patients for such study since they are such a vulnerable group (Cf. Butow et al. (2011) and Eggly et al. (2006)).

2.3.2. Health care interpreting in the oncology setting: global literature review

There is very little literature on healthcare interpreting in the oncology setting. However, the available resources show evidence of numerous instances of language and cultural barriers between oncologists and patients. As a result, there is a demand for interpreting. Butow et al. (2011:2801) for instance explain that:

> Migration is increasing worldwide, with the number of people who do not speak the dominant language of the country in which they live similarly increasing. Immigrants diagnosed with cancer have poorer outcomes than comparable non-immigrant groups, with lower screening and survival rates, more adverse effects, poorer quality life and greater diseases.

The problem of lower quality service received by immigrants worldwide is also supported by Beach et al. (2007:2058) who states that: "there is evidence that non-English speakers in the United States receive lower quality health care and preventive services than English speakers […] the persistence and pervasiveness of health disparities by ethnicity, race, gender and socioeconomic status are well recognized". Describing similar challenges, Butow et al. (2011:2801) add that:

> [The disparities between immigrants and non-immigrant groups in Australia] may be due to unfamiliarity with health care systems, difficulty accessing care, and poor doctor-patient communication. Immigrants often report that they struggle with language difficulties, lack information, and that health professionals do not understand them, which may adversely affect their psychological and physical well being (sic).

Beach et al. (2007:2058) further substantiate the reasons of these disparities as they claim that:

> Explanations for disparities include systematic differences in access to health care, differing cultural attitudes about health or health care, distrust in the health care system or providers, biases in providers' willingness to recommend services for some groups, systematic receipt of poorer quality of care for some groups, and a lack of concordance between the language of providers and patients, resulting in poorer communication and health management for "discrepant" patients.

Although the provision of trained interpreters might be "limited by availability and facilities' budget" (Lubrano di Ciccone et al., 2009:28), all the scholars consulted however believe that part of the solution to alleviate these disparities would be to provide interpreting services in oncology wards. Lubrano di Ciccone et al. (2009:27) for instance state that: "[…] in cancer care where diagnosis can be life threatening and the treatment arduous […] effective medical interpretation is necessary not only for the clinical encounters but also for other health-related activities such as registration, appointments and pharmacy". Beach et al. (2007:2058) also concur with that solution though they are more critical as they support that the provision of interpreting services to bridge language, cultural and ethnical barriers is part of "simplistic solutions that only seem to modestly eliminate disparities". They claim that communication can be bridged in instances where patients meet a bilingual doctor or when the communication is limited to providing tests results. They suggest that there is more that can be done for cancer patients. Quoting Seijo et al. (1995), Marks et al (1987), Jacobs et al. (2005), Hampers (1999) and Woloshin et al. (1997), Beach et al. (2007:2058-2059) argue that in the USA, it has been found that:

> Non-English speaking patients had better recall and asked more questions during visits to bilingual physicians […], they also received more 'straightforward' tests and services, perhaps because these do not require complex decision-making or communication with patients […] Latina women who only spoke Spanish were not less likely to receive breast cancer screening, they were less likely to receive a Pap test [since] Pap tests may require more direct patient-provider communication than mammography and in Canada, women who did not speak English at home were less likely to receive preventive screenings than their English speaking counterparts.

Beach et al. (2007) thus conclude that providing interpreters in oncology wards is a step forward however, they concede with Bell et al. (1999) that "offering advice and information in a patient's preferred language was important to the success of an educational intervention" (Beach et al., 2007:2059). Lubrano di Ciccone et al. (2009) raise the importance of providing interpreting services with professional interpreters rather than *ad hoc* untrained interpreters as they highlight that: "Patients were less likely to have a clear understanding of their diagnosis and discharge orders and less likely to have been told of medication side-effects when using *ad hoc* interpreters" (2009:28). In the course of their research, Beach et al. (2007) find that providing telephone support intervention in patients' preferred languages increases cancer screening rate. In other words, communicating with patients in their preferred language even out of the consultation setting to educate and inform them can increase their adherence as well as follow-up visits. Telephone support intervention can also help to provide a platform for discussions to address some of patients' erroneous beliefs regarding cancer such as: "'medications for pain are ineffective', 'a positive attitude is all you need', 'surgery spreads cancer' and that 'cancer cannot be treated'" (Lubrano di Ciccone et al., 2009:28).

Discussing the technical difficulties that interpreters encounter when working in the oncology setting, (Lubrano di Ciccone et al., 2009) emphasise that: "communication about terminal or life-limiting illness adds to the complexities beyond language discordance to incorporate cultural discordance" (2009:28). This technical difficulty is exceeded by interpreters' lack of specific training in oncology. Beach et al. (2011:2801-2802) thus stress that:

> While the provision of interpreters potentially addresses [the disparity] difficulties, studies have revealed problems with medical interpretation, including accuracy, inconsistency, and confusion regarding the interpreter's role. […] These challenges may be further heightened in oncology because of the complexity of information and treatment options, cultural stigma related to cancer, and the frequency with which bad news is discussed. Australian interpreters do not receive oncology-specific training and often interpret across diseases; thus their knowledge of oncology-specific terms and issues may be limited.

In Butow et al.'s (2011) study, they also compare the accuracy of professional interpreters with family and friend's renditions. The latter's rendition is less accurate than the former although in their study, it seems mostly inconsequential (2011:2802-2804). Of the 1,274 interpretations which prove inaccuracy, they find that non-equivalence is due to medical terms that are either left out or changed (7% of the time), words are changed (40% of the time) and agency is changed (2% of the time). They also find evidence of missing

information (31% of the time) and evidence of added information (15% of the time) (2011:2804). Butow et al. (2011:2804) report the following finding:

> many instances, nonequivalent (sic) interpretation was judged [by the analysts] to have had no effect on the meaning conveyed, an insignificant effect, or potentially a positive effect, in other instances changes were judged to have led to a negative effect on communication, including causing misunderstanding (9.7% of the time), conveying a harder, more paternalistic tone (4.9% of the time), and conveying more certainty than the doctor had intended (3.1% of the time). In some instances, relatives did not disclose prognosis or treatment options. Patients often recognized such manipulation.

Although in their study Butow et al. (2011:2805-2806) conclude that the errors made by untrained *ad hoc* untrained interpreters are inconsequential and they agree in principle on the importance of using professional interpreters, patients sometimes prefer their relatives as interpreters. However, Schapira et al. (2008:588-589) stress that:

> Choosing an untrained interpreter may have important consequences on the final outcome. Studies have clearly documented that, in medical settings, untrained interpreters–such as relatives, friends, secretaries, and janitors who have bilingual skills and happen to be available–are unreliable and may contribute to errors and miscommunication.

Schapira et al. (2008) then conclude that: "Ultimately, professional medical interpreters have the unique ability to assist clinicians in establishing the healing connections that form the foundation of ethical and culturally sensitive care" (2008:591).

With regard to interpreter modalities, in Butow et al.'s (2011:2806) study, the quality of professional interpreters' rendition either done in-person or remotely is the same. However, they report that there might be a certain preferred tendency: doctors, patients and professional interpreters favour different types of interpreter modalities. Butow et al. (2010:2806) thus support that:

> Previous results in the general practice setting comparing interpreter modalities have produced different results. Napoles et al (sic) compared clinician satisfaction with in-person versus video-conference interpreters and found no difference in the rates quality of interpretation, although in person (sic) interpreters were judged to be more culturally competent. Another study found that remote simultaneous interpreting services provided more functionally equivalent interpretations and were preferred by patients and clinicians over in-person consecutive interpretation, although the interpreters preferred the latter. In focus groups, interpreters of cancer consultations emphasized that for bad news consultations particularly, face-to-face interpretation was superior, to ensure that emotion and support was appropriately conveyed.

Providing justifications as for why telephone interpreting is favoured by patients and clinicians over in-person interpreting, they claim that: "The evidence suggests that telephone interpretation may be logistically simpler, cheaper, and as effective, but in some circumstances (e.g. bad news consultations), less preferable than face-to-face interpretation" (Butow at al., 2011:2806).

With regard to the role of the interpreter, Butow at al. (2011) emphasise the active participation of professional interpreters in oncology medical encounters. In agreement with Hsieh (2007), they describe professional interpreters' participation as "co-diagnostician behaviors (sic)" (2011:2806). This behaviour might be due to the lack of training for physicians and professional interpreters that would enable them to work together. Lubrano di Ciccone et al. (2009:28) thus support that: "Despite the evident centrality of interpreters to the health care system, clinicians are rarely trained in how to work with these interpreters". Butow et al. (2011) therefore provide five varieties of behaviour that are observed when professional interpreters work (2011:2806):

> Assuming the provider's communication goals; editorializing information for medical emphases; initiating information-seeking behaviors; participating in diagnostic tasks; and volunteering medical information to the patients. We observed interpreters trying sometimes to reassure the patient, and sometimes clarifying or simplifying information. Of note, this is not dissimilar to the behavior of many doctors, who also rush to console patients and may even contradict themselves in the process.

Acknowledging that the behaviour of professional interpreters is controversial, they recommend "training oncologists and interpreters to better negotiate how information will be conveyed during consultation" (Butow et al., 2011:2806). The goal of Lubrano di Ciccone et al.'s (2009) research being to suggest some model of communication modules that enables oncologists and professional interpreters to achieve an optimal interaction, they suggest one Communication Skills Training (CST) module that aims at: "(i) privileging the doctor-patient dialog, (ii) promoting shared understanding and (iii) being sensitive to cultural differences" (2009:28). To achieve these goals, six strategies are suggested (2009:29):

- Strategies 1 and 2 involve introducing the content and expectations of the consultation with the interpreter and eliciting interpreter's knowledge about the patient that is relevant for a successful visit […] A brief meeting with the interpreter before the consultation will provide an opportunity to inform him/her about the clinician's preferred method of interpretation and seating arrangements, as well as inquiring about the interpreter's awareness of any cultural factors that might interfere with the doctor-patient dialog.

- Strategy 3 involves establishing the doctor-patient-interpreter team. During this step, clinicians should introduce the interpreter to the patient (if not done previously) and explain the process to the patient. Patients should be addressed directly and thus helped to avoid looking at the interpreter. Seating the interpreter just beside and behind the patient, with the interpreter's eyes slightly downcast, can avoid the common triangular arrangement in which the patient and interpreter converse for extended periods to the exclusion of the clinician.

- Strategy 4 explores the culturally held belief that can potentially limit effective understanding and communication between the clinician and the patient.

- Strategy 5 is intended to promote effective interpretation throughout the consultation. It is crucial that the clinician plans ahead what he/she wants to say, to avoid confusing the interpreter by backing up or rephrasing. [In consecutive interpreting], the use of short sentences, the avoidance of idiomatic phrases that can be difficult if not impossible to interpret and the use of frequent pauses are process tasks that make this strategy a successful one.

- Strategy 6 reviews the consultation with the interpreter and provides an opportunity to discuss possible cultural sensitive issues identified by the interpreter and that might not have surfaced during the actual interpretation.

Lubrano di Ciccone et al. (2009) also stress that other CST modules are worth undertaking. Specifically those including "breaking bad news, shared decision making about treatment options including clinical trials, responding to patient anger, conducting family meeting, discussing prognosis, discussing the transition from curative to palliative care and shared decision making about Daunorubicin orders" (2009:29). Lubrano di Ciccone et al. (2009) explain how they have organised a workshop with health care professionals working in the oncology setting so as to train them to work efficiently with professional interpreters. Prior to the workshop, booklets addressing triadic communication during a consultation were sent to participants. During that workshop, a presentation of the literature on health care interpreting and communication was provided using video clips and some role-plays involving a professional interpreter and a simulated bilingual patient were undertaken. Learners received a feedback from all participants: the facilitators, their peers, the interpreter and the simulated patient. The workshop received positive feedbacks (2009:30).

In their study focusing on interpreters' perspective of consultations with migrant oncology patients, Butow et al. (2010) voice one of interpreters' major concerns: the emotional burden when working in the oncology setting. This very concern is also raised by Schapira et al. (2008). Butow et al. (2010:239) report that:

> Many interpreters talked about the emotional impact of sitting in on cancer consultations, particularly those in which bad news was delivered, for which they were ill-prepared. Interpreters noted that some consultations were so distressing that they found it difficult to "switch off" and that it intruded on their home life. They felt this is an under-recognised issue for interpreters for which they get little or no support.

Furthermore, interpreters highlight that their exposure to emotional distress raises a "tension between upholding the code of practice for interpreters that required impartiality, yet responding in a compassionate manner" (Butow et al., 2010:240). They thus stress on the need to do debriefing after consultations; since health care professionals and institutions hardly make provision for debriefing for interpreters. Butow et al., (2010:240) report an interpreter's testimony:

> Unfortunately that is a problem that we all have that there is no debriefing for interpreters. So I can walk out of an appointment feeling very, very bad and there is no one that you can talk to. In all years that I have been working as an interpreter only once have I been offered debriefing and that was at the Coroner's Court. Never in any other situation.

2.3.3. Health care interpreting and communication in the South African oncology setting

There is very little literature on health care interpreting in the oncology setting in South Africa. However, Mullin, Cooper and Eremenco (1998) note that in South Africa, there are two medical cultures that seem analogous: "the medical science versus the folk medicine" (1998:70). They report that:

> South Africa is both a developed and a developing country. Highly trained Western medical doctors offer care equivalent to that offered in any other technologically advanced nation. […] Such advanced medical care has been available to the country's white population and to some members of other races, including a few blacks. In contrast, according to colleagues at Pretoria Academic Hospital, approximately 80% of the nation's poor, rural blacks (the majority of the population) visit traditional healers as their primary or only source of medicine. (Mullin, Cooper and Eremenco, 1998:70-71)

However, more recent reports have described a dichotomy concerning the use of traditional healers in South Africa. Whereas Truter (2007) informs that: "in South Africa, it is estimated that between 60% and 80% of people consult a traditional healer before going to a primary health care practitioner" (Truter, 2007:56), Statistics South Africa has published the results of

its 2011 household general survey and has declared that: "While 70,7% of households favoured public clinics and hospitals, almost a quarter (24,3%) of households said they would first consult a private doctor. The least favoured options were traditional healers (0,1%) and pharmacies (0,3%)" (Statistics South Africa, 2012:15). These results are in contradiction with the report from Fihlani (2013) who has published on BBC that: "[*Sangomas*] remain the first point of contact for physical and psychological ailments for about 80% of black South Africans according to authorities" (Fihlani, 2013).

Mullin, Cooper and Eremenco (1998) are in agreement with Maxwell (1995) who supports that: "health expenditures vary widely by race in South Africa, and in 1987 they averaged R597 for whites and R138 for blacks, per person per year" (Mullin, Cooper and Eremenco, 1998:71). However, whereas the South African Institute of Race Relations (SAIIR) (2011) has indicated that:

> South Africa's proportional health expenditure is the highest in comparison to the BRIC group of countries, but our health outcomes are generally worse, says the South African Institute of Race Relations. Spending is at 9% of the country's Gross Domestic Product (GDP), followed by Brazil's 8% and Russia's 5%. China and India both spend the lowest proportions at 4%.

Hofman and Tollman (2010:798) have also pointed out that in South Africa,

> [p]ublic sector expenditure at approximately R1 600 or US$200 per person per annum, is approximately 4 times the sum expended in other countries of sub-Saharan Africa. Likewise, the per capita costs of a package of interventions to save maternal and neonatal lives in SA is 2 - 4 times that of Cameroon and southern Nigeria, regions with similarly resourced health systems. The difference is largely a function of input costs, human resources in particular. Secondly, within SA the per capita expenditure on non-hospital primary care varies considerably by province and by district, ranging from a high of R505 per person to R220. These figures do not reflect out-of pocket payments and direct costs to families and patients themselves. For example, in 2006 in one rural province, up to 60% of monthly expenditure was consumed on seeking health care, with transport costs accounting for a significant portion. Against this background, since the 2009 national elections the government has renewed assurances to improve health care, including: expanded social grants impacting on household income, with positive effects on nutrition and school attendance (National Treasury 2010); promoting cost-effectiveness and phasing out or redesigning ineffective programmes to ensure greater value for money; improving health care at the district level; introducing a National Health Insurance (NHI) system. During these deliberations, several groups have developed projected costs, with little consensus. Some differences depend on the predicted extent of health coverage. Improved knowledge about effective health care interventions and policy systems requires more careful scrutiny of available evidence and ensuring that costs are taken into account. If this is not done, health care spending will continue to rise with uncertain benefits for population health.

Mullin, Cooper and Eremenco (1998:71) also stress that the Black population in South Africa is struggling the most in terms of health as they face challenges such as higher rate of infant mortality, maternal mortality, infectious diseases, malnutrition, hypertensive disease, and cancer of the cervix, to name just a few. They are in agreement with Baile and Bourne (1996) who, in the course of their research have found that there are

> [d]isparities in screening for cervical cancer. Because of its limited availability to a small segment of the white population, the procedure has not included women at high risk and therefore has not been successful in reducing the incidence of this disease. A study in a Western-style hospital (deHaan, 1993) found that the majority of Xhosa women (75%) presented with advanced cancer (Stage 3 or 4), compared to 21% of white women. Although a very small number of white women refused treatment, 25% of Xhosa women refused treatment and another 25% who accepted treatment died within the first year after diagnosis. (Mullin, Cooper and Eremenco, 1998:71)

Addressing the reasons of the disparities in health care provisions aside from the racial prejudice, Mullin, Cooper and Eremenco (1998:71) are of the following view:

> The public and private sectors typically receive an unequal distribution of health care expenditures, with the private sectors providing services to 20% of the population–predominantly whites (Maxwell, 1995). Kale (1995) attributed the health care discrepancy to insufficient health care personnel, despite the fact that South Africa does have technologically advanced medical facilities. van Vuuren (sic) and de Klerk (1996) examined other reasons why health care is not equally accessible to all members of society. These factors include costs, distance, consultation hours, and attitude of medical personnel. Chetty (1995) looked at the distribution of health services, in terms of beds, fixed clinics, and other facilities, compared with the population in each of the nine provinces and found disparities between them as well as in levels of care within provinces.

From the above quote from Mullin, Cooper and Eremenco (1998), it appears that some of the factors that contribute to the disparities in health care provision in South Africa are still on-going 15 years later. Hofman and Tollman (2010) have mentioned the problems of transportation and cost for Black patients, Herselman (2007) has emphasised the cultural barriers and thus the different mind-set between health care providers and Black patients; the Organisation for Economic Co-operation and Development (OECD) has also highlighted in its 2013 OECD health data that: “In 2011, South Africa had only 0.7 physicians per 1000 population […]. There were also only 1.1 nurses per 1000 population in South Africa in 2011 […]. The number of hospital beds in South Africa was 2.4 per 1000 population in 2010, which is half the Organisation for Economic Co-operation and Development (OECD) average (4.8 beds).” (OECD, 2013).

As mentioned by Hofman and Tollman (2010), following the 2009 elections, the South African government has "renewed assurances to improve health care" (2010:798). However, just as Mullin, Cooper and Eremenco (1998) have pointed out, effective measures are yet to improve communication in the health care services in general and in the oncology setting in particular. They underline that just as in the other countries in the world, in South Africa, consultations in the oncology setting are:

> physician-centered, consisting of closed-ended questions by the physician, while little opportunity for patients to initiate discussions. The majority of the consultation consisted of conveying information regarding the nature of the disease and treatment options. Physicians paid very little attention to psychosocial issues with which oncology patients would have to be dealing when facing a life-threatening illness. (Mullin, Cooper and Eremenco, 1998:73)

Addressing communication barriers in the oncology setting in South Africa, Mullin, Cooper and Eremenco (1998:73-74) affirm that:

> Educational efforts regarding prevention and treatment of cancer have increased in South Africa, but the emphasis seems targeted less to the black population than the white population. For example, although national organizations provide information to patients throughout South Africa, most of this information is in English or in Afrikaans and is not available to Black patients in their native languages. Similarly, most surveys on patient information needs have been carried out with English- or Afrikaans- speaking populations (McLoughin and Oosthuizen, 1996) and are likely to have a Western bias. These results generally indicate that patients want more information about the disease and its treatment than they currently receive, but this trend may not generalize to the black population. […] Bezwoda et al. (1997) reported on a recent study that found that 35% of patients did not know their diagnosis of cancer. "Doctors withheld information to save the patient unnecessary distress because of, for instance, pressure from families who did not wish their relative to know the diagnosis" (p.128). Another study showed that "blacks were significantly less likely to have information about their cancer provided by a doctor, or in their own language, or to be provided with reading material regarding the disease" (p.128).

Although Mullin, Cooper and Eremenco (1998) acknowledge the importance of language and cultural bridging, they implausibly support that: "With the need for an interpreter or a second language on the part of either physicians or patients, 'the possibility of failing to communicate adequately increases immeasurably' (p.129). The authors suggest that physicians learn to be aware of and respect the cultural values of their patients" (Mullin, Cooper and Eremenco, 1998:74). Professionally trained interpreters working in the health care setting are skilled. They aim at breaking language and cultural barriers between doctors and patients; to the researcher, they are therefore the key to overcome cultural and language challenges in multicultural settings.

Addressing the problem of language barrier in the oncology setting, Mullin, Cooper and Eremenco (1998:74) highlight that: "At times, communication becomes problematic because 'in certain situations patients lack adequate or appropriate vocabulary to express ideas or concepts relating to biomedicine' (p.158), especially technology or symptoms." They concur with McLoughlin and Oosthuizen (1996) who favour: "a change on the physician-patient relationship to one of patient participation in decision-making" and add that "'in order for the patient to be able to participate positively in this process, he has to be provided with accurate information in the appropriate language at the appropriate time in the course of the illness' (p.32)" (Mullin, Cooper and Eremenco, 1998:74). On this ground, Mullin, Cooper and Eremenco (1998:74) are in agreement with Bezwoda et al. (1997) who suggest that "nurses may serve as ideal facilitators of communication between physicians and patients". Thus, it must be noted that there is a dichotomy between Mullin, Cooper and Eremenco's (1998) statement suggesting on the one hand that the presence of an interpreter would increase the failure to communicate adequately; and on the other hand that nurses are most suitable to tackle the interpreting function. Nonetheless, Mullin, Cooper and Eremenco (1998:75) concur with Witte and Morrison (1995) as they identify; "language barriers, translation and translator problems, misinterpretation of nonverbal messages, and normative politeness behaviors as areas of potential miscommunication in the intercultural health context. Even if health professionals and patients speak the same language, they may have different understandings for the same words".

Discussing among others the possible shortcomings when using an interpreter, Mullin, Cooper and Eremenco (1998:75) stress that:

> Translators may mistranslate or not provide enough information from patients. Nonverbal messages such as eye contact, head shaking, and smiling can mean different things in different cultures and may cause miscommunication based on each party's cultural assumptions. For instance, Zulus learn to avert their eyes as a sign of respect to a superior or authority figure (Tollman and Msengana, 1990). It would be easy for Westerners to misinterpret this behavior as a sign of deviousness or dishonesty. From a Western perspective, typical Zulu communication can appear to consist of "impoverished speech, paucity of content, and emotional bluntness" (Tollman and Msengana, 1990, p.24). A simple conversation between a Zulu patient and a white physician in South Africa can become derailed because of different attributions to the length of pauses in a conversation. For example, "Zulu-English speakers, on average, speak more slowly than S.A. [South African] English speakers, pauses of relatively short duration do not function as turn exchange signals in Zulu English, and Zulu-English speakers are generally more tolerant of extended monologue than S.A. speakers" (Chick, 1990, p.235). Thus, a busy physician may

> interpret a pause as the end of a patient's statement, but the patient may be gathering his or her thoughts to continue speaking.

Mullin, Cooper and Eremenco (1998) emphasise extensively on cultural differences between White health care providers and Black patients as they point out that:

> Cultural differences that may cause difficulty for physicians include "the prolonged nature of, and wider family involvement in, the decision-making process, the resort to traditional healer, and the role of the husband as the absolute arbiter of decisions about his spouse's health" (p.128). However, it is essential to note that members of the same ethnic group may hold different health and disease beliefs, and it is important not to assume uniformity among them. (Mullin, Cooper and Eremenco, 1998:74)

Referring to Herselman's study, Mullin, Cooper and Eremenco (1998:75) stress that:

> Certain characteristics of black patients in South Africa tend to hinder communication. For instance, they are often defensive, "interpreted as a protective measure, [arising] from patients' discomfort in the clinical setting, sometimes making them reticent or almost emotionless" (p.159). Patients also tend to be polite and deferential, which lead to miscommunication if patients withhold information or out of politeness, distort their situation. Politeness behaviors may cause patients to appear to agree with a health professional even when they do not agree because in such cultures patients cannot question or challenge an authority figure such as a physician (Chick, 1990; Herselman, 1996). For example, one breast cancer patient said she did not want to complain about discomfort because of feeling "ashamed of bothering the nurses."

Mullin, Cooper and Eremenco (1998) also address the question of the relationship expectations between physician-patient from a cultural point of view. They concur with Witte and Morrisson (1995) as well as Herselman (1996) as they submit that:

> Patients often have culturally related expectations from health professionals' behavior. Physicians often have difficulty knowing what would be the best communication strategies. Witte and Morrison (1995) point out two important issues. First, many non-Westerners expect physicians to have a personal relationship with them and prefer indirect messages and questions. Second, patients may have expectations that they will receive treatment, such as prescriptions or injections, at the visit. In some cases, there is no time for physicians to develop a personal relationship with their patients due to work overload, and this could lead to ineffective communication and patients feeling ignored (Herselman, 1996). Herselman (1996) emphasizes the following specific communication problems in physician-patient encounters in South Africa: (a) Physicians' inability to label a condition (i.e., diagnosis); (b) patients' lack of understanding, possibly due to terminology or a reluctance to ask questions; and (c) submissiveness and acquiescence among patients. Although physicians attempt to develop styles of communication that consider patients' perspectives and are appropriate for their education level, there is no universally correct pattern to the strategies employed, and individually tailored approaches are the norm. (Mullin, Cooper and Eremenco, 1998:75-76)

Besides all these challenges to communication in the South African oncology setting, Mullin, Cooper and Eremenco (1998) identify positive elements in the physician-patient relationship:

> On the positive side, Bezwoda et al. (1997) see the physician-patient relationship in South Africa in general as "much less adversarial….Patients have an immense trust in the medical profession and in their doctors in particular. Requests for a second opinion are extremely rare, and hospitals are still perceived as places of healing" (p.130). […] The authors noted that Western-trained physicians tend to have a paternalistic attitude towards patients and believe they know what is in their patients' best interest. They may forget, however, that "personal contact and time are required to foster a good therapeutic relationship. In these relationships the role of the oncologist trained as mediator and re-enforcer of the information and education process has been found to be crucial. (Mullin, Cooper and Eremenco, 1998:74)

Although it is worth stressing how important it if for oncologists to learn to communicate with patients, to respect and to familiarise themselves with their patients' culture and beliefs, to work with a qualified interpreter and to make sure that the information is well understood by patients; it should equally be clear that oncologists, medical practitioners in general should not undertake the role of the interpreter. Since South African faces a shortage of healthcare professionals per habitat (Cf. Organisation for Economic Co-operation and Development (OECD), (2013)), resorting to the services of competent interpreters would allow oncologists to consult with patients in the best conditions possible within the context of a multicultural and multilingual consultation.

There are foreseeable benefits in respecting, considering and finding ways of integrating traditional healing in the Western medical practice as it has been stressed that religion beliefs are linked to health practices in most indigenous South African cultures; and it has been found that traditional practices have an advanced understanding of human nature:

> Many non-Western cultures (and indeed some Western practitioners) do not separate religion from health practices. Among South African tribal groups, a supernatural orientation toward healthcare based in religious tradition is still evident (Herselman, 1996). Illness and disease get attributed to supernatural causes in this worldview. For Zulus in South Africa, the traditional belief system or "family spirit-worship together with beliefs in the supernatural constitute the basis of their social system" (Tollman and Msengana, 1990, p.23). […] A Pretoria physician who studied traditional healers concluded that they had a more advanced understanding of human nature than most of us in the West. For example, with the naturally "systematic" approach seen in the collectivistic societies, healers often make "house calls", visiting patients in the home environment to assess harmony and levels of support received from family members and the community. If they detect disharmony, believed to hinder the healing process, the patient often gets removed from that setting and taken to the home of the healer in an attempt to instill (sic) harmony. Granted, time and cultural constraints, not the least

> of which is the managed dilemma, preclude such a solution in Western medicine. (Mullin, Cooper and Eremenco, 1998:79)

There might be prospects of finding common ground between traditional healing and the Western medical practice since traditional healing is slowly gaining acknowledgement in South Africa as the government seems to gradually making steps to officialise that practice. In this regard, Fihlani (2013) reports that:

> Despite its many years of existence, this industry remains unregulated and no single body oversees the estimated 200,000 practitioners - compared to the 38,236 medical doctors. This is part of the problem, according to the Medical Research Council, which recently established the Indigenous Knowledge Systems Unit to help write policies that would benefit those in this sector. Organisations such as the Traditional Healers Organisation have for years been trying to legitimise the practice and have it held in the same regard as Western medicine. Some even want their services to be paid for by medical insurance. They say the government needs to set up a national register of credible and certified sangomas, with documents verifying their qualifications and outlining their areas of expertise. The Department of Health says there is a great deal of work to be done but say (sic) it hopes its recently established Traditional Healers Council, whose role will include how Western doctors and traditional practitioners can work together, will help bridge the gap between the two worlds.

Having observed the cultural, communicative and linguistic challenges as well as some positive aspects in the South African oncology setting, the discussion concerning the model used in this study to analyse conversations between individuals is provided.

2.4 Conversation analysis applied to healthcare interpreting

Discussing how empirical research was introduced in the field of health care interpreting, Pöchhacker (2006) states that:

> Approaching the activity of interpreting in health care from entirely different disciplinary paradigms, it was researchers in the fields of language and communication, and in the health and social sciences who initiated empirical research on healthcare interpreting several decades before the topic received international attention at the first *Critical Link* conference in 1995.

Researchers in these various fields have discussed the role of the interpreter in some medical settings including in mental health; they have also analysed the rendition of interpreters as well as communication dynamic in the medical setting by audio recording or videotaping consultations since such analysis should be done using empirical data (Cf. Pöchhacker

(2006)). Pöchhacker (2006) reports that: "for studies with linguistic orientation, it seems natural to treat discourse as qualitative data, taking into account, where possible, not only verbal but also the nonverbal (paralinguistic and kinesic) dimensions of language" (2006:152). Thus, in order to study the cognitive aspects of the interpreting process, methods borrowed from linguistics and sociology fields of study such as Conversation Analysis (CA) have been applied in Health care Interpreting Studies. CA is a type of discourse which emphases sequences of turn-taking and how participants negotiate the course of the conversation as well as their understanding of the course of the conversation. In this regard, Wooffitt (2005:35) states that:

> CA examines how speakers' conduct displays a sensitivity to the normative expectations associated with sequential organisations, such as paired action sequences. There is a focus on people's own interpretation of on-going interaction as revealed in turn-by-turn unfolding of conversation.

Explaining the methodology undertaken by researchers when using CA, Wooffitt (2005:42) explains that:

> First, there is the investigation of ordinary talk as the vehicle for interpersonal social actions: utterances are examined as activities people do to each other. Second, CA examines the highly patterned nature of these verbal activities in interaction. It seeks to identify and analyse the properties of recurrent sequences of interaction. Finally, it seeks to identify the normative expectations which underpin action sequences […] such as question-answer sequences or invitation-response sequences.

Using CA to analyse transcripts in their study on interpreted doctor-patient communication, Meyer et al. (2001) analyse discrepant discourse paths and how doctor, patient and untrained *ad hoc* interpreter negotiate their interaction since they are in a bilingual and cross-cultural context. They are of the view that "[f]rom the perspective of functional pragmatics, doctor-patient communication in medical institutions is basically characterized by an asymmetric distribution of knowledge. Stocks of knowledge differ not only with regard to medical issues, but also in relation to institutional type of discourse" (Meyer et al., 2001:70). From the analysed sequence, they find that "[i]n interpreted briefing, this process of adaptation seems to be more difficult because of the interpreter's lack of institutional knowledge, which may lead them onto 'discrepant discoursal path' (Wadensjö, 1992)" (2001:70). With regard to the negotiation of interaction modes in a bilingual setting, Meyer et al. (2001:70) elaborate on the benefits gained from using CA:

> Looking at the transcript from the perspective of Conversation Analysis will allow us to follow the unfolding interaction in this particular briefing for informed consent

> from a member's perspective. Indeed, the sequential development of turns taken by the German doctor, her patient of Portuguese origin and the niece, escorting her uncle, shows –among other things – how the participants deal with the bilingual and (possibly) cross-cultural setting and especially, how they negotiate and switch naturally between different interaction modes in order to help the elderly patient with limited knowledge of German to understand the doctor's explanations of the planned medical procedures.

After analysis of this sequence, Meyer et al. (2001:73) share their finding as they conclude that: "From the perspective of Conversation Analysis, we can say in conclusion that the participants finally agree upon a rather flexible management of different interaction modes as resources in this particular briefing for informed consent." With regard to how the use of CA has benefited their study, Meyer et al. (2001:75-76) state that:

> Discourse-based analyses such as this one are worth undertaking from an interpreting studies perspective so as to investigate the "translational culture" in which interpreters – of any kind – will have to operate, and to examine strategies for dealing with specific problems facing the professional, as in the case of (elderly) clients with "only some" proficiency in the provider's language.

CA has also been used in a South African study in the healthcare setting. Friedland and Penn's (2003:96) study is motivated by the challenges that remain in South African health care setting although formal training in interpreting exists and there is a literature available on the matter. In order to overcome the language and cultural barriers, Friedland and Penn (2003:96) affirm that:

> What is required is a clearer understanding of how cultural and linguistic diversity will impact on clinical interviews and of the dynamics of the mediated interview. It is important to understand what constitutes a successful mediates interview in order to train professionals and mediators appropriately and to develop new resources. What, for example, are facilitators to the process and what factors inhibit the flow of information? What can the health professional do to optimize the information flow and minimize barriers?

In order to provide answers to these questions, Friedland and Penn (2003) use CA "as a technique for exploring the dynamics of a mediated interview". In other words, they use CA "to identify both facilitators and inhibitors of a successfully mediated interview, using a detailed microscopic analysis of the dynamics involved" (Friedland and Penn, 2003:95). The methodology they follow constitutes in audiotaping and later transcribing verbatim the interview between the two language pathologists, with one of them being the interpreter, and the Zulu parents of an 8-year-old-child who had been injured in a motor vehicle accident; translating the Zulu interactions into English; using CA conventions such as: timed pauses,

turn numbering, laughter and overlaps in their transcription and interviewing the interpreter immediately after the consultation so as to analyse the interview and comment on facilitators and inhibitors. Their methodology is motivated by the fact that the combination of the interpreter's interview and the analysis of the consultation using CA aims at "[validating] their reality against the dynamic as unfolded by the CA and to check their emergence in the actual data" (2003:98). Friedland and Penn (2003:98) also add that:

> This aspect highlights a critical advantage put forward by the proponents of CA and that is that the evidence lies in the data itself and does not rely necessarily on the imposition of a subjective framework of analysis by the researcher, a pitfall in so many other areas of qualitative research. Lesser and Milroy (1993) suggested that the analyst's interpretation of communication success and failure can only be derived from evidence provided by the observable behaviours of the participants.

Hence, CA is a useful method to analyse salient features of health care interpreting such as: turn-taking, turn length, reported speech, kinesic element, topic management, interruptions and repairs, to name just a few. Using CA, Friedland and Penn (2003:98) analyse the transcribed data focusing on aspects such as repair, turn taking and topic management. With regard to the facilitators, Friedland and Penn (2003) find that the establishment of roles and routine, the role distribution, the interviewing techniques, the code switching and the familiarity and cooperation between the interviewer and the interpreter participate in bridging language and cultural barriers. However, factors such as: different agendas, the complicated repair trajectories, the errors in translating are inhibitors. Friedland and Penn (2003) also distinguish some factors that may either be facilitators or inhibitors: the reduction and condensation of information, cultural brokerage, the use of markers to signal language shift and the pronominal usage. Friedland and Penn (2003) thus conclude that:

> CA seems to provide us with objective indices of conversational success and highlights interview dynamics in a way which established checklists may not do. The layers of complexity which are superimposed by the introduction of a third party in a clinical interview perhaps present too complex a challenge for the standard checklist, A full understanding of the dynamics, social and power aspects, shifting roles and pace of the of (sic) an interview is exposed through CA. It is a context sensitive analysis. We see CA as a useful additional tool as part of a battery of approaches to understanding the process of interpreting. It provides microscopic validation of some of the processes identified through taxonomies. (Friedland and Penn, 2003:109)

2.5 Conclusion

In this chapter, I provide a review of literature in the field of liaison interpreting as well as a review of theory in the field of health care interpreting in the radiation oncology setting. I also elaborate on the review of theory in the field of communication in oncology, and I discuss the use of conversation analysis as well as its existing application in liaison interpreting. Concerning liaison interpreting, it was established that the issue in defining the interpreting activity as well as the interpreter finds its roots among others in the different expectations towards the role of interpreters as well as the interpreting activity and the lack of institutionalisation of the profession. Nevertheless, in this study and in South Africa, the nomenclature used is "liaison interpreting", and the interpreter working in statutory services is referred to as the "liaison interpreter" or the "interpreter" (Cf. Erasmus, 1999:50). With respect to health care interpreting in the oncology setting, there is evidence of communication and cultural barriers between health care professionals working in the oncology setting and patients. The consequences of such barriers can not only be lethal for patients, but also create a difficult and emotionally draining interaction for both health care providers and patients. In order to bridge communication and cultural barriers, scholars are in agreement that professional interpreters should be part of the oncology team. However, for interpreters to work efficiently in that setting, they need to receive a formal training in interpreting in general and in interpreting in the oncology setting in particular; their role and duties as well as the role and duties of the institution they work with need to be clarified; their status needs to be acknowledged and made official and they need to be respected as professionals. Furthermore, for a successful communication, it is vital that health care professionals and interpreters receive training so as to learn how to work efficiently together. One of the methods that can be used to identify communication and cultural breakdowns in an interpreted doctor-patient consultation is Conversation Analysis (CA). The findings of analysed data using CA can provide further solutions to improve communication in the oncology setting.

CHAPTER 3: CASE STUDIES OF HEALTH CARE INTERPRETING MODELS

"2.4.6 To promote multilingualism this policy [National Language Policy Framework] determines the use of different languages in government structures as follows: […]

***2.4.6.2. Communication with members of the public:** For official correspondence purposes, the language of the citizen's choice must be used. All oral communication must take place in the preferred official language of the target audience. If necessary, every effort must be made to utilise language facilitation facilities such as interpreting (consecutive, simultaneous, telephone and whispered interpreting) where practically possible."*
(Department of Arts and Culture, Republic of South Africa, 13:2003)

3.1. Introduction

In this chapter, the researcher provides a description of health care interpreting models and training and accreditation models implemented elsewhere in the world, notably in Australia, Belgium, Switzerland and the United States. The interpreting training and accreditation applied in South Africa are then examined.

3.2. Description of health care interpreting models

3.2.1. Health care interpreting in Australia

To ensure that the rights of patients and consumers when receiving or seeking health care are met throughout the country, the Australian Charter of Healthcare Rights was developed in 2007 and 2008 by the Australian Commission on Safety and Quality in Health Care. The charter was endorsed in July 2008 by the Australian health minister as the Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Health Care, 2013). There are seven Charter rights: *Access*, which stipulates that patients and consumers have the right to health care. They can therefore access services to address their healthcare needs; *Safety*, which means that patients and consumers have the right to receive safe and high quality care by professional, skilled and competent healthcare providers; *Respect*, which implies that health care provider own respect to the patients and consumers, to their culture, their beliefs, their values and their personal characteristics; *Communication*, which states that

patients and consumers have the right to be informed about services, treatments, options and costs in a clear and open way. In other words, patients and consumers have the right to receive open, timely and appropriate communication about their health care, in a way they can understand; *Participation*, which means that patients and consumers have the right to be included in decisions and choices about their care and their health service planning; *Privacy*, which stipulates that patients and consumers have the right to privacy and confidentiality of their personal information and *Comment*, which stipulates that patients and consumers have the right to comment on their care and address all their concerns (Australian Commission on Safety and Quality in Health Care, 2013). The Australian Commission on Safety and Quality in Health Care (2013) has made the charter available on its website in audio file, in braille and translated into 17 community languages. In the specific case of the State Government of Victoria, the charter is also available in an audio file, in braille, in printed brochure and documents in English and in 25 community languages, namely: Arabic, Bosnian, Burmese, Chinese simplified, Chinese traditional, Croatian, Dinka, German, Greek, Hindi, Hungarian, Italian, Khmer, Macedonian, Maltese, Polish, Russian, Samoan, Serbian, Sinhalese, Somali, Spanish, Tagalong, Turkish, Vietnamese (Victorian Government Health Information, 2011).

The Victorian Provincial Government will be examined as a case study for language service provision in publicly-funded healthcare services, since it reveals the greatest amount of detail online concerning its language management programmes in the public healthcare system. The Victorian Provincial Government (2010) declares that:

> The Victorian government recognises the importance of ensuring that Victorians from culturally and linguistically diverse backgrounds have full and fair access to healthcare services. As a patient or consumer of a publicly-funded healthcare service such as a public hospital or healthcare service, you have the right to an accredited interpreter for communication needs with your healthcare provider. Interpreters should be provided at important points during your care, such as when discussing medical history, treatments, test results, diagnoses, during admission and assessment and when you are required to give informed consent. Informed consent is the voluntary agreement by a patient to a proposed health care management approach given after proper and adequate information is conveyed to the patient about the proposed management, including potential risks and benefits and alternative management options.

The Victorian Government (2012) also sets out the duties of public hospitals towards the implementation of this language service policy as well as towards the constant improvement of service delivery:

> All public hospitals have been issued with the Victorian Government's language services policy, 'Improving the Use of Translating and Interpreting Services: A Guide to Victorian Government Policy and Procedure'. The guide stipulates the minimum government guidelines for the provision of interpreting and translating services.

These guidelines cover the following aspects: the Departmental language services, policies and procedures; the arrangement of language services; important information about the interpreter; how to prepare for interpreting services and how to work effectively with an interpreter.

Concerning the departmental language services, policies and procedures, the Victorian Multicultural Commission (2012:5) states that:

> Individual departments and agencies may have their own language services policy and procedure guidelines that fit within the whole of government policy framework but take into account more specific service contexts and procurement arrangements. Government departments may have specific requirements for interpreting and translating services, based on their client groups and the type of services provided. These may include: preferred language service providers for sourcing language services; methods of funding and purchasing language services; and preferences for face-to-face interpreting, telephone interpreting and/or video-conferencing. Government departments that fund or provide direct care services should establish clear policies for funding and delivering language services. These policies should: be consistent with wider Victorian Government policy; be consistent with other relevant departmental policies; take into account relevant legal issues; acknowledge the need to use NAATI [National Accreditation Authority for Translators and Interpreters Ltd] accredited practitioners where interpreters and translators are required; address the needs of current and potential clients; and seek to define situations where interpreters 'must', 'should' and 'could' be used.

With respect to the arrangement of language services, the Victorian Multicultural Commission (2012:9) recommends that as per the policy of the Victorian Government, interpreters employed by government and funded agencies must hold the National Accreditation Authority for Translators and Interpreters Ltd (NAATI) Professional accreditation where possible. The Victorian Multicultural Commission (2012:9) also recommends that interpreters be sourced according to the demand for interpreting in each organisation. The sourcing can thus either be through an interpreting agency, or by employing full-time or part-time interpreters.

As regards the important information about interpreters, the Victorian Multicultural Commission (2012:10) states the role of an accredited interpreter as follows:

> The interpreter acts as the 'voice' of both parties and for this reason will interpret using the first and second person rather than the third person. An accredited interpreter will act in accordance with the Australian Institute for Translators and Interpreters (AUSIT) Code of Ethics and interpret everything that is said. An accredited interpreter will not add, modify or delete information. This includes profanities and nonsensical mutterings. An accredited interpreter will remain impartial at all times and will not express an opinion or act as an advocate for the client.

However, the Victorian Government also acknowledges paraprofessional interpreters as well as recognised interpreters. Whereas paraprofessional interpreters are interpreters who undertake the interpretation of non-specialist dialogues, recognised interpreters are interpreters who are acknowledged by NAATI as working in languages for which NAATI does not test and it has no specification of level of proficiency (The Victorian Multicultural Commission, 2012:10). The Victorian Multicultural Commission (2012:9) thus adds that:

> Recognition is intended to be an acknowledgment that the candidate has had recent and regular experience as an interpreter, but no level of proficiency is specified. A Recognised person has reasonable proficiency in English and has completed basic preparation training. You should use NAATI-accredited professional interpreters where possible. When accredited interpreters are not available at this level, a NAATI-accredited paraprofessional or NAATI-recognised practitioner can be used. Paraprofessional and recognised interpreters may be the only practitioners available for less common languages. The language services provider may ask if this is acceptable to your client and you may need to assess whether your client's needs will be adequately met.

The Victorian Government also acknowledges that when there is a minimal risk of miscommunication or misunderstanding to the organisation or the client, it may be appropriate to receive assistance from a staff member who speaks a language other than English; employees who provide such assistance are called language aides (The Victorian Multicultural Commission, 2012:11). However, the Victorian Multicultural Commission (2012:11) highlights that:

> There are a number of important differences between the role of staff with multilingual skills and accredited interpreters, such as qualifications and skills, accountability and professional standards, and language proficiency. It is important that the language skills of language aides are verified in both LOTE [Language Other Than English] and English, often through a NAATI Language Aide or Interpreter test, so that clients and colleagues can have confidence that the staff member's language skills are sufficient for the role. Organisations should maintain a database of language aides within their departments so staff can access their language skills quickly and easily when necessary. Multilingual staff may also use their LOTE in the course of their normal work. In these cases, the agency and the worker should be aware of the limits to the worker's fluency and seek the assistance of an accredited interpreter if the communication has become complex or potentially risky.

The Victorian Multicultural Commission (2012:11) also stresses that there is a language allowance available to the staff of some government and funded agencies provided by the Victorian public service. To be eligible, staff must engaging in working directly and regularly with speakers of language other than English (LOTE) and pass the NAATI Language Aide Test, Paraprofessional Interpreter or Professional Interpreter test.

Concerning how to prepare for interpreting services, the Victorian Multicultural Commission (2012:15) recommends that officials assess the need for an interpreter first. Thus, in cases where the patient demonstrates no understanding of English, has a limited proficiency of English, relies on relatives or friends to communicate, prefers to communication in his/her mother tongue or is a second language speaker exposed to a stressful situation or in an unfamiliar environment; it is advised to use an interpreter. In case patients refuse to use an interpreter, it is important that healthcare providers attempt to understand the reasons behind that refusal, rectify the problem and reassure patients. Healthcare providers can then explain that they are the one needing interpreting services, speak to the relatives or friends to understand the reasons for the refusal, or use a telephone interpreter to assist with the issue and explain the need for an interpreter. If patients do not change their minds, healthcare providers may either continue the interview and document their concern regarding language barrier or suspend or reschedule the interview as relative and friends are not to be used as interpreters (The Victorian Multicultural Commission, 2012:15). Secondly, it is recommended to identify the language spoken by the patient either by establishing the patient's country of origin, by asking the patient or the person accompanying the patient or by using visual aids that list languages (The Victorian Multicultural Commission, 2012:16). Then the parties should choose one of the three modes of interpreting available in Victoria: onsite interpreting, telephone interpreting or videoconferencing. The former involves the physical presence of the interpreter during the interview; the next one implies that telephone interpreters deliver their services via a telephone and in the latter; interpreters deliver their service via video conference (The Victorian Multicultural Commission, 2012:17).

Lastly the healthcare providers should book an interpreter. To request onsite interpreting, specific information has to be sent to the language service provider such as:

> The client's name, the language/dialect that is required, the preferred sex of the interpreter (if applicable), the date and time the interpreter is required – ensure you

> allocate enough time prior to the interview to brief the interpreter, the type of interview, for example, a medical or legal appointment or court hearing etc., the address of the agency requiring the interpreter, the name and telephone contact details of the person the interpreter needs to report to, the nature of the matter to be discussed, for example, an aged care health assessment, a family violence police interview etc., Approximately how long the interview will take; and the interpreter's name, if you or the client wishes for a specific interpreter for continuity of care reasons. (The Victorian Multicultural Commission, 2012:18)

When booking a telephone interpreter, the healthcare provider should also inform the language service provider about the telephone system that will be used between for instance a speaker phone; and a handset that will be shared by the interviewer and the client (The Victorian Multicultural Commission, 2012:18).

With respect to how to work effectively with an interpreter, the Victorian Multicultural Commission (2012) recommends that procedures be followed during, at the end and after interviews. During interviews, the guideline stipulates the following:

> Talk directly to the client and maintain eye contact; use the first person when speaking to your client. For example, say 'What time did you arrive today?" instead of "What time did she arrive today?" Use clear language and avoid using slang, colloquialisms and metaphors; make one point at a time; pause for the interpretation after the completion of a full sentence, never mid-sentence; keep questions, statements and comments short. This gives the interpreter time to understand what you have said and to pass information on to the client in stages; allow the interpreter to clarify information with you. If there is a need to clarify information with the interpreter, ask that this is explained to the client first; allow the client to ask questions or raise issues at any time in the interview. If you have any questions about the client's cultural background, ask the client directly and not the interpreter; summarise the discussion occasionally to ensure the client understands the information. Do not ask the interpreter to edit your information to suit the client's background. (The Victorian Multicultural Commission, 2012:22)

At the end of the interview, the Victorian Multicultural Commission (2012:22) recommends to summarise key points with patients and make sure that they have understood any of the information conveyed. After the interview, the interpreter may be debriefed. Any issues experienced during the interview related to the role of the interviewer and the interpreter should be discussed; the interpreter should not be asked to express opinions on patients and what they have said; the interviewer may provide any positive feedback about the interpreting and the ways in which the interpreter assisted in making the consultation successful; the interviewer may as well raise any unprofessional or unsatisfactory practices with the interpreter and with AUSIT. In that respect, the Commission (2012:22) stresses that:

> You, as well as your staff and clients, need to be confident that interpreting services are of the highest quality. Maintaining and promoting the professionalism of interpreting services is therefore extremely important. You should expect accredited interpreters to be accountable and comply with the Code of Ethics developed by AUSIT. […] If an interpreter fails to comply with the principles outlined in the AUSIT Code of Ethics, you have the right to take action, and should do so in the interests of maintaining professional standards of interpreting in Australia. […] If you have an issue such as losing bookings, charging incorrect fees or providing interpreters with inappropriate levels of accreditation, it is advisable to discuss the matter with the person responsible for dealing with complaints.

As the Victorian Multicultural Commission (2012:25) points out, in order to promote the availability of interpreters, a National Interpreting Symbol has been developed and is displayed in all services where interpreting services are provided. The National Interpreting Symbol therefore indicates where people can request language assistance when using government services.

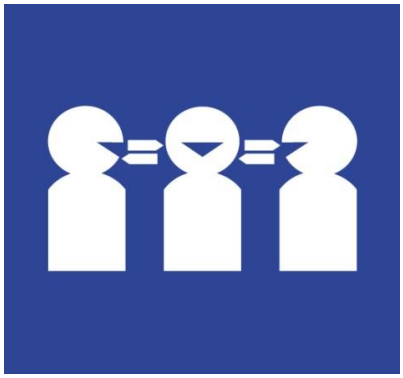


Figure 3.1: National Interpreting Symbol

The National Interpreting Symbol is a national public information symbol developed by Victoria in partnership with the Commonwealth, state and territory governments. Thus, the Victorian Multicultural Commission (2012:25) emphasises that:

> It is important that all Government Departments and funded agencies make it clear that interpreters are available to clients who feel that they require language assistance. The most effective way of promoting the availability of language services is by ensuring that all staff members are aware of your organisation's language services policy and have been adequately trained in identifying the need for language assistance and acting on this requirement. […] Service providers are encouraged to display the symbol in a variety of settings including client contact areas such as front desks or reception areas, in public areas where language services are available and on websites.

3.2.1.1. Interpreting training and accreditation in Australia

Interpreting training in Australia has to be approved by the National Accreditation Authority for Translators and Interpreters Ltd (NAATI). NAATI (2013) thus declares that:

> NAATI's primary purpose is to strengthen inclusion and participation in Australian society by assisting in meeting the nation's diverse and changing communication needs and expectations through: setting, maintaining and promoting high national standards in translating and interpreting, and implementing a national quality-assurance system for credentialing practitioners who meet those standards. NAATI approval of the courses run by institutions in translation and interpreting is a critical part of NAATI's national quality assurance system. Where a course at an educational institution holds NAATI approval, students who complete the qualification at the standard required by NAATI may apply for accreditation from NAATI without further testing.

The National Accreditation Authority for Translators and Interpreters Ltd (NAATI) is the only agency to issue translation and interpreting accreditations in Australia. Institutions that would like to provide translation and interpreting training may apply for NAATI's approval of their course. NAATI considers courses such as: Diploma (Vocational Education and Training (VET) Sector), Advanced diploma (Vocational Education and Training (VET) Sector), Bachelor Degree, Postgraduate Diploma and Master's Degree; and it may approve courses that lead to the following accreditations: Advanced Translator, Conference Interpreter, Professional Translator, Professional Interpreter, Paraprofessional Translator and Paraprofessional Interpreter (NAATI[1], 2013:1-2). It is imperative to stress that though NAATI and AUSIT work together to state and maintain the translation and interpreting service provision standards, they are two different entities, as highlighted in the following statement:

> AUSIT and NAATI are two quite separate organisations, although both are involved in maintaining professional standards and furthering the interests of the translation and interpreting profession. AUSIT, the Australian Institute of Interpreters and Translators Incorporated, is the national professional association for interpreters and translators. NAATI, the National Accreditation Authority for Translators and Interpreters, is a national standards body owned by the Commonwealth, State and Territory Governments of Australia. NAATI tests and accredits translators and interpreters in Australia and overseas. It also approves tertiary-level courses in translation and interpreting which fulfil stringent criteria. AUSIT and NAATI work together to set, maintain and monitor standards in the translation and the interpreting profession in Australia. AUSIT recognizes NAATI accreditation as the minimum

[1] NAATI. 2013. "A guide to approval of courses in translating and interpreting. Vocational Education and Training (VET)"

> basic qualification for practicing as a professional translator and interpreter in Australia. NAATI endorses and promotes the AUSIT Code of Ethics for interpreters and translators. (AUSIT, SA)

Following the discussion on the implementation and the use of healthcare interpreting in Australia, the next paragraph, examines how healthcare interpreting is tackled in Belgium.

3.2.2. Health care interpreting in Belgium

In Belgium, community interpreting is mostly referred to as: "interpreting and intercultural mediation" and interpreters working in a medical setting are mostly referred to as "mediators". Cherbonnier (2002) accounts that "interpreting-mediation" started in Belgium in the 1970s mainly due to the migration of populations from North Africa. To address the immigrant communities' health care needs, the project FIIMMS (Formation d'Interprètes Immigrées en Milieu Médico-Social[2]) was established in 1984. It however ran only until 1987. In 1992, the "Cultures & Santé[3]" then called the "Comité Médico-Social pour la Santé des Immigrés[4]" with the support of the FIM (Federal Impulse Fund for the Migration Policy) started the "Projet Médiatrices[5]" which they renamed ISM (Interprétariat Social et Médical[6]) project in 1993; a name that was kept until 1999, which was when the project was dissolved. The ISM project had two goals: Taking forward what the FIIMS did by training and providing interpreters for community interpreting purpose in Brussels in order to support populations from Morocco and Turkey, and integrating some immigrants socially through the interpreting training. These trained immigrants would then use their skill to support their communities and in a way, promote Belgian culture.

Women were chosen for this project because they constituted the majority in these communities and also because providing health care to women and children was easier if the mediator was female. Interpreters were therefore mostly selected based on their personality. Those who appeared to have good communication skills and a minimum of education (from a certificate of completion of primary school education onwards) were selected. Nonetheless,

[2] Translation: Training of women immigrant as interpreters in the medico-social setting.
[3] Translation: Cultures & Health.
[4] Translation: Medico-Social Committee for Immigrants' Health".
[5] Translation: Women Mediators project.
[6] Translation: Social & Medical Interpreting.

the "intercultural mediation" activity raised three main questions: the questions of quality control, ethics and scope of the mediator's duties and regulating the activity so that it acquires professional recognition. After the ISM project shutdown, due to the increasing demand of interpreting services in the healthcare setting, in 2000 some of the mediators trained during that programme started working for two entities: the CIRÉ (Coordination et Initiatives pour Réfugiés et Etrangers[7]) that was then in charge of medico-social interpreting services in Brussels and the hospital, within the *programme fédéral de médiation interculturelle*[8]. The languages in demand have also increased since 1993 due to the migration of populations from East and Central Europe (Cherbonnier, 2002). The CIRÉ is still very active. Since it works on site with active organisations to defend the rights of refugees and immigrants in Belgium, it works with the FEDASIL (Federal Agency for the Reception of Asylum Seekers) (Coordonation et Initiatives pour Réfugié et étrangers, 2013); which in its turn works with the SeTIS (Service de Traduction et d'Interprétariat en milieu Social[9]) (Federal Agency for the Reception of Asylum Seekers, 2013). The SeTIS (Service de Traduction et d'Interprétariat en milieu Social[9]) trains and supplies cultural mediators mainly in the French community, but also in the Flemish community. It provides mediators to public services and the ASBL (association sans but lucratif[10]) for social tariffs (Service de Traduction et d'Interprétariat en milieu Social, 2011). Mediators are remunerated per hour and for their transportation. On the website of the Federal Public Service of Health, Food Chain Safety and Environment of Belgium, intercultural mediation is recognised as being an important function carried by intercultural mediators or mediators to ensure that patients' rights are respected and to make sure that consultations between medical practitioners and allophone patients take place in the best conditions in terms of communication.

In 2009, intercultural mediation acquired professional status since hospitals can apply for funds to the Directorate-General for Healthcare facilities Organisation (DG1) of the Federal Public Service of Health, Food Chain Safety and Environment when they need a permanent mediator on site (Federal Public Service: Health, Food Chain Safety and Environment, 2013). Thanks to this new status, the controversy that occurred in the 1990s regarding the name and more specifically the role of mediators is clarified. In the 1990s, some medical practitioners wanted the line to be drawn so as to clearly determine the scope of mediators' work, and to

[7] Translation: Coordination and Initiatives for Refugees and Foreigners.
[8] Translation: Federal Programme for Intercultural Mediation.
[9] Translation: Translation and Interpreting Service in a Social Setting.
[10] Translation: Non-profit Association.

make sure that they do not replace medical practitioners during consultations; but at the same time, some mediators were struggling to determine the scope of their role as mediators and interpreters as some medical practitioners were more demanding than others (Cherbonnier, 2002). Since 2009, the role of mediators has been described as follows:

1. Liaison interpreting: The mediator is expected to interpret everything that will be said as accurately as possible. On this regard, the Health Department abides by the standard of the Massachusetts Medical Interpreter Association.
2. 'Culture brokerage': The mediator is expected to breach cultural differences between medical practitioners and allophone patients. He or she is expected to make both parties aware of cultural differences.
3. Escorting patients: The mediator is expected to support patients and their family out of the medical setting. He or she is expected to assist patients filling in forms, understanding how the hospital functions or to which office to go for a specific service.
4. Listening and assisting: The mediator is expected to support patients during consultations so that they do not feel isolated due to language barriers.
5. Mediation of conflicts: In case of conflicts of values, the mediator is expected to verify whether the conflict is due to linguistics or cultural differences. When it is the case, if the mediator has been trained to resolve conflicts he or she can attempt to solve the issue by clarifying the origin of the conflict. Otherwise, he or she has to refer the case to an "Ombudsman[11]".
6. 'Advocacy' or defending the rights and interests of the patient: The mediator is expected to defend the rights and interests of patients especially when they are victim of racism and discrimination.
7. 'Outreach' service: The mediator is expected to reach the patients from his/her cultural background out of the medical setting to query whether they are satisfied with the services received and whether they have questions that they would like to address regarding their medical conditions or the services received. The mediator will then report these feedbacks and questions to the medical service.

[11] The term "ombudsman" comes from Swedish and means "to defend the rights of another person". It also refers to the person (a man or a woman) who assists you when you have a complaint.
(Translated from the Portal belgium.be : Official information and services. Original text in French: Le mot "ombudsman" vient du suédois et signifie "défendre les droits de quelqu'un d'autre". C'est aussi la personne (un homme ou une femme) qui vous aide quand vous avez une plainte.)

8. Highlighting difficulties: The mediator is expected to highlight any difficulty faced by allophone patients. The hospital should then have a structure that will follow up with the mediator's report.

9. Information: The mediator is expected with the support of medical practitioners, to provide information sessions to allophone patients. These sessions aims at giving a platform to patients to ask all questions they might have. The last task is not necessary when the mediator also qualifies as a medical staff. (Federal Public Service: Health, Food Chain Safety and Environment, 2013).

Backes (2007) points out that there are three types of translation services provided in health care settings in Belgium: interpreting on call during which the interpreter goes on the site where his or her services are requested, written translation and telephone interpreting. These services are all provided by SeTIS (Service de Traduction et d'Interprétariat en milieu Social[9]). Besides offering these three services, the SeTIS Brussels also offers permanent interpreting services to institutions. However, SeTIS Brussels only offers telephone interpreting services for emergency situations that do not impose the presence of the interpreter and that will not take more than 15 minutes of communication on the telephone. They neither operate at night, nor over the weekend (Service de Traduction et d'Interprétariat en milieu Social Bruxelles, SA).

3.2.2.1. Interpreting training and accreditation in Belgium

According to the available literature, it is the SeTIS (Service de Traduction et d'Interprétariat en milieu Social[9]) that trains community interpreters and makes their services available to public services and other clients. It is also the SeTIS that gathers complains and takes measures to ensure that interpreting services provided by their team is of the best quality (Cf. Backes (2007), SeTIS (SA)[12], SeTIS Bxl (2013)[13]).

According to the SeTIs Brussels, there are objective and subjective criteria that candidates in community interpreting should meet in order to be selected. The objective criterion consists of: *having the linguistic knowledge*: Having a sound written and oral knowledge in one's first language as well as a thorough knowledge of some other languages and a very good oral

[12] SeTIS. SA. "Qu'est-ce qu'un SeTIS? "

[13] SeTIS Bxl. 2013. "Formulaire de réclamation"

communication skill in French; *having the right level of education*: ideally vocational higher education and *having the possibility to be on contract*: in this regard, the conditions of those who have languages that are in high demand are different from those who have languages that are unpopular. Those that have high demand languages may either work under the ACS (Agents Contractuels Subventionnés[14]) status according to the regulations applied in Brussels and they may therefore either enjoy a status of permanent workers, part-time workers or full-time worker. They also may work under an *Activa* contract which is a fixed-term contact; or they may sign a contract in accordance to article 60 (7) that provides either fixed-term, part-time or full-time working agreements. Concerning those who have unpopular languages, they collaborate with the *chèques ALE*[15]. With regard to the subjective criterion, they are both at interpersonal and at personal level. The SeTis Brussels selects the candidates based on: *their interpersonal* abilities it is to say the ability to connect to others, to work in team in a spirit of collaboration and openness to the others and empathy; *their ability to maintain oneself as a third party* in other words, the ability to distance oneself from one's life experience and to other's life experience so as not to be overwhelmed with emotions during working sessions; *their ability not to intervene* that is the ability not to directly respond to a request, and maintain one's position as the secondary service provider; *their ability to decentre* in other words, the ability to listen to divergent opinions on a same subject and to put one's own point of view into perspective and not to be judgemental; *their ability to call into question* that is to say the ability to turn a critic into positive input and a learning experience. Some other criterions are taken into consideration such as: punctuality, autonomy, organisation skills and flexibility (SeTIS Bxl, 2013).

On 20 June 2007, the Flemish and French SeTIS approved the prerequisites to work as a community interpreter in terms of training and interpersonal ability, and amongst other, how the interpreting task should be undertaken (*Profil-métier de l'interprète en milieu social*[16], SeTIS Bxl, 2013). In that document, it is stated that training is organised differently according to each linguistic community; however, the content of the training should enable prospective community interpreters to acquire the necessary skills so as to be fit for the profession. The desirable level of education expected from candidates is A-Level (COFETIS-

[14] Subsidized contract agents
[15] Chèque ALE (Agence Locale pour l'Emploi): local employment agency cheque: The ALE links workers with employers for the realisation of precised tasks.
[16] The community interpreter's job profile

FOSOVET absl, 2007:10). Besides having linguistic knowledge in their first language, it is also stated that community interpreters must be:

- able to speak and read one of the Belgian official languages at an advanced level (B2) as per the standard set by the Common European Framework of References for languages
- knowledgeable of the tools and techniques to look for information, they should be able to use these tools and techniques
- knowledgeable of how the sectors they are called to work into function
- knowledgeable of, understand and respect the deontology of the profession. In other words, respecting confidentiality, being discreet, giving a faithful and objective rendering of the source message, not intervening , being impartial, refusing to intervene when the outcome would breach the code of ethics relating to the respect of the individual and when the outcome would jeopardize the quality of the interpreting service
- knowledgeable of the technique used in interpreting in other words: using the "I" subject pronoun, working in the consecutive mode, taking notes, reproducing a message which involves: listening and concentrating, analysing, memorising, synthetizing the message and reproducing it logically
- knowledgeable of the principles of communication: verbal and nonverbal communication, intercultural communication as well as the complex principles of communication such as: maintaining a triadic communication, distancing oneself from the parties receiving the interpreting service, presenting oneself professionally, keeping one's private life to one's professional duties and being able to handle one's emotions
- knowledgeable and respectful of the labour regulations and/or the principles of collaboration (COFETIS-FOSOVET absl, 2007:8-10).

Following the case study of the Belgian healthcare setting, the next section examines how healthcare interpreting is tackled in Switzerland.

3.2.3. Health care interpreting in Switzerland

According to the Swiss Red Cross, the Swiss Confederation, the Federal Department of Home Affairs (FDHA) and the Federal Office of Public Health (FOPH) (2011:42) patients have the right to treatment when they are ill. In an emergency, doctors have the obligation to treat patients and to refer them to an appropriate service; they also have the right to be consulted, to decide about the treatment option they favour and to receive second opinion from another doctor; patients have the right be informed of their state and the options available to them; they have the right to be supported and accompanied by relatives and persons of confidence; they equally have the right to confidentiality. Information about patients can only be given to relatives with the patient's consent; and patients have the right to consult their file. However, patients do not only have rights; they also have obligations. They have the duty to cooperate with medical practitioners by providing them with information; follow doctor's instruction and to comply with hospital regulations.

In the case of language barriers between medical practitioners and patients, though the Swiss Red Cross, the Swiss Confederation, the Federal Department of Home Affairs (FDHA) and the Federal Office of Public Health (FOPH) (2011:45) acknowledge the dangers of language and cultural barriers as well as the importance of interpreting service provision, in Switzerland patients do not have the right to an interpreter in the health care sector. Nonetheless, it is reported that most hospitals have a free interpreter service and there are many agencies ready to provide interpreting services. Besides, the provision of onsite interpreting, there is also a telephone interpreter service (the Swiss Red Cross, the Swiss Confederation, the Federal Department of Home Affairs (FDHA) and the Federal Office of Public Health (FOPH) 2011:46). The Swiss Red Cross, the Swiss Confederation, the Federal Department of Home Affairs (FDHA) and the Federal Office of Public Health (FOPH) (2011:45) also emphasise that just as intercultural interpreters are trained and available to provide interpreting services and are obliged to maintain confidentiality, contrary to in Australia, relatives and friends are allowed to interpret for patients, although they recommend that such a service be provided by professionals.

3.2.3.1. Interpreting training and accreditation in Switzerland

Hagenow-Caprez (2008) elaborates on the results of the research conducted to address this question of the adequate level of language skill necessary to tackle the growing demand for healthcare interpreting in Switzerland:

> The results of the survey show that the proposal put forward by the INTERPRET association – that testing of the requisite level of skills in the local official languages should no longer be defined as a certification requirement, but as a condition for admission to the training modules – was only welcomed by a small minority. It is feared that there would be a number of undesirable consequences – e.g. that for the "new" migrant languages it would take too long for trained interpreters to become available, or that the people recruited would increasingly be second-generation migrants who are less proficient in the foreign language concerned and have a poorer knowledge of the cultural environment. On the other hand, the studies show that certain aspects of the system could indeed be improved so as to promote the language skills of intercultural interpreters and to optimize translation services overall. To this end, in conclusion, nine recommendations are formulated, together with concrete measures for implementation.

Hagenow-Caprez (2008) presents an overview of the recommendations given to the Federal Office of Public Health as follows:

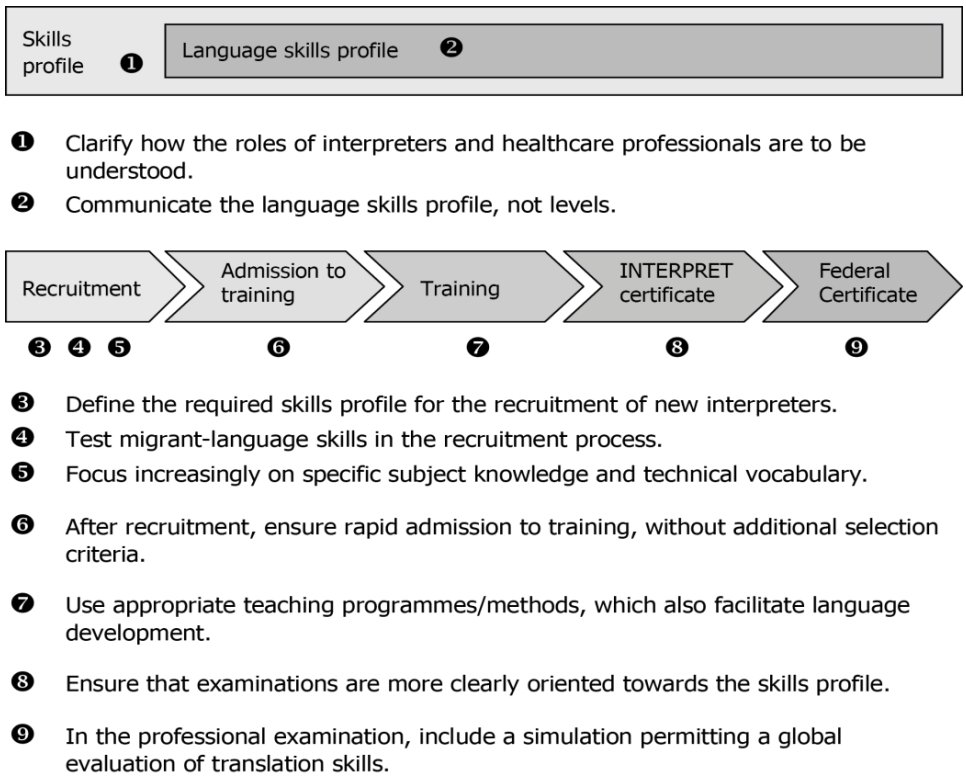


Figure 3.2: Hangenow-Caprez (2008) "What level of language skills is necessary? Definition of the linguistic qualifications required for admission to training and for certification of intercultural interpreters"

The Federal Office for Public Health (FOPH) considers these recommendations to represent the standards for admission to the community interpreting education. However, INTERPRET is the independent Swiss association in charge of community interpreting throughout the country. Created in 1999, INTERPRET is an umbrella organisation that regroups community interpreters, professional community interpreting agencies and training institutions. Its goal is to set and maintain standards in the community interpreting profession. INTERPRET also manages the centre of competence for community interpreting in Berne, as well as the office of qualification ran by IDEA sagl at Tessin (INTERPRET, 2012)[17]. Throughout Switzerland, there are eight institutions recognized by INTERPRET that offer accredited modules in community interpreting. These institutions and the modules offered are listed in the table below:

Training institutions	Cities	Canton	Module 1	Module 2
ECAP	Zürich	ZH	Yes	Yes
intercultura	Bern	BE	Yes	Yes
HEKS MEL, Basel	Basel	beide Basel	Yes	Yes
DERMAN, SAH Schaffhausen	Schaffhausen	SH	Yes	Yes
Agenzia DERMAN Ticino	Viganello	Ticino	Yes	Yes
Appartenances	Lausanne	Romandie	Yes	Yes
AOZ Medios	Zürich	Zürich	Yes	Yes
verdi - Interkulturelles Übersetzen in der Ostschweiz	St. Gallen	Ostschweiz	Yes	No

Figure 3.3: INTERPRET. 2012. "Institutions de formation et modules reconnus".

As per the above table and as stressed by INTERPRET, the community interpreting training is done through two modules: Module 1, Community interpreting in a three-way situation, and Module 2, which consists of information relating to training, health and social systems. Whereas the first module focuses on the role of the interpreter in a triadic communication and emphasises basic interpreting techniques, the process of the intervention as well as possible communication problems, the second module instructs about the organisations and institutions that deal with training, health and social affairs by comparing them with the structures in place in migrants' countries of origin. This module also targets the acquisition of

[17] INTERPRET. 2012. "L'association INTERPRET".

specialised terminologies (INTERPRET, 2012)[18]. Community interpreters who have long years of experience and who have thus acquired the necessary knowledge for Module 1 and/or Module 2 may obtain a certificate for the corresponding modules by validating the acquisition of their knowledge (INTERPRET, 2012)[19]. KEK CDC Consultants (2010) mention the various procedures undertaken by aspiring community interpreters to acquire a certificate: "Only around a third of translators registered with the placement agencies supported by the FOM and who are placed in assignments possess an INTERPRET certificate that has been acquired either through portfolio analysis, through the attendance of two training modules or through a procedure of equivalence" (KEK CDC Consultant, 2010). Furthermore, in order to improve training and the acquisition of qualification to work as a community interpreter, the Federal Office of Public Health (FOPH) has highlighted that: "Between 2011 and 2013, the FDPH will be aligning its subsidisation practices in the area if community interpreting education specifically with the needs of the individual regions. Post-qualification of interpreters who are already working for an agency will be emphasised" (the Federal Office of Public Health (FOPH), SA).

As stated by INTERPRET, there are two types of community interpreting certificates: the INTERPRET certificate and the *brevet fédéral* (Federal Diploma). The *brevet fédéral* (Federal Diploma), (INTERPRET (2012)[20]) has been issued since 2009 by the State Secretariat for Education, Research and Innovation (SERI). This diploma is equivalent to a higher and professional education qualification and is granted to experienced professionals who guarantee a high quality of service in the most challenging situations. To be granted the *brevet fédéral* (Federal Diploma), community interpreters must pass a professional exam which comprises a written exam and a final exam. To be admissible, candidates must possess:

- A diploma in secondary education or a training equivalent to the secondary level II
- A certificate of completion of modules 1 and 2 or equivalent certificates that validate prior experience in community interpreting
- A certificate attesting that the candidate has spent a minimum of 15 hours under supervision
- Certificates attesting to the linguistic competence of the interpreter in his working language and the local official language (French)

[18] INTERPRET. 2012. "Module de formation".
[19] INTERPRET. 2012. "Validation des acquis".
[20] INTERPRET. 2012. "Brevet fédéral".

- A certificate attesting that the interpreter has at least 150 hours of practical experience in community interpreting, plus a certificate attesting that the interpreter has had practical experience for at least a year (a minimum of 750 hours) in the fields of health, social work, training or migration

Following the discussion on healthcare interpreting in the Swiss setting, the next paragraph examines how healthcare interpreting is tackled in the USA.

3.2.4. Healthcare interpreting in the USA

The Office of Minority Health (OMH), US Department of Health and Human Services (DHHS) has acknowledged that "with growing concerns about racial, ethnic, and language disparities in health and health care and the need for healthcare systems to accommodate increasingly diverse patient populations, language access services (LAS) have become more and more a matter of national importance" (Office of Minority Health (OMH), U.S. Department of Health and Human Services (DHHS), 1:2005). Describing the laws applied in the US concerning language provision, Schapira et al. (2008:588) stress that:

> Recognizing the importance of clear communication in health care, federal law, under title VI, requires all health care organizations receiving federal funds to provide appropriate interpretation services by bilingual staff or professional interpreters free of charge for patients with limited English proficiency. However, the Office of Civil Rights allows patients the option of using family and friends in lieu of a professional. In these situations, it is recommended that a waiver of interpreter be signed by the patient to ensure informed consent, because most patients do not understand the dangers of miscommunication resulting from faulty interpretation.

Thus, in 2000 the Office of Minority Health (OMH) published the first *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (National CLAS Standards). The National CLAS Standards addresses the need for equitable and effective health care provision in the US cultural and racial diversity. It therefore provides a framework for all health care organisations to cater efficiently for all US citizens regardless of their cultural and linguistic background (The Office of Minority Health (OMH), US Department of Health and Human Services, SA). Discussing the vision behind the National CLAS Standards, the Office of Minority Health (OMH) (SA) declares that:

> In fall of 2010, the Office of Minority Health launched the National CLAS Standards Enhancement Initiative in order to revise the Standards to reflect the past decade's advancements, expand their scope, and improve their clarity to ensure understanding and implementation. With the enhancement initiative, the National CLAS Standards will continue into the next decade as the cornerstone for advancing health equity through culturally and linguistically appropriate services.

A decade after the establishment of the National CLAS Standards, there has been an improvement, as described in the OMH's table below.

Expanded Standards	National CLAS Standards 2000	National CLAS Standards 2013
Culture	Defined in terms of racial, ethnic and linguistic groups	Defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics
Audience	Health care organizations	Health and health care organizations
Health	Definition of health was implicit	Explicit definition of health to include physical, mental, social and spiritual well-being
Recipients	Patients and consumers	Individuals and groups

Figure 3.5: Enhancements of the National CLAS Standards in "National CLAS Standards Fact Sheet" (OMH, SA)

In 2005, the American Institute for Research (AIR) has developed a guideline for the Office of Minority Health (OMH), US Department of Health and Human Services (DHHS). The guideline aims to tackle language provision for limited English proficient (LEP) patients by implementing language access services in health care organisations. As much as the implementation of language access services seems to have already borne fruit in for instance New York where since 2006 the New York Department of Health has made it a regulation for limited English proficient (LEP) patients to receive services from interpreters and to have access to translated documents in the language they understand best (Cf. Spolsky (2009) in chapter 1); in some other departments, the implementation of language access services (LAS) seems still to be a work-in-progress since, referring to the oncology field Surbone (2010:4) states that:

> In the United States, the Joint Commission is developing and promoting standards for culturally competent care that include language services as a key element of patient-centered care. The Office of Minority Health calls for a universal implementation of the National Standards for Culturally and Linguistically Appropriate Services in

> Health Care. This attention to language is to be integrated with attention to the cultural, spiritual and religious perspectives for all patients and their families.

The discrepancy in language access services (LAS) throughout the US is highlighted by Schapira et al. (2008:589) who also point out the complexity of the healthcare system in the US:

> There are wide gaps in the availability of interpreter services, in part because of the lack of uniformity regarding government requirements and public and private reimbursement strategies and policies. Under Medicaid and the State Children' Health Insurance Plan (SCHIP), states may pay for interpretation services and state expenditures are eligible for federal matching payments of 50% or more. It is estimated that 10 states pay for interpreter services under Medicaid and SCHIP. Some states authorize reimbursement for interpreter services, while others contract with specific organizations to provide such interpretation. In some areas, hospitals may include interpretation costs as allowable costs used to establish overall payment rates. Medicare does not pay for interpretation, although it is estimated that over two million seniors have limited English proficiency. This important omission is worth noting because Medicare policies influence coverage by private insurance companies. Although data are scarce, private insurers for the most part do not cover interpreting costs. Some managed care companies actually demand the provision of interpreters without providing any funds for these services! The American Medical Association and others have raised concerns about physicians having to bear the costs of interpretation. A thoughtful analysis of possible payment models published by Ku and Flores [2005] reviews four different options that include insurance payment directly to interpreters, insurance contracting with telephone firms, funding community organizations to form language banks that recruit and train interpreters and serve as preferred contractors for insurers, and finally a modification of existing reimbursement schemas for physicians such that an additional payment is required for every encounter codified as involving a patient with limited English proficiency. The extra dollars could be used either to hire bilingual clinicians or pay for interpreters, at the discretion of each practice or hospital.

3.2.4.1. Interpreting training and accreditation in the USA

With regard to interpreting training, Schmit (2013) provides a list of US tertiary institutions offering interpreting training. Among these 18 institutions, seven have specialised courses in medical interpreting:

- CALIFORNIA STATE UNIVERSITY: Medical Interpreting (English – Spanish)
- LOS ANGELES INSTITUTE OF TRANSLATION AND INTERPRETATION: Spanish Healthcare Interpretation Programme. Languages: Spanish – English Certificate of 40-hour training in Medical interpreting Languages: Chinese – English,

Korean – English, Japanese – English, Spanish – English, Arabic – English, Armenian – English, Vietnamese – English

- NEW YORK UNIVERSITY: Certificate in Medical Interpreting. Languages: Spanish – English, Chinese (Mandarin and Cantonese) – English Certificate in Medical Interpreting: A Non-Language Specific Approach
- TENNESSEE FOREIGN LANGUAGE INSTITUTE: Medical Interpretation Technique courses for Spanish speakers
- UNIVERSITY OF ARIZONA – NATIONAL CENTER FOR INTERPRETATION: Medical interpretation
- UNIVERSITY OF BOSTON: Medical interpreting certificate program. Languages: Chinese – English, Spanish – English, Portuguese – English
- WAKE FOREST UNIVERSITY: MA in Intercultural Services in Healthcare and Graduate Certificate in Intercultural Services in Healthcare. Languages: Spanish – English (Schmit, 2013).

The Masters degree in Intercultural services on Healthcare at the Wake Forest University for instance is divided in core courses and elective courses. The core courses are to be completed in 29 hours and comprise:

> Health Communication: Patient-Provider (3hours), Applied Interpreting Studies (3 hours), U.S. Heritage Speakers and Bilingualism (3 hours), Special Topics: Cross-cultural Communication (3 hours), Language Use and Technology (3 hours), Localization and Terminology (3 hours), Healthcare Landscape (3 hours), Organizational Behavior (3 hours), Internship (1hour) and Applied Research Project (4 hours) (Wake Forest University: Department of Romance languages, SA).

The elective courses should be completed in six hours. Students are to select two of the following modules:

> Applied Translation Studies (3 hours), Discourse Organization and Interpreting (3 hours), Sociolinguistics and Dialectology (3 hours), Special Topics: Medical-Scientific Translation (3 hours), Special Topics: Audiovisual Translation (3 hours), Special Topics: Legal Translation (3 hours), Spanish for Medical Professions (language specific) (3 hours), Spanish-English Interpreting (language specific) (3 hours) (Wake Forest University: Department of Romance languages, SA).

In the case of New York University, the Certificate in Medical Interpreting and the English Certificate in Medical Interpreting: A Non-Language Specific Approach are not part of the university's degree programme. They are labelled "non-credit offerings". As described by the New York university, the certificate in medical interpreting consists of a:

> 120-hour curriculum designed to train entry-level medical interpreters in Spanish or Chinese (Mandarin and Cantonese) to meet the needs of doctors' offices, hospitals, emergency rooms, and other medical facilities. Recent New York City legislation requires that all city services, including medical facilities, provide translation and interpreting services for residents with limited English proficiency. Also, recent New York State regulations require that all healthcare facilities in the state provide interpreting services to limited-English-proficiency patients by skilled interpreters. During their studies, students are encouraged to volunteer in a New York hospital. Upon completion of the program, students have attained the following: Interpreting skills, Knowledge of English medical terminology, A vocabulary of language-specific medical terms and expressions, Training in cultural and linguistic sensitivity, Ethics and confidentiality training, Skills in professional conduct for various clinical settings, Preparation to work in any hospital setting. Students must pass a written and oral entrance exam to test their proficiency in English and Spanish or Chinese prior to registering for the first course in the sequence, Introduction to Medical Interpreting and Terminology (New York University: School of Continuing and Professional Studies, SA).

As described by New York University's School of Continuing and Professional Studies (SA), students are required to complete two courses: Introduction to Medical Interpreting and Terminology and Medical Consecutive Interpreting.

California State University has a different interpreting training programme although, like New York University, they also offer training in healthcare interpreting in the framework of a "professional advancement" rather than a "degree program" (California State University: College of Extended Studies and International Development, SA). The California State University provides the following description of the offered training:

> Medical interpreting is a rapidly expanding field as more hospitals and other health industry services opt to provide language services to improve care and efficiency. As a collaborative endeavor between doctor, patient and interpreter, medical interpreting complements and contrasts with the more widely studied legal interpreting. CSULA [California State University, Los Angeles] Extension's classes are designed to prepare the student for medical-field work as a Spanish - English medical interpreter in inpatient and outpatient settings. The first class introduces students to the fundamental techniques and practice of translation and interpreting, including consecutive and simultaneous interpreting, and sight translation. The class presents basic medical vocabulary in English and Spanish and reviews grammatical and other structural differences between the two languages. Written and oral practice and reading comprehension exercises with medical vocabulary are included. (California State University: College of Extended Studies and International Development, SA).

As per the above description, the training takes places through two courses namely, introduction to medical interpreting and intermediate medical interpreting. They are both

completed after 11 sessions (44 hours) over a period of six months. It is also stressed by the California State University that "the second class continues to develop these skills while also orienting students to the various forms of exam certification which exist in this field" (California State University: College of Extended Studies and International Development, SA).

It is important to highlight that tertiary institutions are not the only ones offering training in healthcare interpreting in the USA. There are also some independent organisations, associations, companies and agencies that offer both healthcare interpreting training and healthcare interpreting services. It is the case of: Arch Language Network, Nationalities Service Center, Cross Cultural Communications and The Minnesota Language Connection, to name just a few.

As an independent structure, the healthcare interpreting training offered by Nationalities Service Center, for instance, is designed as a 40 hour course taking place over a period of either five or six days depending on the course. Students have to take a language proficiency test that is payable additionally to the course fees. The test as well as the fees are waived for returning students. The offered course topics are described as follows:

> *Basic Interpreting Skills*: What is - and isn't - your job as an interpreter? What are the professional standards for medical interpreters? Includes techniques and skill drills: The Roles of the Medical Interpreter, Code of Ethics, Interpreting Techniques, Sight Translation, Intervening, Managing the Flow of an Interpreted Session. *Introduction to Health Care*: What should medical interpreters know about medicine? How does the US health care system work? Includes "A Day in Medical School" module: The Culture of Biomedicine, Anatomy, Medical Procedures, Medical Terminology. *Culture in Interpreting*: What happens when Western medicine meets other cultural ideas about healing? How can interpreters help clients - and health care providers - understand what is happening in a culturally appropriate way?: Self-Awareness, Basic Characteristics of Specific Cultures, Traditional Healing Practices, Culture Brokering. *Communication Skills for Advocacy*: When should an interpreter become an advocate? How can you fully understand your clients' needs?: Listening Skills, Appropriate Advocacy. Course material are included in the cost of the course. All students will receive: A fully updated 450-page medical interpretation textbook, A bilingual medical glossary in the student's language combination, A guide to commonly prescribed medications (Nationalities Service Center, 2013)[21]

In relation to the exam certification, the Certification Commission for Healthcare Interpreters (CCHI) is one of the organisations involved in testing healthcare interpreters and granting

[21] Nationalities Service Center. 2013. "Bridging the Gap: Medical Interpreter Training Workshop".

them an accreditation. As pointed out by the Certification Commission for Healthcare Interpreters (CCHI):

> CCHI is the first organization certifying healthcare interpreters to receive NCCA accreditation. The National Commission for Certifying Agencies (NCCA) accredited the CHI™-Spanish Certification affirming that the exam was developed in compliance with the NCCA's Standards for the Accreditation of Certification Programs. This is an outstanding achievement, strong and clear recognition of CCHI's leadership and great news for healthcare interpreters, healthcare providers and other stakeholders. For example: 1) Healthcare providers utilizing CHI™-Spanish certified interpreters can be confident that they meet their Joint Commission accreditation requirements. 2) CHI™-Spanish certification holders can be proud that their certification now has the same professional status as nurses, respiratory therapists and other NCCA accredited programs. Welcome to CCHI Founded in 2009, CCHI is a 501(c)(6) organization whose mission is to develop and direct a comprehensive credentialing program for healthcare interpreters, brings together representatives from national and regional non-profit interpreting associations, language companies, community-based organizations, educational institutions, healthcare providers, and advocates for LEP individuals (Certification Commission for Healthcare Interpreters (CCHI), 2009).

As per the above quotation, it appears that the National Commission for Certifying Agencies (NCCA) is the US body in charge of granting accreditations to accessing organisations. The Commission for Certifying Agencies (NCCA) furthermore submits that:

> The National Commission for Certifying Agencies (NCCA) was created in 1987 by ICE to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs/organizations that assess professional competence. Certification programs that receive NCCA Accreditation demonstrate compliance with the NCCA's Standards for the Accreditation of Certification Programs, which were the first standards for professional certification programs developed by the industry. The NCCA standards require demonstration of a valid and reliable process for development, implementation, maintenance, and governance of certification programs. NCCA uses a rigorous peer review process to establish accreditation standards; evaluate compliance with the standards; recognize organizations/programs which demonstrate compliance; and serve as a resource on quality certification. Certification organizations that submit their programs for accreditation are evaluated based on the process and products, and not the content; therefore, the Standards are applicable to all professions and industries. Program content validity is demonstrated with a comprehensive job analysis conducted and analyzed by experts, with data gathered from stakeholders in the occupation or industry. The NCCA Standards are comprehensive and cover all aspects of the certification program(s), including administration, assessment development and recertification. NCCA standards are consistent with *The Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1999)* and are applicable to all professions and industries. NCCA accredited programs certify individuals in a wide range of professions and occupations including nurses, automotive professionals, respiratory therapists, counselors, emergency technicians, crane operators and more. To date, NCCA has accredited approximately 300 programs from more than 120 organizations (The National Commission for Certifying Agencies (NCCA), 2013).

The American Translator Association (ATA) also supports to provide a voice for translators and interpreters. The American Translator Association (ATA) provides a database of translators and interpreters to prospective clients. It has foremost established certification programmes for translators, but as per the information provided on their website's page *ATA Certification Program*, no certification programme is established for interpreters (The American Translator Association (ATA), 2013).

Concerning interpreting training and accreditation in the USA, in her examiner's report to the present study Angelelli (2014) highlights that:

> Some of the programs mentioned offer courses in terminology, ethics, etc. Some are theoretical discussions about issues in the field. Some are on line, others are face-to-face. Some include theory and practice, some are taught by researchers and some by practitioners. They represent the variation and lack of standards in the education of medical interpreters. This perhaps could be discussed and problematized as it has consequences (e.g. little respect/prestige compared to other forms of interpreting, less remuneration, etc.) Education is confused with training. Certification is in the hands of industry (that may not necessarily know the difference between knowing language or terminology and being proficient in interpreting) and the consequences in quality also needs to be discussed.

The above section provides an account on how language management and healthcare interpreting are handled in four countries: Australia, Belgium, Switzerland and the USA. The training programmes and accreditation procedures and offices of these four countries have also been provided. Thus, the next section discusses how health care interpreting training and accreditation is managed in South Africa.

3.2.5. Health care interpreting training and accreditation in South Africa

As per the information provided by the South African Translators' Institute (SATI) (2010), the establishments offering training in interpreting are mainly tertiary institutions. They comprise:

- DURBAN UNIVERSITY OF TECHNOLOGY (DUT): National Diploma: Translation and Interpreting Practice
- NORTH-WEST UNIVERSITY (POTCHEFSTROOM CAMPUS): Besides, the North-West University also lists "Translation and Interpreting Studies" as part of the subjects offered at its School of Languages. In this regard, it is stated that:

> Translation and Interpretation Studies is offered as a three-year major within the programme B.A. Language and Literature Studies. Within the framework of the South African Constitution that provides for equal rights for the eleven national languages in South Africa, Translation Studies is probably one of the most important courses in the New South Africa. The translator is the bridge-builder between languages and cultures and can, in this way, help to facilitate closer contact in the diversity of peoples in the country to help obviate misunderstandings at cultural and linguistic levels. In Translation Studies we lead you into the world of interlanguage communication. In the first year of study we provide and [sic] overview of all the facets of the field of study and help improve your linguistic competency and do work on text and language editing. In the second year the emphasis is on language and translation theories and the role of culture in translation, the editing of texts and on teaching you some "tricks of the trade". In the third year we look at translation in a more specialized way – the translation of focused texts such as literary texts, economic texts, etc. and we give more attention to interpreting and also the status of language in South Africa. We also provide guidance on how to start your own translation practice (North-West University: School of Languages, 2013).

- UNIVERSITY OF JOHANNESBURG: BA Language Practice, Honours in Language Practice, MA in Language Practice, MA (Applied Linguistics) Research Masters and PhD in Language Practice. The description that the University of Johannesburg provides with regard to the postgraduate programme is as follows::

  > The postgraduate programme in Applied Linguistics is aimed at the specialised education and training and research needs of language practitioners such as translators, interpreters, text editors, language planners, copywriters and language teachers. Translation and interpreting are complex linguistic, cognitive and textual processes that, among other things, also entail socio-cultural mediation. Given the complexity of these activities and hence the interdisciplinary nature of language practice, these programmes offer a balance of theoretical, practical and experiential knowledge and skills (University of Johannesburg: Department of linguistics, 2011).

- UNIVERSITY OF LIMPOPO (TURFLOOP CAMPUS): At postgraduate level, students have the possibility to specialise in interpreting.

- UNIVERSITY OF PRETORIA: BA Honours (Translation and Interpreting Studies), MA (Translation and Interpreting Studies), MA specialising in Applied Language Studies (Option: Translation and Interpretation)

- UNIVERSITY OF SOUTH AFRICA (UNISA): BA (Honours)(Linguistics with specialisation in translation studies), MA (Linguistics)(Translation Studies) (dissertation only), D. Litt et Phil. (Linguistics)(Translation Studies).

- UNIVERSITY OF STELLENBOSCH: Advanced interpreting theory and practical interpreting are some of the compulsory modules students can chose from in order to complete an Honours degree in translation (University of Stellenbosch: Departement Afrikaans en Nederlands, 2009); as part of the modules to complete in order to be granted a Postgraduate Diploma in Translation, translation and interpreting theory are compulsory modules whereas practical translation is an elective modules (University of Stellenbosch: Departement Afrikaans en Nederlands, 2009)[22]; In other to complete a Master's in Translation, students can choose interpreting theory as one of their compulsory modules (University of Stellenbosch: Departement Afrikaans en Nederlands, 2009)[23]

- UNIVERSITY OF THE FREE STATE: To complete a BA (Language Practice), students must take courses such as "The professional, cultural and sociolinguistics aspects of interpreting" (second year) and "Interpreting (theory and practice) (third year) (University of the Free State, 2013:75-76). To complete a Postgraduate Diploma in Language Practice, students take a module in interpreting theory and as well as, amongst others, courses in consecutive and simultaneous interpreting. The same interpreting modules are required from students who wish to be granted a BA Hons (Language Studies). Interpreting theory and conference interpreting are the modules that students undertaking an MA (Language Practice) must complete (University of the Free State, 2013:115-121)[24].

UNIVERSITY OF THE WITWATERSRAND: At undergraduate level, a Diploma in Legal Interpreting (accredited by SASSETA) is offered. The programme may be taken in eighteen months to two years part-time or, in exceptional cases, one year full-time. The programme consists of nine short courses run by the Wits Language School, each of which lead to a

[22] University of Stellenbosch: Departement Afrikaans en Nederlands. 2009. "Postgraduate Diploma in Translation".
[23] University of Stellenbosch: Departement Afrikaans en Nederlands. 2009. "MA in Translation".
[24] University of the Free State. 2013. *Rule book 2013. Faculty of Humanities: Art and sciences Postgraduate programmes*.

recognised certificate of competence. Three of the courses are English courses. The other courses are: *Introduction to Interpreting Skills, Liaison Interpreting in Specific Contexts, Language Refinement for Language Practitioners, Law theory for Interpreters, Introduction to Legal Interpreting* and *Intercultural Communication & Mentoring in the Workplace*. *Liaison Interpreting in specific contexts* is the only module which contains a health care interpreting component (Wallmach, 2014: personal communication). Topics covered include conversational interaction and strategies, turn-taking and power relations, stress management, emotional intelligence, conflict management, powerful communication (leading and pacing) and managing interaction with clients in at least two contexts, which may include business, health-care, education and legal interpreting. The general BA degree does not offer a module in interpreting, although there is one module in translation methods and techniques.

At postgraduate level, the University of the Witwatersrand offers a Postgraduate Diploma in Translation and Interpreting, a one-year Honours in Interpreting, and a two-year MA in Translation (Option: Interpreting). The Honours and MA follow a similar curriculum in the first year, which includes two modules in interpreting: *Principles and Practice of Interpreting* and *Conference Interpreting Skills*, plus *Interpreting Studies* (interpreting methodology). Students are also expected to study translation as well as aspects of linguistics, law and economics. In the second year of the Masters degree, students must complete *Specialised Conference Interpreting Skills, Professional Language Enhancement, Report Writing and Transcription Skills* and *Advanced Interpreting Studies* in addition to the research report. The interpreting component is taught via professional short courses run by the Wits Language School and credited towards the degrees of Honours and MA.

The South African Translators' Institute (SATI) (2010) also indicates that short and ad hoc courses are offered by various institutions for specialisation, as hoc or refresher purposes. Two such institutions are:

- The Wits Language School, which provides continuing education to adult learners, teachers a number of eight-week professional short courses in interpreting using a blended approach (mixed contact teaching and online learning) in order to enable adult, working students, many of whom may already be working as professionals, to learn across different times and locations, and to make self-paced learning possible. The postgraduate interpreting courses are taught by AIIC accredited trainers. These

courses bear credit towards the Honours/MA in Translation (Option: Interpreting), and contain a similar number of notional study hours as a semester course taught once a week.

- The Department of Afroasiatic Studies, Sign Language & Language Practice at the University of the Free State in Bloemfontein, referred to as the Unit for Language Facilitation and Empowerment (University of the Free State, 2013)[25]

It therefore appears that unlike the four countries that have been reviewed (Australia, Belgium, Switzerland and the United States), in South Africa, there is no specialised training or certification in health care interpreting. In South Africa, most institutions offer training and certification in consecutive interpreting, legal interpreting, simultaneous interpreting and interpreting methodology/theory.

Concerning accreditation in general, the South African Translators' Institute (SATI) (2007) states that:

> The language profession in South Africa is unregulated. This means there is no government requirement or provision for accreditation or any other form of proof of competence. Clients, however, often require assurance that the language practitioner they employ is able to do a good job. For this reason, SATI began a system of voluntary accreditation in late 1990. Only accredited members have voting rights within the Institute. Accreditation is voluntary, but the system has become widely recognised and is used as a recommendation or prerequisite for job applications by a number of institutions. It should, however, be borne in mind that there are also good language practitioners who have not been accredited – either because they have felt no need to do so or because accreditation is not yet available in their language or discipline. Accreditation is available only to members of the Institute and can be applied for after three months of membership. If membership of the Institute lapses, accreditation lapses as well. Although SATI recognises that accreditation is offered by other organisations, the Institute does not accept these for purposes of accreditation with SATI. Members can acquire SATI accreditation ONLY through testing.

However, on 4 March 2014, the South African Language Practitioners' Council Bill (as amended) was passed by the National Assembly on 4 March (Jamal et al., 2014). This Act should address the issue of accreditation and regulation in the future.

Unlike the National Accreditation Authority for Translators and Interpreters Ltd (NAATI) in Australia, with the South African Translators' Institute (SATI):

> Academic qualifications are also not considered in the granting of accreditation. All SATI accreditation is based on practical testing of the candidate's competence in the

[25] University of the Free State. 2013. "Unit for Language Facilitation and Empowerment".

> discipline and languages concerned. Owing to the historical disadvantages suffered by some South Africans under apartheid, it was decided that SATI accreditation would not be based on formal or academic qualifications, but only on proof of competence in practice. This ensures a level playing field for all candidates. Accreditation is offered at professional level only. This means that a high standard is required of candidates and that a high percentage do not pass the exams. Over the years it has been shown that it is rare for candidates without a reasonable amount of experience to pass the exams. (SATI), 2007).

With regard to the accreditation of interpreters, the South African Translators' Institute (SATI) (2007) indicates that:

> Accreditation is currently available only for simultaneous or conference interpreting. This is available for both spoken languages and South African Sign Language (SASL). In time, the Institute hopes to introduce accreditation for liaison and court interpreting as well. Because of the logistics involved in testing interpreting skills, testing sessions are held once or twice a year at different centres, depending on demand. (South African Translators' Institute (SATI), 2007)[26].

From the above information provided by the South African Translators' Institute (SATI), it appears that the South African Translators' Institute (SATI) does not offer accreditation in liaison interpreting. Furthermore, unlike in the four countries that have been reviewed (Australia, Belgium, Switzerland and the United States) not only does no institution offer specialised training and certification in health care interpreting, but there is no accreditation in health care interpreting and no official agency or organisation that provides interpreters in the public service in South Africa.

3.3. Conclusion

In this chapter, a description of the health care interpreting models as well as the training and accreditation models implemented in Australia, in Belgium, in Switzerland and in the USA have been provided. The training and accreditation applicable in South Africa is also discussed.

[26] South African Translators' Institute (SATI). 2007a. "Interpreter Accreditation".

CHAPTER 4: METHODOLOGY

"To paraphrase Snow (1964), 'Closing the gap between cultures is a necessity. When apart…then no society is going to be able to think with wisdom. Each side has a good deal to learn from the other. Isn't it time we began?'" (Mullin, Cooper and Eremenco, 1998)

4.1. Introduction

This part of the thesis presents the methodology used in the course of this exploratory study. The pilot study aims at evaluating the linguistic landscape as well as assessing the necessity of providing healthcare interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital, the methodology of the pilot study includes on-site observation and the collection of data through patient interviews and distributing questionnaires to the Department's medical personnel. The pilot study conducted forms part of the methodology for the main study as it informed the main study.

In the next section, I report on the state of healthcare interpreting in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital. The report is followed by a discussion on the preliminary investigation conducted as part of a pilot study undertaken at the Department.

4.2. Health care interpreting in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital

In South Africa, it appears that the majority of South Africans attending public hospitals face similar difficulties to immigrants. Herselman (2007) describes some of the challenges faced by public hospital patients in South Africa: financial constraints, difficulties accessing healthcare, cultural, social and language barriers between doctors and patients, trust issues between doctors and patients, and the impact of cultural beliefs to name just a few (Cf. Chapter 1). Some of these constraints have been observed in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic hospital.

As per the information provided at the end of 2012 by the Head of the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic hospital, the Department consists of 144 staff members including 40 radiation therapist staff members at the hospital and 30 interns in radiation therapy from the University of Johannesburg; 30 doctors, including eight consultants and 22 registrars, 15 nurses, six medical physicists, four extra staff, including three clerks and one secretary, a researcher and 14 cleaners. There are also some porters, social workers, a receptionist, a nutritionist and a psychologist who cater for cancer patients. The staff members are very diverse in terms of their language and cultural backgrounds. However, it was observed that Black South Africans, Black Africans from other countries, White and Eastern Asian doctors were individually a minority compared to Indian doctors; and Black South African nurses were a majority compared to White nurses. No Indian or Eastern Asian nurse was seen on the premises. All cleaners, porters and clerks were Black South Africans, the medical physicists were mainly Black South Africans compared to Coloureds, and radiation therapists were very diverse culturally[27].

The patients attending the Department were also culturally and linguistically diverse. Their age varies from around 4 years old to about 70 years old. The Department has set up one room especially for children with cancer. Though it was observed that there are mostly Black South African patients, the Department also caters for White, Coloured, Indian, Arabic patients. Whereas some of the White patients are as diverse as being from Italian, English, Portuguese and Afrikaans cultural backgrounds, there are also some African patients from foreign countries such as for instance the Democratic Republic of Congo (DRC), the Republic of the Congo, Namibia and Mozambique. The South African patients also had very diverse cultural backgrounds: Ndebele, Xhosa, Zulu, Swati, Tswana, Tsonga, to name just a few. It was also observed that among patients many are pensioners, unemployed or from the working class.

Among the South African patients, two African individuals, a man and a woman, have voluntarily assumed the role of spiritual leaders: when they arrive in the morning, they invite other patients sitting in the waiting area to pray with them. The nurses, the cleaners, the receptionist and the porters usually join them in prayer. They pray and sing mainly in South African indigenous languages. At times, the prayers and singing are accompanied by

[27] The researcher highlights the race classification not with the intention to discriminate, but to describe the language and cultural landscape of the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital. This language and cultural landscape may either affect or benefit the relation between medical staff and patients.

testimonies of healing or recovery by the spiritual leaders. When there are White patients in the waiting area, the spiritual leaders may then code mix English and their language, but the prayers and songs mainly remain in their native language.

The receptionist was observed sending text messages to patients to remind them of their appointments with the doctors. Sometimes, she would call patients with head cancer who were unable to read. She would also call patients who were not English literate and speak to them in a South African indigenous language.

Concerning *ad hoc* interpreting provision, in general the nurses are called upon to bridge language barriers between doctors and patients who speak South African indigenous languages. When the nurses are not available, doctors attempt to receive interpreting from anyone: radiation therapists, cleaners, anyone who at that moment would help them to communicate in any way at all with their patient. It was observed that one of the nurses originates from Congo and is therefore usually requested to interpret for the other nurses or for doctors who are not French literate, as there are some French speaking doctors in the Department.

Nurses affirm that they have no problem tackling the language diversity in the Department, as long as they are not confronted with foreign languages such as French, Portuguese, Arabic and Italian for instance. All staff members of the Department seem to be ready to assist in bridging language barriers whenever they can, although physicists in charge of the radiation equipment have reported that they are seldom called upon to assist with interpreting due to the fact that they are hardly directly involved with patients.

4.3. Pilot study: Research methodology

Three methods are used to investigate the research problems: on-site observation, interviews and the distribution of questionnaires.

The researcher undertook an on-site observation in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital for a month. The aim was to examine and understand how the Department functions on a daily basis, to observe the work dynamic in the Department; make contact with the staff, to verify whether there is a need for

interpreting services in the Department, and then evaluate how the pilot study should be conducted.

Interviews were conducted with 100 adult patients as part of the pilot study. The purpose was to capture qualitative data about patients' linguistic and social profiles. The researcher wanted to be able to identify the patients in terms of their culture, language proficiency and literacy, their profession and the clinic they were attending. When engaging with patients who were not English literate, the researcher received interpreting assistance by one of the porters. The questions utilised in the interview are included as an appendix to this report.

A questionnaire was also distributed to all staff members in order to capture qualitative and quantitative data. The aim was to profile the staff in terms of the function they occupy in the Department: their culture, their multilingualism, their familiarity with receiving interpreting services in general; their familiarity with receiving professional interpreting services; the time they spend when consulting patients; their opinion about the usefulness of the provision of a professional interpreting service in the Department and whether they are aware of any language policy applied by the hospital or by the Department. 144 questionnaires were distributed and 79 were returned. The questionnaire distributed is included as an appendix to this report.

The data collected during the pilot study is analysed using descriptive and comparative statistical methods.

4.4. Pilot study Data analysis

4.4.1 Analysis of on-site observation: From November 2012 to December 2012

The Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital has four clinics, each catering for different types of cancer. Clinic 1 caters for head and neck cancers, Clinic 2 provides care for skin cancer and on Wednesdays, prostate cancer, Clinic 3 is reserved for breast cancer and Clinic 4, gynaecology, cervical cancer and children patients. According to the Head of the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital, head and neck cancer patients are mostly men, skin cancer

patients are mostly White patients, breast cancer patients are race disparate and cervical cancer patients are dominantly Black patients. This was confirmed by observation.

From the on-site observation it was noticed that the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital provides its services to approximately one hundred patients daily during a typical clinical day. On Monday, follow up patients are catered for; Tuesday is dedicated to radiation patients; Wednesdays and Fridays are patient-on-treatment review days. Though prostate cancer patients are interviewed on Wednesdays, on Thursday all new patients with cervical cancer as well as patients from peripheral hospitals are attended to. During the weekend, there are doctors on call in case of emergency.

With regard to the work dynamic in the Department, on clinical days, it is rush hour from 7:30 am or 8am until around 1pm or 2pm. All staff members are busy; the waiting area is usually full of patients. Two doctors may have to share a consultation room, or to see a doctor leaving the consultation room looking for interpreting assistance. After 2pm, the waiting area is quite empty because by that time, almost all patients have already been interviewed.

It was also observed that the Department can be a depressing environment to be in because of the constant exposure to illness and to people's distress. Mondays are particularly difficult because it is head and neck cancer day. Head and neck cancer are visible, unlike cervical cancer for instance. Some patients are unable to speak because they have a hole in their neck that is sometimes bleeding, some others have lost one eye or both or their head, face or neck may be deformed. Yet, as disclosed in the pilot study, some of them have limited English proficiency and benefit from the assistance of their relatives, including children, in communicating with the doctors. The on-site observation was followed by the patients' interviews. The next paragraph presents some of the results from patients' interviews including patients' linguistic and social background.

4.4.2. Analysis of patients' interviews: December 2012

Patients' gender

100 adult patients were interviewed in the course of the part of the pilot study focusing on identifying patients socially and linguistically. Patients were selected randomly while waiting for their files in the Department's waiting area. Interviews were conducted for three working

days from 7 December 2012 to Tuesday 11 December 2012. As per the chart below (figure 4.1), 23 men and 77 women were interviewed.

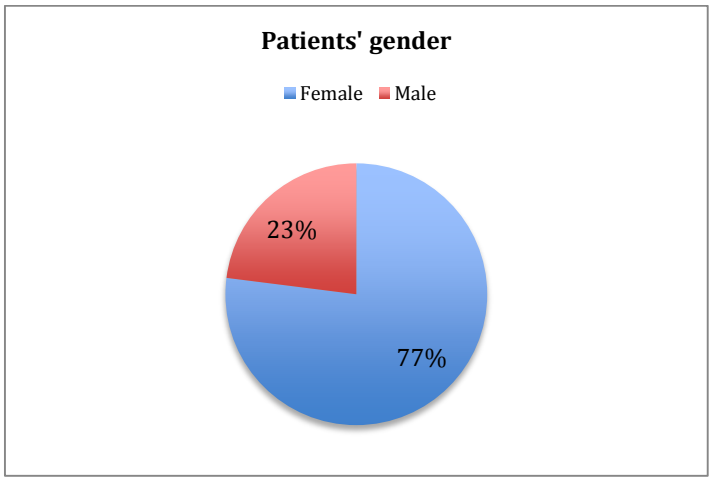


Figure 4.1: Patient's gender

Patients' social and financial background

In order to have a better understanding of patients' social and financial background, patients were asked to provide information about their profession. As per the graph below (figure 4.2), 63% of the interviewed patients are pensioners and unemployed. In general, 80% of the interviewed patients either have a low income or no income at all. As a public hospital's facility, the Department of Radiation Oncology is subsidised by the government and is therefore bound to provide its services at a low cost compared to private hospitals. In this regard, the Johannesburg Hospital states that "[t]he costs of providing these services to the population of Gauteng Province and in addition to the neighbouring provinces are funded by a National Tertiary Services Grant as well as Provincial allocation" (Johannesburg Hospital, 2013). This explains why the Department accommodates approximately a hundred patients on working days. Patients at Public hospital do not have the means to go to private hospitals as the latter are expensive and therefore cater for wealthier patients who are usually members of medical aids (Cf. Chapter 1). In the graph below, 22 classes are identified. "XXX" stands for patients who did not disclose their profession.

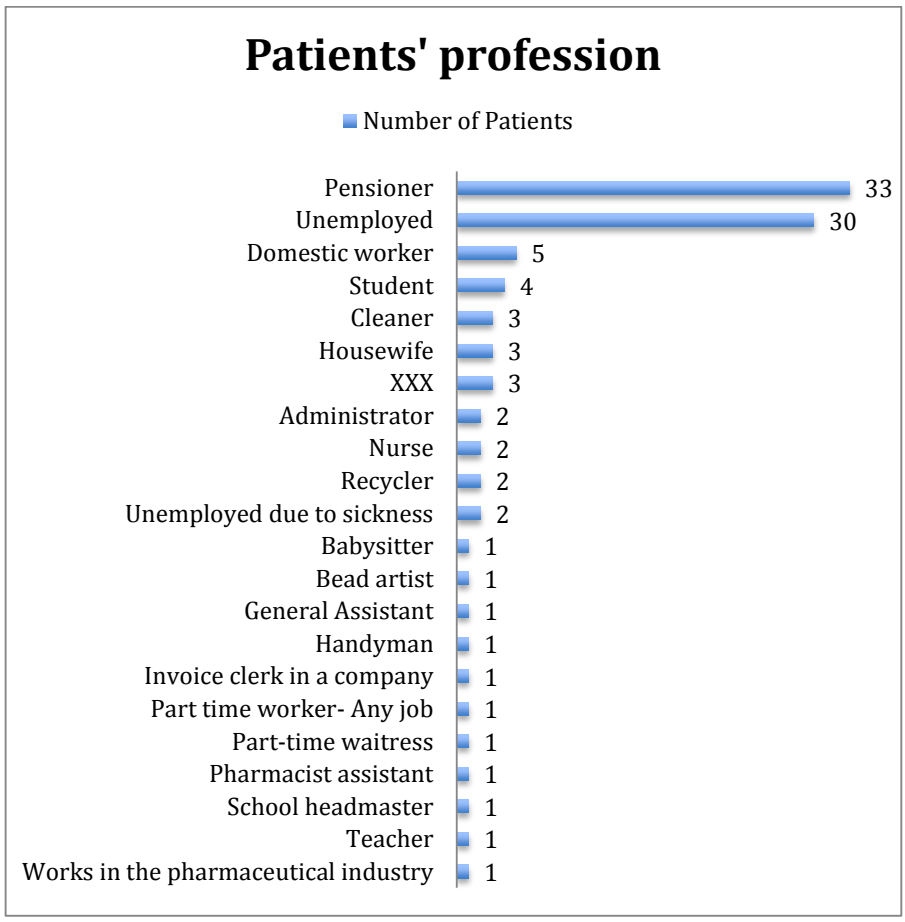


Figure 4.2: Patients' profession

Whereas this paragraph provides information relating to patients' social and financial background, the next paragraphs present information reporting on patients' linguistic background.

Patients' first language

During the interviews, patients were asked for their first language. All patients responded to that question. The list of the languages as well as the number of patients sharing the same first language is provided in the chart below (figure 4.3). It appears that the majority of the patients were isiZulu first language speakers (19%), followed by Sesotho first language speakers (18%). The chart also shows that some patients described themselves as being bilingual first language speakers. The researcher made a distinction between those who described themselves as being "Afrikaans and English" and "English and Afrikaans"

bilingual first language speakers as it might be an indication of the cultural or the social background these patients relate the most to. The chart (figure 4.3) also shows that some patients of foreign origins consulted doctors in the Department: two Mozambicans, one Italian, one Burundian, one Congolese from the Democratic Republic of Congo and one Portuguese.

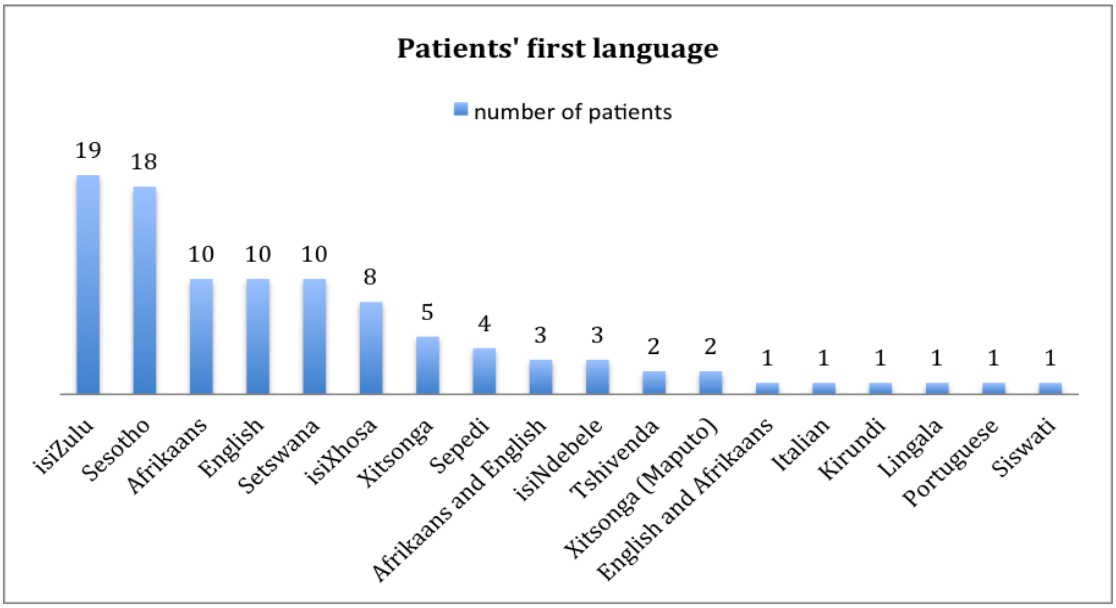


Figure 4.3: Patients' first language

Some patients knew other languages besides their first languages. Thus, the next paragraph provides information related to the additional languages that patients know as well as a chart of patients knowing the same combination of languages.

Additional language(s) known[28] by patients

There are 309 instances of languages spoken by patients in addition to their first language. Thus, patients generally know an average of 3.09 languages, including their first language. The least number of additional languages known is one and the maximum is eight.

[28] Throughout this research report, the researcher discusses in term of "languages known by patients" or "languages that patients know" instead of languages that patients can speak because the level of literacy of the patients has not been formally tested. Patients gave an account of their own level of literacy in the various languages they claimed to know. Furthermore, whereas some patients claimed that they could speak, read and write some languages, some others declared that they could either only speak or only understand some languages; which is part of the reasons why to the researcher, it seems more appropriate to use the verb "to know" rather than using the modal auxiliary "can" speak.

The table providing the languages and the language combinations shared by several patients is included in the appendix. From the data collected it appears that Black South African patients are the most multilingual. The same table shows that whereas 8 out of the 100 patients interviewed claim not to speak another language besides their first language, 22 patients out of 100 claim to have English as additional known language, followed by 7 patients out of 100 claiming to have Afrikaans as an additional known language, 5 patients out of 100 claiming to have both English and Sesotho as additional languages and 2 patients out of 100 claiming to have the following languages and combination of languages as additional known languages:

- Afrikaans, English, isiZulu and Sesotho
- English and isiZulu
- English and Sepedi
- English, isiZulu and Sesotho
- isiZulu and
- Portuguese

Thus, the following chart (figure 4.4) summarises the number of patients knowing one language individually as an additional language.

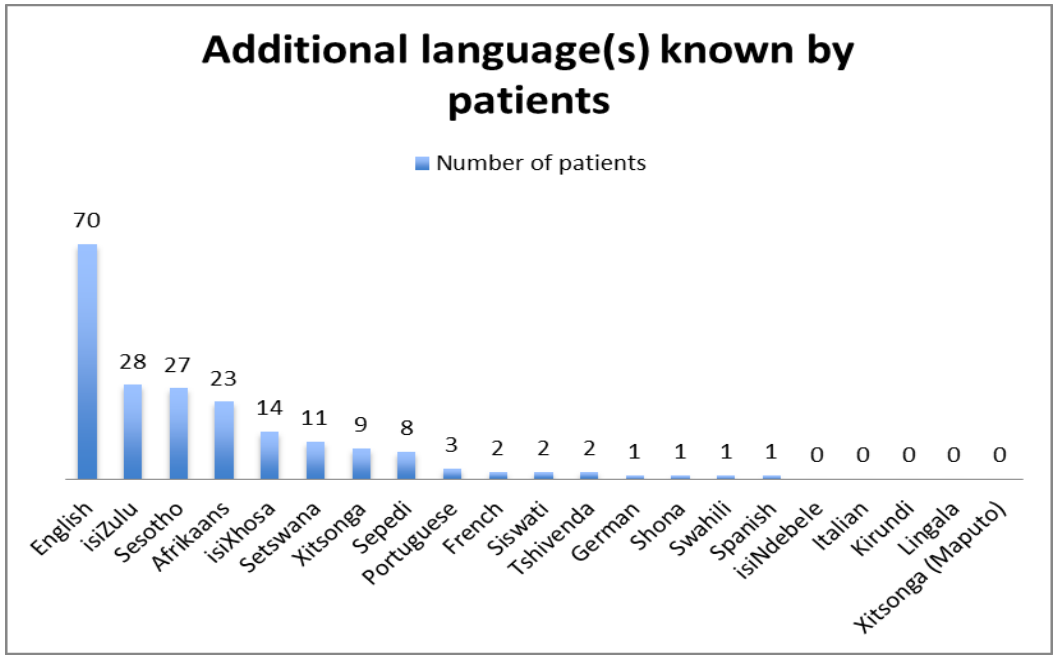


Figure 4.4: Additional language(s) known by patients

The chart above (figure 4.4) reports that English is the language most commonly known by patients, as 70% of them claim to be able to speak it, followed by isiZulu (28%), Sesotho (27%), Afrikaans (23%), isiXhosa (14%), Sepedi (8%). Whereas Portuguese is spoken by 3% of the patients and French, Siswati and Tshivenda are each spoken by 2% of the patients, German, Shona, Swahili and Spanish are each spoken by 1% of patients. Although isiNdebele, Italian, Kirundi, Lingala and Xitsonga (Maputo) are represented in the chart of patients' first languages, none of these languages is known as an additional language by any other patient.

It is impressive to see that patients can speak five, six and even eight languages as is found in this exploratory study. However, this also raised questions relating to the level of oral proficiency and literacy of these polyglots. In order to determine how well patients knew the languages they claimed to know, they were asked to grade themselves in terms of how well they could speak all the languages they claimed to know, whether they could read and write the languages they claimed to know and how well they could read and write these languages. In some instances, in the course of the interview, the researcher also evaluated the level of English oral proficiency of patients. The different grades[29] were ranked in terms of:

- Language A: very good
- Language B: good
- Language C: mediocre
- Language N/A: the knowledge of the language is insignificant
- Language 0: non-existent
- Language XXX: the patient did not provide information about the level of oral proficiency or the level of literacy of the language he or she has claimed to know

The tables providing the level of oral proficiency as well as the level of literacy of patients with respect to their first language, the languages they claim to know in addition to their mother tongue are included as part of an appendix to this study. However, it is important to indicate that in the time allocated to complete this study, it was not possible to categorise participants' language profiles according to universally accepted scales such as the European Framework.

[29] The scale A, B, C, D is a professional one used to grade professional interpreters' languages. In the course of this study, participants who claimed to be English A for instance could be, if tested in English, categorised as English B. No formal language testing could be done on participants. Thus, the analysis of the pilot study was based on participants' own judgement of their level of competency in the languages they claimed to know, as well as on the researcher's judgement of their competency whenever applicable.

With regard to the patients' oral proficiency in the additional languages they claim to know, these tables report that Afrikaans is a language additionally known by 24 patients but only 10 of them could be categorised as "Afrikaans A" which means that they are very proficient in that language; they understand and speak it very well across registers. Two of them could be categorised as "Afrikaans B" which means that they understand the language well and can express themselves well although they might have an accent or make few mistakes when they speak. Three of them could be categorised as "Afrikaans C" which means that they might understand the language well, but they might have difficulties speaking Afrikaans across all registers of the language. One patient could be categorised as "Afrikaans N/A" which means that the level of proficiency is inconsequential and one patient was categorised as "Afrikaans XXX" which means that the level of oral proficiency was undisclosed. Whereas one patient admitted that he or she was only able to understand Afrikaans, the other one admitted to be able to understand but to hardly be able to speak it.

Among the 56 patients who declared that they knew English as an additional language, 44 of them could be categorised as "English A", three as "English B", eight as "English C", and three as "English N/A". One patient admitted that he or she could only speak English, whereas another one admitted that he or she could understand it but hardly speak it.

Of the two patients who claimed to know French as an additional language, one can be categorised as "French A" and the other, as "French N/A". Only one patient declared to know German and could be categorised as "German B".

14 patients claimed to know isiXhosa as an additional language of which three could be categorised as "isiXhosa A", two as "isiXhosa B", and three as "isiXhosa C". Six patients admitted that they were able to speak isiXhosa, but they could neither write nor read it.

With regard to isiZulu, 30 patients claimed that they knew that language as an additional language including 16 who could be categorised as "isiZulu A", one as "isiZulu B", three as "isiZulu C" and three as "isiZulu XXX". Seven patients admitted that they could only speak isiZulu.

The three patients who claimed to know Portuguese as an additional language could all be categorised as "Portuguese A". The only patient who claimed to know Shona as an additional language admitted only to be able to speak it and not to write it.

Six patients declared to know Sepedi as an additional language including two who could be categorised as “Sepedi A”, and two as “Sepedi XXX”. Four patients admitted that they could only speak that language. Concerning the 27 patients who claimed to know Sesotho as an additional language, 10 could be categorised as “Sesotho A”, two as “Sesotho C”, one as “Sesotho N/A” and three as “Sesotho XXX”. 11 of these patients said only to be able to speak Sesotho.

Of the 12 patients who claimed to know Setswana as an additional language, four could be categorised as “Setswana A”, three as “Setswana XXX” and five admitted only to be able to speak the language. The two patients who declared to be able to speak Siswati admitted that they were only able to speak it and not to write it.

The patient who said that he knew Swahili as an additional language admitted only to be able to speak it whereas the patient who claimed to know Spanish could be categorised as “Spanish B”. Among the two patients who declared to know Tshivenda, one could be categorised as “Tshivenda A” whereas the other one can only speak the language.

Nine patients declared that they know Xitsonga as an additional language, including three who could be categorised as “Xitsonga A”, two as “Xitsonga XXX” and four patients who can only speak the language.

From the above results, the following can be deduced:

- 43 of these polyglot patients have claimed to be able to speak but they can neither write nor read in the languages they know in addition to their mother tongue
- Three patients can understand but are unable speak, nor write nor read the additional languages they claimed know

In the course of this analysis, the researcher focuses on language speakers who have an oral proficiency A for three reasons. Firstly, when comparing the level of oral proficiency of language A speakers with their level of literacy there are very few changes. In general, language A speakers have the same level of literacy. The tables providing the level of oral proficiency and literacy in both the first language category and the additional language category is provided as an appendix to this report. Secondly, language A speakers are higher in number in both the category of first language and additional language. And thirdly, the analysis of that population provides interesting patterns.

In the chart below (figure 4.5), the data issued from patients' first language oral proficiency is compared with patients' additional language oral proficiency. The four bilingual English and Afrikaans double A patients are included in the "English A" and "Afrikaans A" results.

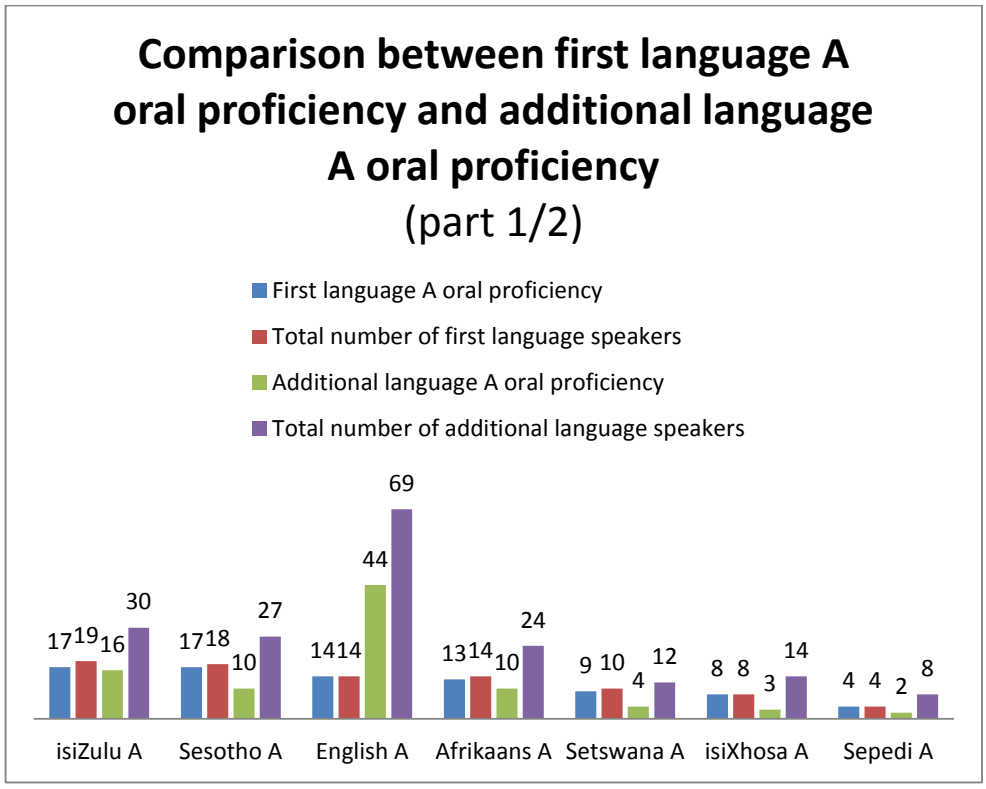


Figure 4.5: Comparison between first language and additional language oral proficiency A (part 1)

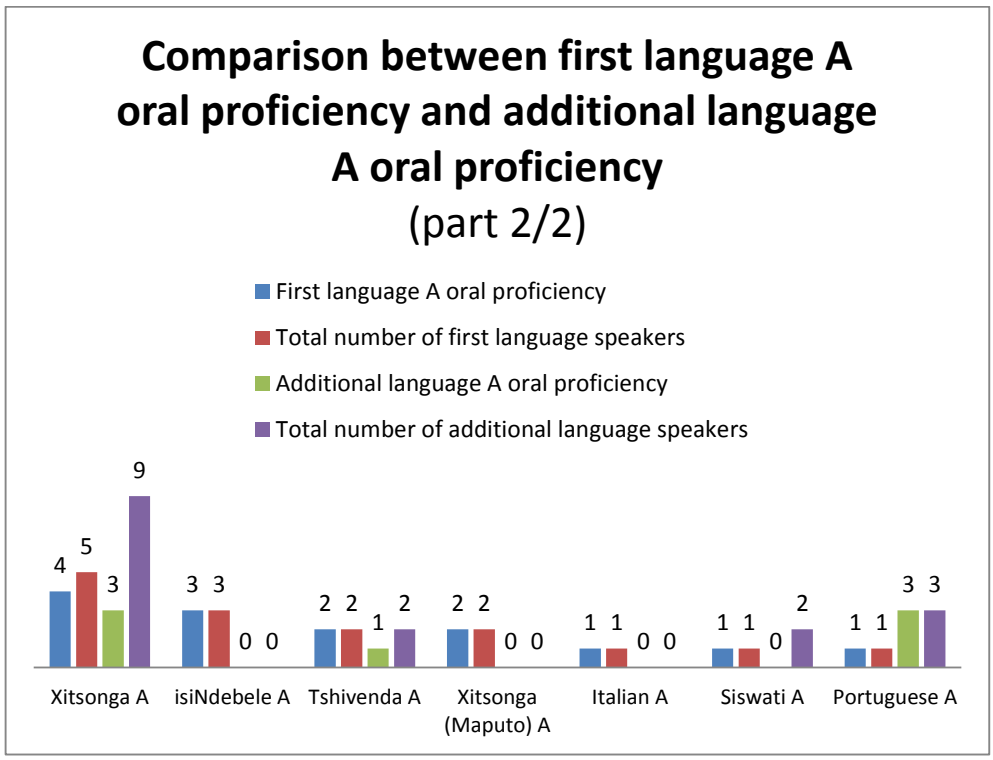


Figure 4.6: Comparison between first language and additional language oral proficiency A (part 2)

From the information provided above (figure 4.5 and figure 4.6), it can be derived that 96% of first language speakers have claimed to be "first language speaker A". When compared to the "additional language speakers A", it can be deduced that the "first language speakers A" are higher in number than the "additional language speakers A" except for "English A additional language speakers" (44 English A as additional language speakers against 14 English A as first language speakers) and Portuguese A additional language speakers (3 Portuguese A as additional language against 1 Portuguese A as first language speaker). Four conclusions can be drawn from this analysis:

- All first language English speakers categorised themselves as "English A";
- All additional language Portuguese speakers categorised themselves as "Portuguese A";
- English is not only the language mostly known by patients, it is also the best known language to the majority of patients as 58% of patients categorised themselves as "English A";
- Most patients know their first language better than they know their additional languages.

In the face of such a polyglot population, patients were asked to name the language(s) they would prefer to use during a consultation with the doctor. The patients' preferred language is thus summarised in the next paragraph.

Patients' preferred language when consulting with the doctor

The graph below (figure 4.7) shows in detail the languages that each patient would like to use when consulting with the doctor. Some patients expressed the desire to speak only one language whereas some others provided a range of languages they would not mind using when consulting with a doctor.

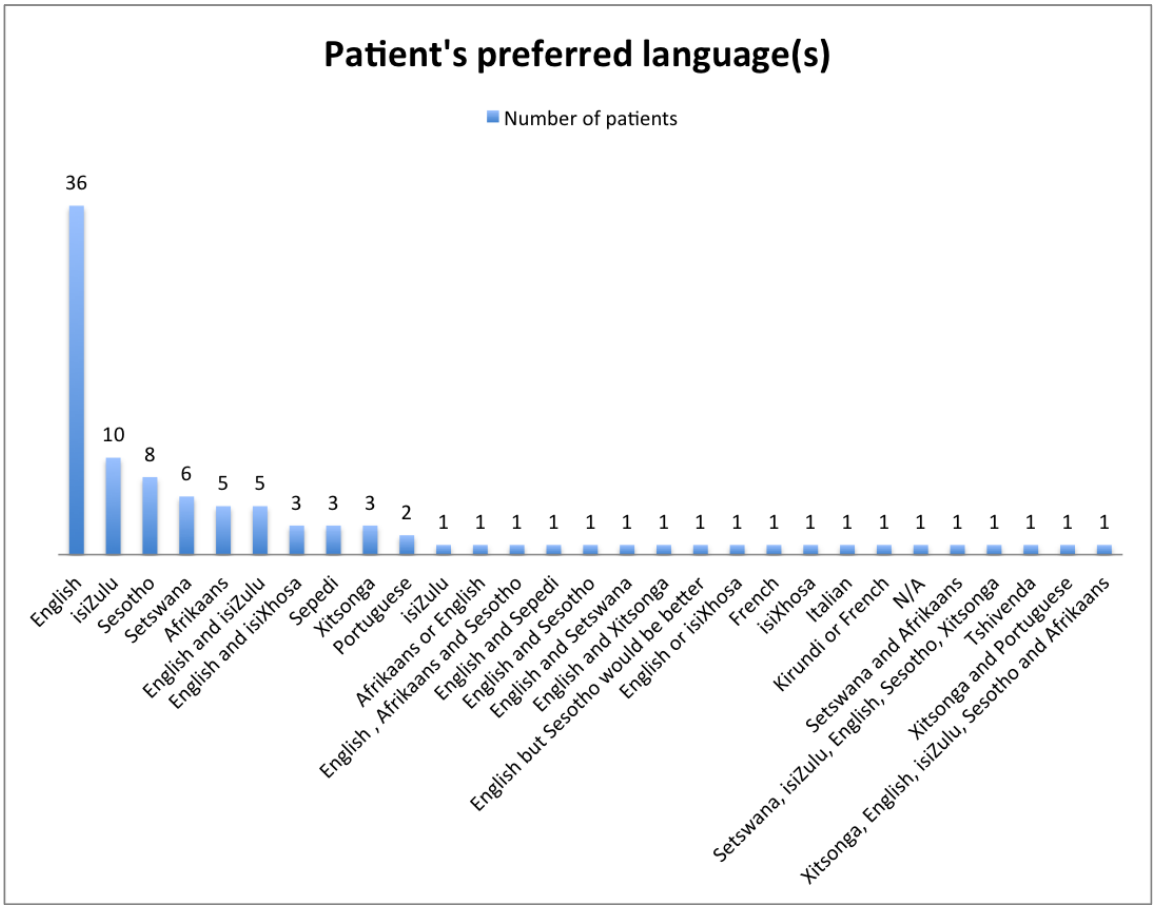


Figure 4.7: Patient's preferred language(s)

Whereas the chart above (figure 4.7) focuses on each patient in relation to the languages that they have mentioned, the following chart (figure 4.8) focuses on the languages themselves in

order to find the languages that are mostly preferred by patients. Thus, on figure 4.8, it appears that English is the most preferred language.

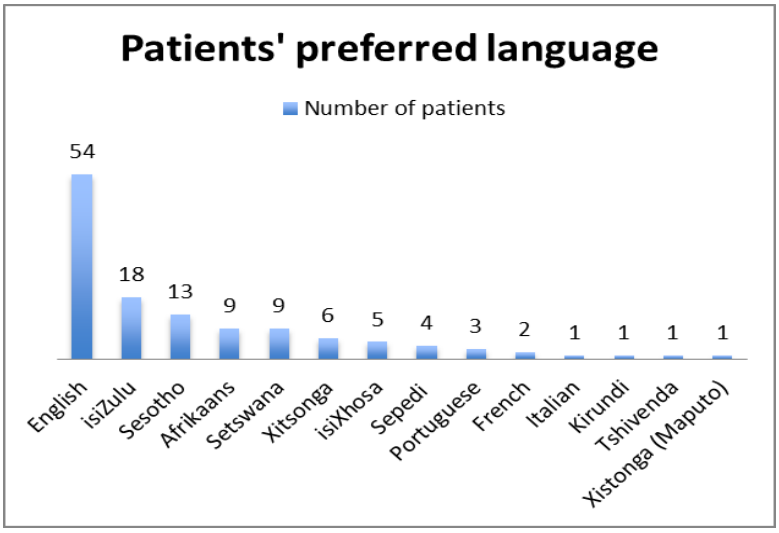


Figure 4.8: Patients' preferred language

The above chart (figure 4.8) indicates the following:

- English is the language that patients prefer to use when consulting with the doctor;
- The number of patients who speak a language as a first language is lower than the number of patients who have a preference for a certain language with the exception of: English, which has 14 first language speakers against 54 patients who prefer to speak it; Xitsonga, which has five first language speakers against six patients who prefer to speak it; Portuguese, which has one first language speaker against three patients who would prefer to speak it. It can therefore be concluded that there is a tendency that patients prefer not to speak their first language with the doctor;
- Whereas a language that does not figure in the list of first languages is listed as a preferred language of communication, some of the languages that figure in the list of first languages are not in the list of preferred language. French is included on the list of preferred language though none of the patients is a French first language speaker. Ndebele and Siswati are listed on the list of patients' first languages but they do not figure in the list of the preferred language(s);
- Sepedi, Kirundi and Italian have an even number of first language speakers and preferred language of communication with the doctor;
- Patients who can speak English tend to prefer to use it when consulting with the doctor.

The fact that the majority of patients prefer to speak English when consulting with the doctor raises the question to know whether they do so because their English is better than their first language or whether there could be another reason behind this. The next section therefore aims at comparing the level of proficiency of patients' first language with the level of proficiency of patients' preferred language(s).

Comparison between patients' first language proficiency and preferred language proficiency

The following graph (figure 4.9) provides a comparison between the number of patients who speak a first language at a certain level, with the number of patients of the same level who would prefer to speak that language with the doctor. In this graph, the bilingual Afrikaans and English speakers have not been added to the individual English and Afrikaans speakers because this table aims at contrasting values of the same nomenclature. This is the reason why this table only shows the results of patients whom have preferred to speak one language with the doctor. The graphs showing the data that did not match, in other words the combination of languages as well as patients' level of proficiency in their language combinations is attached as an appendix to this study.

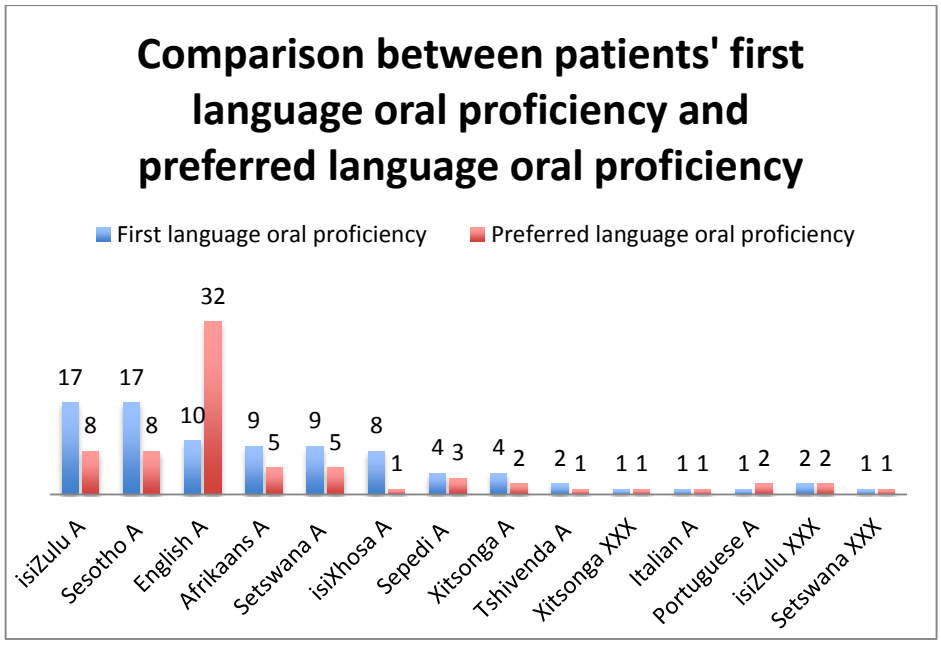


Figure 4.9: Comparison between patients' first language and preferred language oral proficiency

Thus, this graph (figure 4.9) indicates the following:

- Among the patients who exclusively preferred to speak isiZulu, Sesotho, English, Setswana, isiXhosa, Tshivenda, Xitsonga, Italian and Portuguese, patients either have a level of oral proficiency "A", or an undefined oral level of proficiency "XXX"
- In general, the number of first language speakers is higher than the number of patients preferring to speak that language:
    - Eight language groups of patients have a higher number of first language speakers than second language speakers preferring to speak their first language with the doctor: isiZulu A, Sesotho A, Afrikaans A, Setswana A, isiXhosa A, Sepedi A, Xitsonga A and Tshivenda A;
    - Four language groups of patients have an equal number of first language speakers and second language speakers who prefer to speak a language with the doctor. The majority of these languages have an undefined level of oral literacy: Xitsonga XXX, isiZulu XXX, Setswana XXX and Italian A;
    - Two language groups of patients have a higher number of second language speaker than first language speakers preferring to speak a language with the doctor: English A and Portuguese A.

After comparing patients' level of oral literacy, the researcher undertook to compare their level of literacy; i.e. patients' ability and skills to read and write the languages they have claimed to know. Such a comparison is relevant, since doctors also write prescriptions and notes to patients. In the case of cancer patients, doctors may write advice relating to the food patients should eat more of, how they should take treatments or when their next appointment or next radiation treatment is scheduled for. Thus, patients should be able to read to have access to the information provided.

Comparison between patients' first language literacy and preferred language literacy

The following graph (figure 4.10) aims at comparing the number of patients who have a certain level of literacy in a giving first language with the number of patients of the same level of literacy who would prefer to use that language with the doctor. In this graph, the bilingual Afrikaans and English speakers have not been added to the individual English and Afrikaans speakers because this table aims at contrasting values of the same nomenclature. This is the reason why this table only shows the results of patients who only had one preferred language of use with the doctor. The graphs showing the data that did not match, in

other words the combination of languages as well as patients' level of literacy in their language combination is attached as an appendix to this study.

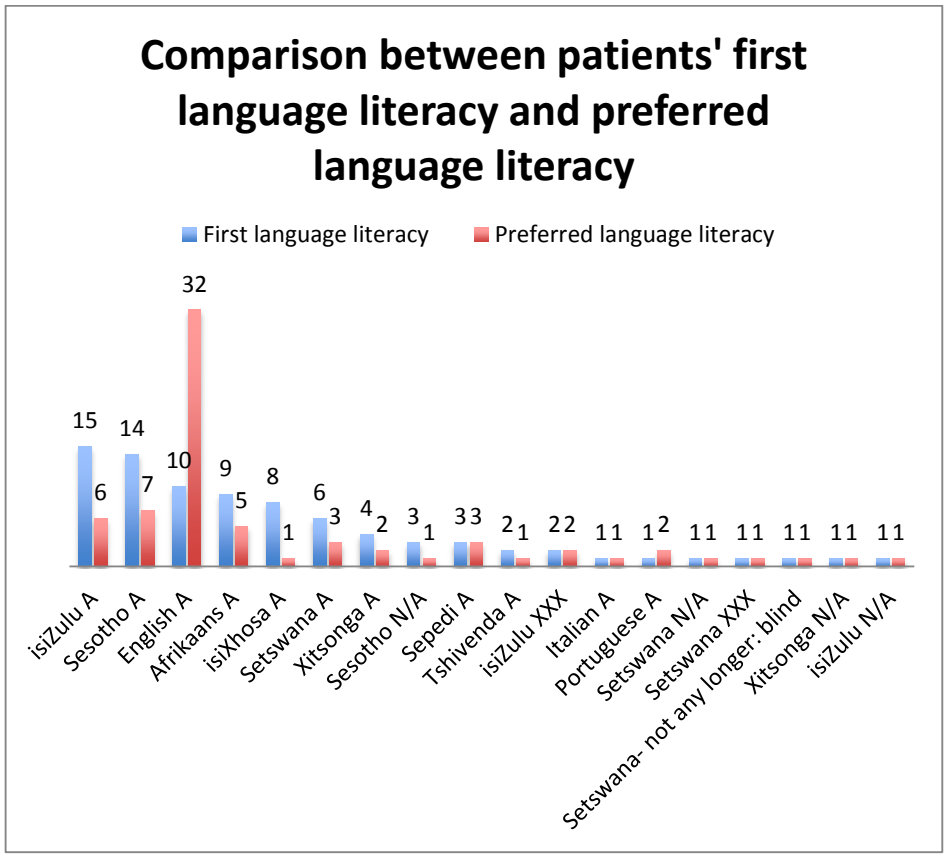


Figure 4.10: Comparison between patients' first language literacy and referred language literacy

The graph above (figure 4.10) indicates the following:

- In general, patients' level of literacy is lower than their level of oral proficiency. In other words, patients are more skilful at speaking rather than reading and writing the languages they have claimed to know. This statement is substantiated by the fact that this graph has more language N/A patients than the graph reporting the level of oral proficiency;
- English A patients have the same level of oral proficiency and literacy; the same applies to Portuguese A patients and the Italian A patient;
- Some patients might have become blind as a result of a head cancer. These patients are therefore unable to read and write.

Following the pilot study focussing on patients, the researcher undertook a study on the medical staff working in the Department of Radiation Oncology, Charlotte Maxeke

Johannesburg Hospital. The aim was to identify the medical staff linguistically and culturally, to determine whether they have experience working with trained interpreters and to evaluate their opinion with regard to working with trained interpreters. Some of the results of the medical staff questionnaire are given below.

4.4.3. Analysis of medical staff questionnaire: From December 2012 to January 2013

Medical staff function

As per the graph below (figure 4.11), out of 144 staff, 78 took part in the pilot study by filling in a questionnaire; thus a percentage of participation of 54%. The questionnaire and the individual answers provided by the medical staff are included as an appendix to this research document.

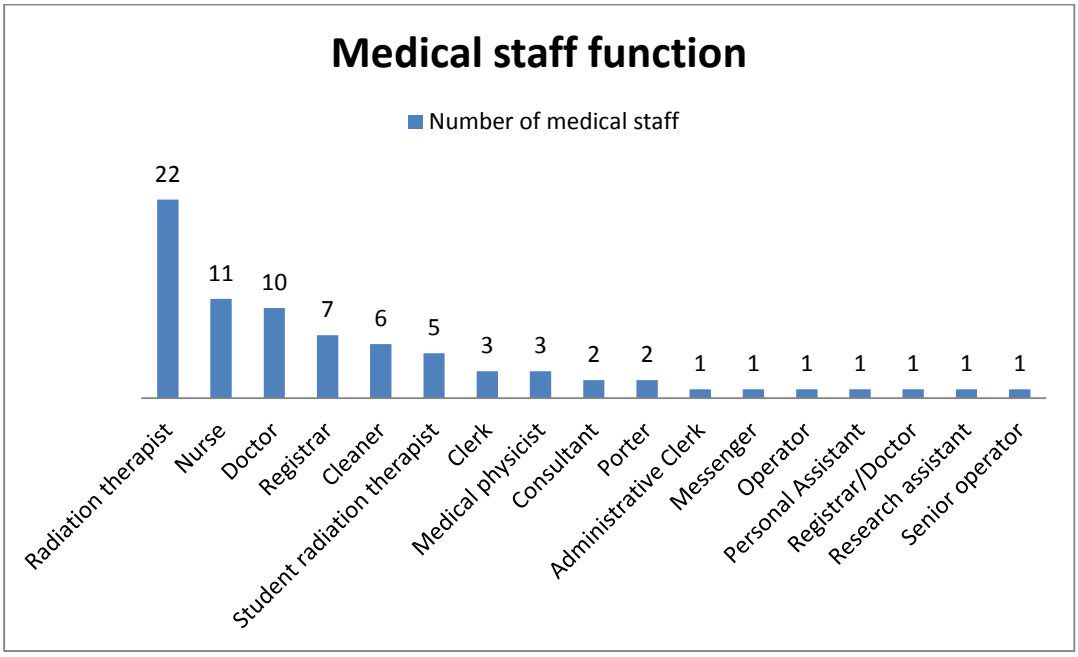


Figure 4.11: Medical staff function

The percentage of participation per function is the following:

- 100% of clerks, porters, personal assistant and research assistant;
- 73% of nurses;
- 66% of doctors;

- 55% of the radiation therapists;
- 50% of medical physicists;
- 42% of cleaners;
- Only 16% of student radiation therapists took part in the pilot study because most of the others were students from the University of Johannesburg. The Head of radiation therapists informed the researcher that permission might be needed from their institution in order for them to take part in the study. She thus advised that these students should be left out of the pilot study to avoid a cancellation of the pilot study.

Some functions which had not been mentioned by the Head of the Department emerged from the questionnaire such as: messenger, consultant, operator and senior operator. The next questions on the questionnaire aimed at identifying the medical staff in terms of their linguistic background. Thus, the next paragraph provides information related to the first language of the medical staff.

First language of medical staff

The following graph (figure 4.12) provides the number of medical staff pertaining to a specific first language.

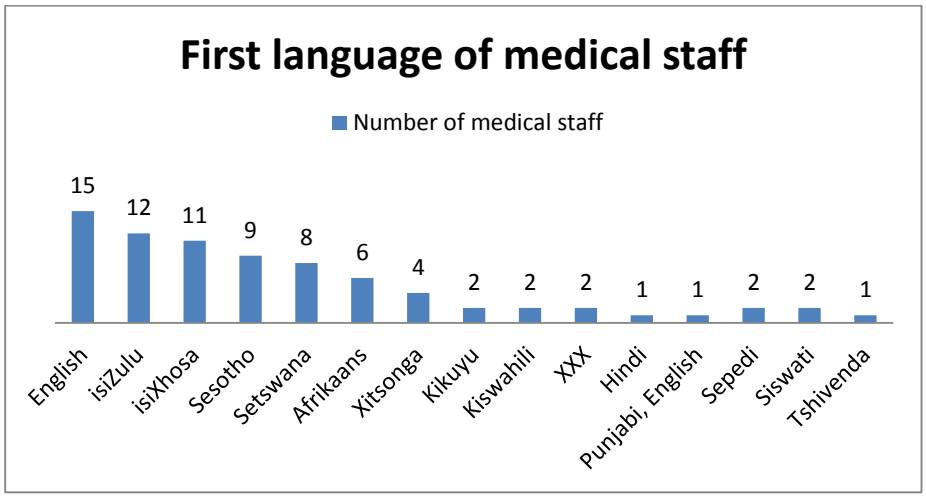


Figure 4.12: First language of medical staff

In line with the data provided above (figure 4.12), the majority of medical staff who participated in the pilot study has English as a first language. The percentage of medical staff per languages is as follow:

- 19% of the medical staff who participated in the pilot study are English speakers preceded by;
- 15% are isiZulu first language speakers;
- 14% are isiXhosa first language speakers;
- 11% are Sesotho first language speakers;
- 10% are Setswana first language speakers;
- 7% are Afrikaans first language speakers;
- 5% are Xitsonga first language speakers;
- 2% are Kikuyu, Kiswahili, Sepedi and Siswati first language speakers;
- 1% is Hindi and Tshivenda first language speakers.

Whereas 2% of the medical staff who participated in the pilot study did not disclose their first language, one medical staff reported to be a bilingual first language speaker Punjabi and English. The researcher was also interested to find whether the medical staff was as polyglot as the patients. She thus asked questions with respect to the additional languages known by the medical staff. The next paragraph provides that information.

Additional languages known by the medical staff

By adding all the languages that the medical staff can speak, 316 of languages could be recorded in addition to their first language. Thus, the medical staff in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic hospital generally knows an average of 3.09 languages, including their first language. The least number of additional languages known is two and the maximum is eleven.

The tables providing the number of languages and the language combinations that the medical staff shares are included in the appendix. From the data collected it appears that Black South African medical staff are the most multilingual. These tables also show that whereas one out of the 78 medical staff members who filled in the questionnaire neither provide information about his or her first language nor about the additional language(s) he or she might know; 21 medical staff members out of 78 know only one language beside their first language; among these medical staff, 10 have declared to know English and 10 have declared to know Afrikaans. One of these medical staff members did not provide information with regard to the additional languages known. He or she provided information on his or her

first language (Sesotho), and filled in the form in English which lead the researcher to conclude that that medical staff knows at least one language beside Sesotho: English.

12 medical staff members out of 78 claim to know two languages beside their first language. The additional languages of these medical staff members are different and consist in:

- Afrikaans and isiZulu (2 medical staff);
- Afrikaans and Italian (1 medical staff);
- English and French (1medical staff);
- English and isiZulu (6 medical staff);
- English and Kiswahili (2 medical staff);

15 medical staff members out of 78 claim to know three languages beside their first language; 13 medical staff members out of 78 claim to know four languages beside their first language; seven medical staff members out of 78 claim to know five languages beside their first language; five medical staff members claim to know six languages beside their first language whereas one staff member is a bilingual first language speaker and claims to know five languages besides his or her mother tongue. The additional languages of these medical staff members consist in:

- Afrikaans, English, isiXhosa, isiZulu, Sepedi, Sesotho;
- Afrikaans, English, isiXhosa, isiZulu, Sepedi, Setswana (2 medical staff);
- English, isiZulu, isiXhosa, Sesotho, Setswana, Tshivenda;
- Bengali, German, Hindi, Malay, Russian.

Whereas one staff member claims to know seven languages apart from his or her first language, two medical staff members claim to know ten languages beside their first language. The additional languages of three staff members are the following:

- Afrikaans, English, isiXhosa, isiZulu, Sepedi, Tshivenda, Xitsonga;
- Afrikaans, English, isiNdebele, isiZulu, Sepedi, Sesotho, Setswana, Swazi, Tshivenda, Xitsonga;
- English, isiNdebele, isiXhosa, isiZulu, Sesotho, Setswana, Shona, SiSwati, Tshivenda, Xitsonga.

Thus, the following chart (figure 4.13) summarises the number of staff members claiming to know one language individually as an additional language.

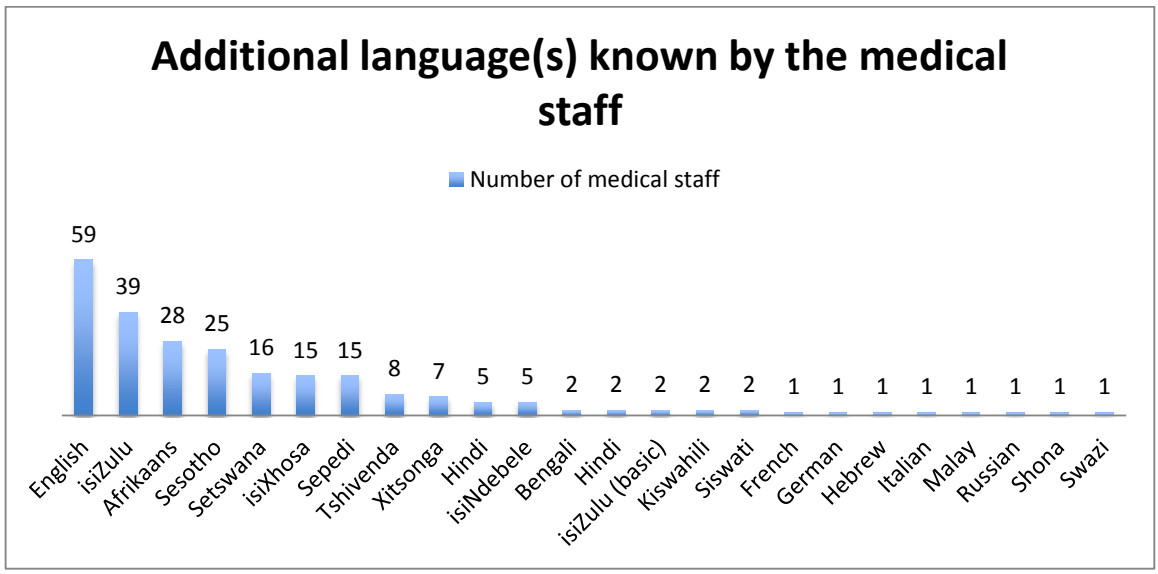


Figure 4.13: Additional language(s) known by the medical staff

The chart above (figure 4.13) shows that English is the language most commonly known by the medical staff as 59 out of 78 medical staff members, thus 75% of the staff who participated in the pilot study reported to know English in addition to their first language. This result is followed by: isiZulu 50%; Afrikaans 35%; Sesotho 32%; Setswana 20%; isiXhosa and Sepedi 19%; Tshivenda 10%; Xitsonga 8%; Hindi and isiNdebele 6%; isiZulu (basic), Kiswahili and Siswati 2% and French, German, Hebrew, Italian , Malay, Russian, Shona and Swazi 1%.

These results manifest that in general, the medical staff at the Department of Radiation Oncology is polyglot though English is the first language of the majority of these staff members (16 out of 78 staff members) and the most commonly known language (59 out of 78 staff). By joining these numbers, the researcher can conclude that English is known by 75 out of 78 medical staff who took part in this study; thus a percentage of 96%. Followed by:

- isiZulu known at a basic level and more by 51 out of 78 medical staff members, 65%;
- Afrikaans and Sesotho each known by 34 out of 78 medical staff members, 43%
- isiXhosa known by 26 out of 78 medical staff members, 33%;
- Setswana known by 24 out of 78 medical staff members, 30%;
- Sepedi known by 17 out of 78 medical staff members, 21%;
- Xitsonga known by 11 out of 78 medical staff members, 14%;
- Tshivenda known by 9 out of 78 medical staff members, 11%;
- Kiswahili and Siswati each known by 4 out of 78 medical staff members, 5%;

- Hindi known by 3 out of 78 medical staff members, 3%.

Whereas Kikuyu and Punjabi are only known by their first language speakers, isiNdebele, Bengali, French, German, Hebrew, Italian, Malay, Russian, Shona and Swazi are only known as additional languages known by some medical staff members.

The next questions in the questionnaire submitted to the medical staff aimed at ascertaining whether they are expected to make use of their polyglottism to provide medical services to patients. The next paragraph presents and reviews their answers.

What language is the medical staff expected to use to provide medical services to patients in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital?

The following tables (figure 4.14) provide the answers of the questions asked in the medical staff questionnaire. The goal of these questions was to find how the medical staff is expected to use the languages they know in the Department.

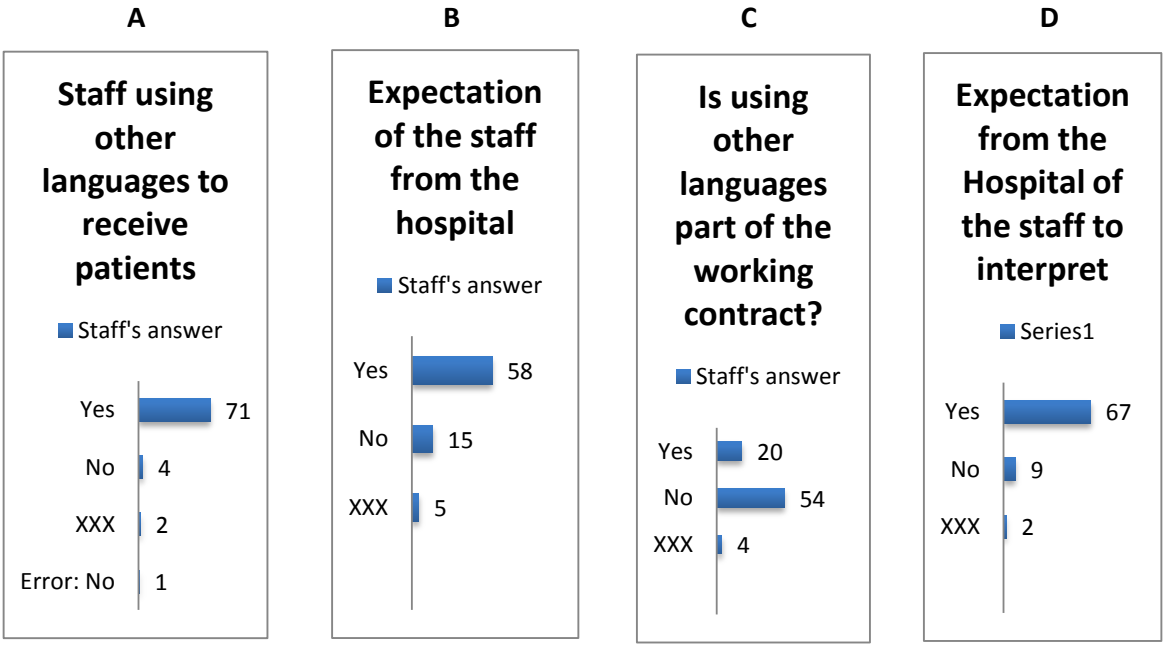


Figure 4.14: Expectation from the medical staff towards the languages they can speak

Table A provides the answers to question number five of the questionnaire: "Have you ever used the other languages you know to consult, treat or receive a patient?" Whereas two participants did not answer that question, thus the indication "xxx", one participant made a

mistake in answering that question. He answered “no” although he or she obviously does not exclusively use his or her mother tongue to cater for patients. The researcher had observed him also using English to assist some patients. Thus the indication “Error: No”. To that question, 71 out of 78 medical staff members affirm using languages other than their first language to consult, treat or receive patients.

Table B presents the answers to question number six of the questionnaire: “Is it something that the hospital expects of you to do?” Whereas five participants skipped that question, 58 out of 78 of the medical staff members who took part in this study are of the opinion that the hospital expects them to make use of all the languages they know in order to provide medical services to patients.

Table C reports the answers to question number seven of the questionnaire: “Is it part of your contract with the hospital?” Four participants did not answer. However, whereas 20 out of 78 medical staff members assert that their contract stipulates that they must make use of all the languages they know to cater for patients, 54 out of 78 medical staff members rather negate that such a close is part of their contract with the hospital.

Table D presents the answers to question number eight of the questionnaire: “Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient?” The table shows that two participants did not answer but 67 out of 78 medical staff members believe that the hospital expects them to render an *ad hoc* interpreting service whenever there would be language barriers between a colleague and a patient.

From the answers provided by the medical staff in this section, the researcher can deduce that 91% of the medical staff who took part in the study make use of the all languages they know to cater for patients. Nonetheless, although 74% of the participants assert that the hospital expects them to do so, 69% state that this is not part of their working contract with the hospital. 85% of the participants are of the opinion that the hospital also expects them to provide *ad hoc* interpreting services to their colleagues whenever there are language barriers with patients. Thus, it is interesting to find how many of these participants have been involved either as the provider of the *ad hoc* interpreting service, or the beneficiary of the *ad hoc* interpreting service in the Department. The next paragraph presents the participants’ answers to that question.

Medical staff who have provided ad hoc interpreting services

The following set of charts (figure 5.15) gives an account for the medical staff's answers with regard to whether they have undertaken or received *ad hoc* interpreting services in the Department; and whether they have ever received interpreting training.

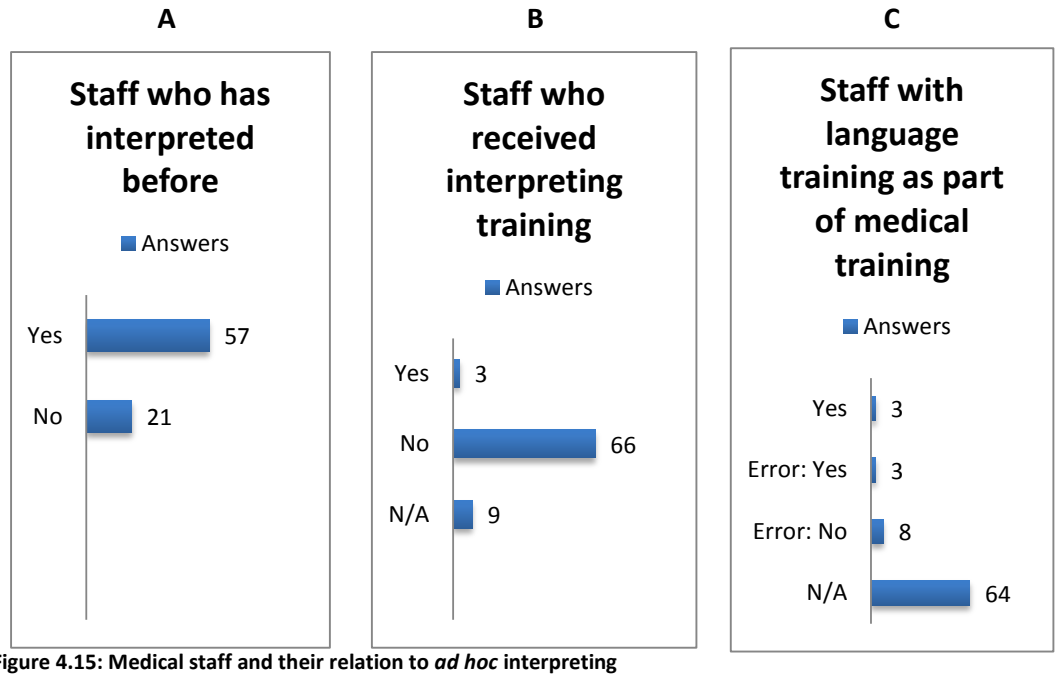


Figure 4.15: Medical staff and their relation to *ad hoc* interpreting

Table A presents the answers to question number nine of the questionnaire: "Have you ever interpreted for a doctor or a patient?" 57 out of 78 medical staff members who took part in this study confirmed having provided *ad hoc* interpreting services in the Department. However, to the next question that is: "If yes, have you ever received a training in interpreting" (table B) 66 out of 78 participants report to have never received a training in interpreting. Only three of the participants assert to have received interpreting training before. Nine participants were non-applicable (N/A) to that question. These participants did not provide an answer to that question because they are part of those who asserted to have never provided *ad hoc* interpreting services.

Table C summarises the answers of the next question: "If yes, was it part of your medical training?" To that question, the three participants who claimed to have received interpreting training, answered "yes". Whereas 11 participants erroneously answered that question by stating "yes" (three participants) or "no" (eight participants), 64 participants were non-applicable (N/A) to this question as they had responded "no" to either question nine or ten.

From this section of the questionnaire, it appears that three medical staff members have claimed to have received some training in interpreting. The researcher approached these three medical staff to query about their interpreting training and she found that whereas two of them are radiation therapist students, the third one is a porter. Whereas the radiation therapist students reiterated that the interpreting training was part of their medical training, the porter asserted that she filled in the questionnaire out of kindness; she had never been trained in interpreting.

The next section of the questionnaire aimed at investigating whether interpreting services were been provided in the Department either by professionals or strictly on an *ad hoc* basis. This section also aimed at investigating how familiar the medical staff is with professional interpreting services, working with a professionally trained interpreter and how to work with a professionally trained interpreter. Therefore, the next paragraph provides information with regard to how interpreting activities are undertaken in the Department.

Medical staff and their relation to professional interpreting services within the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic hospital

The following charts (figure 4.16) provide information related to the number of medical staff who have received *ad hoc* interpreting services from their colleagues; and how many medical staff have experience with working with professional trained interpreters.

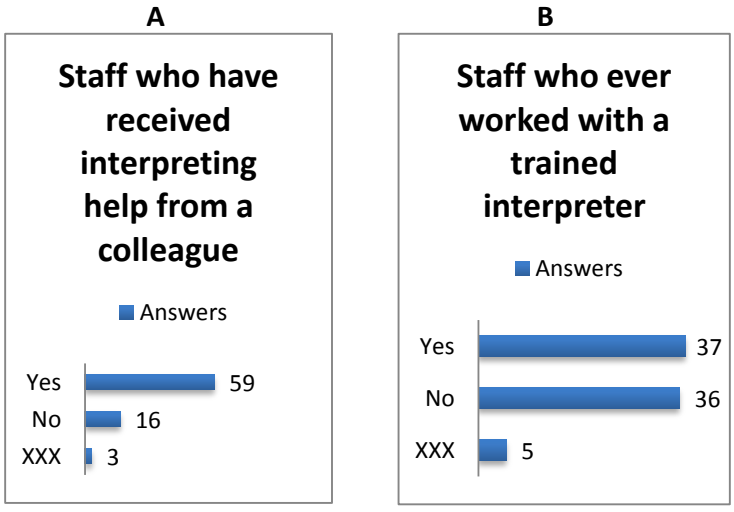


Figure 4.16: medical staff and their relation to interpreting

Table A presents the answers to question number ten of the questionnaire: “Has a colleague or another staff member of the hospital ever helped as an interpreter for you?” 59 out of 78 medical staff members answered positively. 16 out of 78 medical staff members answered negatively and three did not provide an answer hence the annotation “xxx”.

Table B renders the answers to question number 11 of the questionnaire: “Has an interpreter ever assisted you in consulting, treating or receiving a patient?” The aim of that question was also to assess the medical staff understanding of an “interpreter”. The researcher wanted to find whether to the medical staff, an interpreter is anyone who would assist them with interpreting service including a colleague who assumes that role when catering for a patient, or someone who would exclusively have that role when catering for a patient including a family member or anyone accompanying the patient. Thus, it was interesting to realise that to the first question, 59 participants claimed to have received interpreting services from a colleague; and to the second question 36 claimed to have never received assistance from an interpreter. From these results, the researcher deduces that it is highly probable that the medical staff makes a distinction between receiving *ad hoc* interpreting services from a colleague and from a non-colleague. It is possible that they do not consider their colleagues as interpreters; rather, they consider a family member or anyone escorting a patient as one.

The next charts (figure 4.17) provide information on whether the medical staff has experience with working with professionally trained interpreters.

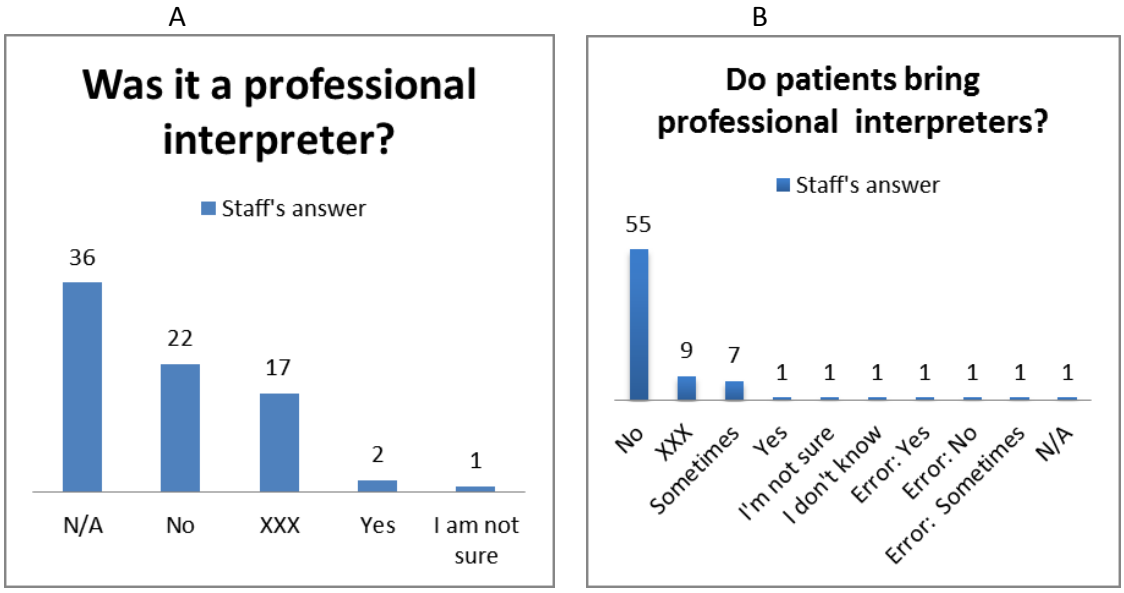


Figure 4.17: Medical staff and their relation to professional interpreting

Following question 11 of the questionnaire: “Has an interpreter ever assisted you in consulting, treating or receiving a patient?” One of the next questions is: “Was it a professional interpreter?” Table A (figure 4.17) presents the staff’s answers to that question. Since 36 participants have previously claimed not to have ever been assisted by an interpreter, 36 participants are not eligible to answer that question, thus the annotation N/A. Table A (figure 4.17) shows that only two out of the 42 participants eligible to answer that question assert to have worked with a professional interpreter.

The next part of the questionnaire aimed at finding whether patients come to the Department with their own interpreters and whether the latters are professionally trained interpreters or relatives. The aim was also to verify the answer of the medical staff members who would have claimed never to have been assisted by an interpreter. Table B (figure 4.17) summarises the staff’s answers to question 12.a of the questionnaire: “Are they professional interpreters?” The majority, 55 out of 78 participants, claim that patients are not accompanied by professional interpreters. Seven participants said that it happened that patients have come with a professional interpreter with them and one participant clearly states that “Yes” patients bring professional interpreters with them. The answers “error: yes”, “error: no” and error: sometimes” pertain to participants who were not eligible to answer this question because they previously denied that patients use an interpreter at all.

Since two participants have claimed to have worked with a professional interpreter before, and two other participants who declared to have received some interpreting training, it can be deduced that 94% of the medical staff who participated in this study do not know how to work with a professionally trained interpreter, what to expect from working with a professionally trained interpreter and what the work of a professionally trained interpreter really entails. The last part of the questionnaire aimed at collecting opinions as per whether the medical staff thinks that they will benefit from working with professionally trained interpreters in the Department. Their answers are summarised in the next paragraph.

The graphs below (figure 4.18) summarises the answers to the question: "Will it be useful for hospitals to work with interpreters?" The researcher informed participants that by interpreter, she means professionally trained interpreters.

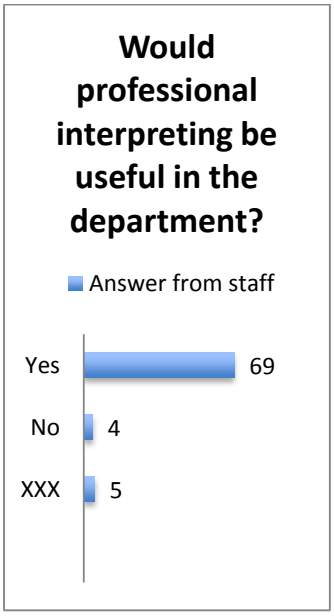


Figure 4.18: Staff opinion towards the usefulness of professional interpreting in hospitals

69 out of 78 medical staff members are of the view that hospitals will benefit from working with professionally trained interpreters. Five participants did not provide an answer, and four participants are of the opinion that hospitals will not benefit from working with trained interpreters. Three of these participants substantiated their answers. They wrote the following:

- "No patient complained for not being assisted with interpreting. Everybody knows that the language of communication is English"
- "What about confidentiality?"
- "We don't have time to call and wait for an interpreter. The Department is too busy"

4.5. Conclusion

In this chapter, the researcher outlined the procedures followed the pilot study which informs the methodology for the analysis for the main study in chapter 5. The methodology for the pilot study includes on-site observation and the collection of data through patient interviews and the distribution of questionnaires to the medical personnel working in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital. The analysis of the on-site observation, the patients' interviews and the medical personnel's questionnaires shed light on the polyglottism of the patients and the medical personnel and the popularity of English among both set of participants. Nonetheless, despite the seeming popularity of English, the analysis of the medical personnel's questionnaires reveals that there are still language and cultural barriers between numerous patients and the medical personnel. Furthermore, the analysis also indicates that interpreting services are needed in many instances and provided on an *ad hoc* basis by colleagues or patients' relatives. The pilot study therefore demonstrated the feasibility of the main research study. It has been established that interpreters are needed and used on an *ad hoc* basis in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Hospital. Hence, the aim of the next chapter is to compare the interpreting service provided by *ad hoc* interpreters such as a nurse to that of a trained interpreter

CHAPTER 5: ANALYSIS

"It is therefore argued that it is incumbent upon analysts who are interested in studying interactions, or who use interactional material as data, to analyse their data at the same level of detail and organisation as was demonstrably relevant to the participants in the recording. In this sense, CA [Conversation Analysis] offers formal analyses at a greater level of detail, and relies upon a distinctive vocabulary of technical terms to capture this detailed organisation." (Wooffitt, 2005)

5.1. Introduction

In the previous chapter, the pilot study, a preliminary investigation which aimed at informing the main study, clearly indicated that professional interpreting services may assist in improving service delivery at the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital. In this chapter, the main study aims to analyse the communication dynamics in interpreted doctor- patient consultations in the Department and to elucidate the researcher's objective, which was to compare nurses' interpreting performance to that of trained interpreters. The methodology used comprises the audio and video recording of the interpreted doctor-patient consultations, the transcription of recordings of the interpreted doctor-patient consultations, the analysis of the transcribed data through conversation analysis (CA), and the processing of the data collected from the questionnaires and the video recordings.

The next section elaborates on the methodology used to undertake the main study, followed by a thorough analysis of the transcribed interpreted doctor-patient consultations using conversation analysis (CA) as the main method of analysis.

5.2. Main study

5.2.1. Research methodology

The research methodology followed in the main study consists firstly of collecting audio and video data by recording three interpreted doctor – patient consultations with three doctors, three patients and two interpreters all working in three different oncology clinics. The three consultations are allocated within two clusters in which the interpreter's performance in each

case is contrasted. The first cluster consists of a doctor, a patient and a trained interpreter who has not received any input as per the oncology terminology commonly used in the Department (the trained interpreter did however receive an isiZulu-English glossary of medical terms issued by the Department of Health), has received introductory training in liaison interpreting at Wits Language School. The second cluster is composed of a doctor, a patient and a nurse who has not received any training in interpreting acting as an *ad hoc* interpreter. Thus, there are three recordings, two of the trained interpreter without input from the Department of Radiation Oncology in Charlotte Maxeke Johannesburg Academic Hospital, and one recording of the nurse acting as an *ad hoc* interpreter.

The two areas of focus are contrasted first to provide an answer to the research questions formulated in chapter 1, concerning the nurses' claim that they interpret better than trained interpreters. The trained interpreter and the *ad hoc* nurse interpreter are therefore compared in order to determine who interprets better in this context. The comparison between the trained interpreter and the nurse *ad hoc* interpreter will be based on factors that contribute to the success of consultations such as: accuracy, clarity, and the interpreter's ability to "represent fully" the original speaker in his/her interests and intentions (Cf. Pöchhacker (2002:96-97)). Thus, it is important to mention that the researcher does not intend to conduct a raw linguistic error analysis, but to analyse the effectiveness of the various interactions. These analyses will then be supplemented in Chapter 6 by an exploration of the researcher's and the participants' perceptions of the success of the interactions. These perceptions will then be contrasted with the results from the conversation analyses.

In addition to the method mentioned above, a questionnaire was distributed to all participants so as for them to assess the interpreting service provided, its usefulness as well as their level of satisfaction. Separate feedback forms for doctors, patients and interpreters were designed and administered to the relevant participants and have been included as an appendix to this report.

As part of the research methodology applied in this exploratory study, the second step consists of the transcription of the recordings. This task is undertaken by the using proprietary transcription software *f4 2012,* which enables the researcher to capture timings electronically, listen to the audio files and type in a single interface. While transcribing, the researcher focused on representing turn-taking, duration of turns, overlaps, pauses, silences, emphasised words, words softly spoken, laughter as well as the kinesic elements and other

occurrences that take place during the consultation. Transcription symbols are used to represent some of these occurrences. The list of transcription symbols is provided at the beginning of this research report. The transcriptions were back translated from isiZulu into English with the assistance of a Zulu transcriber.

The third step undertaken as part of the research methodology, and which is presented in the next section is the analysis of the transcribed data using Conversation Analysis (CA).

In the course of the analysis, the researcher has identified a specific interactional order that is common to all the recorded follow-up[30] consultations. The consultations tend to take place in three phases:

- Phase one: The doctor checks on the patient and enquires about the patient's state of health since the last consultation. The diagnosis was already made in the first (previous) appointment.
- Phase two: The doctor physically examines the patient.
- Phase three: The doctor makes recommendations and where applicable, writes out prescriptions for the patient.

It could therefore be concluded that all three recorded consultations were typical of a doctor-patient consultation as well as an interpreted doctor-patient consultation in this context.

The analysis of the interpreted doctor-patient consultations using Conversation Analysis (CA) focuses on six specific aspects: turn length, overlaps, interruptions during consultations, the use of direct versus indirect speech when interpreting, and the kinesic elements which include the positioning of participants (Cf. Wallmach, 2014 (forthcoming)). These aspects are discussed in detail below.

In interpreted doctor-patient consultations, appropriate turn-taking and turn length are key components of successful interviews. As stated by Bot (2005:110) "the assignment of turns [refers to] who is allowed to speak when". Nonetheless, she stresses the complexity of 'control' over the session that should accompany the management of turn-taking:

[30] The researcher was only permitted by the Wits Medical Research Ethics Committee to select follow-up patients for this study and not new patients, to avoid causing additional discomfort to new patients who had just been forced to face the diagnosis of cancer.

> […] the issue of 'management' features in the concept map: one of the main concerns of therapists with reference to interpreter-mediated talk is the issue of 'control'. Who is in charge of the session? In the concept map, participants agree on the statement that the therapist should have the directorship of the session, which means he is the one who manages the dialogues. Also, formally, the therapist is responsible for the session. On the other hand, therapists report that they do not always feel in charge when they work with an interpreter. This contradiction between the therapist's formal responsibility and his experience makes this issue of control an important one. (Bot, 2005:110)

Roberts, however, is of the opinion that as an active participant, it is the interpreter that should be in control of the session, asserting that: "As the two primary participants do not know each other's language and language use conventions, the only person who can logically maintain, adjust, and if necessary repair problems in communication is the interpreter" (Roberts, 1997:10). Thus, the analysis of the consultation using CA aims at examining how turn taking is handled and whether or not the interpreters are in control of the sessions.

The analysis of overlapping turns is relevant to this study, as it provides an insight on whether or not there is a good communication flow between participants; whether or not each participant waits for his or her turn and whether or not the interpreter has a good control over the communication and manages to interpret without being pressured or interrupted by participants. In other words, the analysis provides insight as to whether or not there is a power struggle between participants. In this regard, Bot states that:

> It seems reasonable to assume that overlap is a way of getting the turn when there is a struggle for the floor. More specifically, I suppose that overlap will be used when the current speaker has not projected a transition-relevance place. Overlap does not necessarily lead to a near-immediate turn transfer: the current speaker can continue his turn – the overlapper usually stops talking then. Even when overlap is used, it is not the listener alone who manages the turn transfer: the current speaker has to yield before turn transfer can actually take place. However, in such cases, it is not a very subtle attempt to get the turn and I expect its analysis will give some insight into the power-relationships at the transition place and I expect it can serve as an indication of who manages the turn transfer. (Bot, 2005:125)

This analysis also attempts to explain the possible reasons for overlaps in the course of the interpreted doctor-patient consultations.

Nayak et al. (2005) have asserted that many factors hinder good communication in oncology departments; among others, the lack of individual offices to ensure patients' privacy and the constant interruptions during consultations (Cf. Chapter 2). Thus, interruptions during the consultations are analysed in order to verify this assertion, to count the occurrences of

interruption that take place during consultations, to identify the nature of the interruptions and to observe how they affect the consultations.

Concerning the use of first person (direct speech) versus third person (indirect speech) when interpreting, Dubslaff and Martinsen (2005) explain that:

> There is general agreement in the literature that interpreters should use the speaker's first person (direct speech) when rendering the utterances of primary participants in face-to-face encounters. Handbooks and guidelines explaining professional practice to beginners, untrained practitioners and/or professional clients provide ample evidence of this (e.g. Adams et al. 1995; Gentile et al. 1996; Galal & Galal 1999; Phelan 2001; Baaring 2001; Domstolsstyrelsen 2003), as do accounts of interpreting in publications directed at scholars within Translation Studies (e.g. Wadensjö 1998a). Thus, the first person is regarded as the norm followed by professional interpreters (Harris 1990; Wadensjö 1998b; Pöchhacker 2004; Hale 2004) and exceptions to this norm are explicitly mentioned as such (Shlesinger 1991: 152; Gentile et al. 1996: 25–26, 88; Meyer 2002: 53). (Dubslaff and Martinsen, 2005:212)

With regard to the use of the third person, Dubslaff and Martinsen (2005) highlight that:

> In contrast, so-called natural interpreters or lay interpreters tend to use the third person (indirect speech) in community interpreting (Shackman 1984; Knapp & Knapp-Potthoff 1985). Third-person style is thus regarded as the norm in this context (Harris 1990; Pöchhacker 2004). Exceptions are found in e.g. Shackman (1984), who maintains that direct vs. indirect style is partly a matter of personal preference. (Dubslaff and Martinsen, 2005:212)

Hence, the analysis of the transcriptions sheds light on which norm each interpreter adheres to; the norms followed by professional interpreters or the norms followed by lay interpreters.

Niemants (2012:170) stresses the importance of 'multimodality', in other words, kinesic elements such as gaze, gesture and body movements. The analysis of the kinesic elements, including participants' positioning, aims at observing the physical dynamics between participants, and whether they use body language or movements that would either facilitate or hinder consultations. In this regard, Morain (1976) emphasises that to language practitioners, the knowledge of a language alone is not enough. It is just as important to have a cross-cultural knowledge of kinesic elements pertaining to the culture of the language spoken as it is to have a good knowledge of the general culture behind the language and the language itself. Accordingly, she states: "Whether or not a teacher decides to teach active production of gestures, it is essential that students be instructed in how to read the kinesic signs which they encounter in the foreign culture. Unless they are visually literate in this respect, some serious misunderstandings can occur." (1976: 211). Morain (1976: 212) also stresses that

> [i]t is clear that the danger is not so much that language students won't recognize a kinesic signal when they see one, but that they will give what they see the wrong interpretation. Sensitizing them to the entire kinesic system—facial expression, eye contact, posture, gesture, and rhythm of movements—is the teacher's responsibility when visual literacy is one of the cultural goals.

Hence, it is important to verify whether the interpreters involved in this study are culturally literate and sensitive about the cross-cultural kinesic elements throughout the consultations.

In the next section, the data is analysed in detail according to the six selected aspects Thus, the first analysis provided in the next section focuses on kinesic elements.

5.3. Data analysis

Kinesic elements

In all three consultations rooms, the furniture was fixed. Hence, the arrangements could not be altered for the camera to be always positioned behind the patient. The following picture is a representation of the consultation room in which consultation 1 took place. This representation includes the position of all three participants.

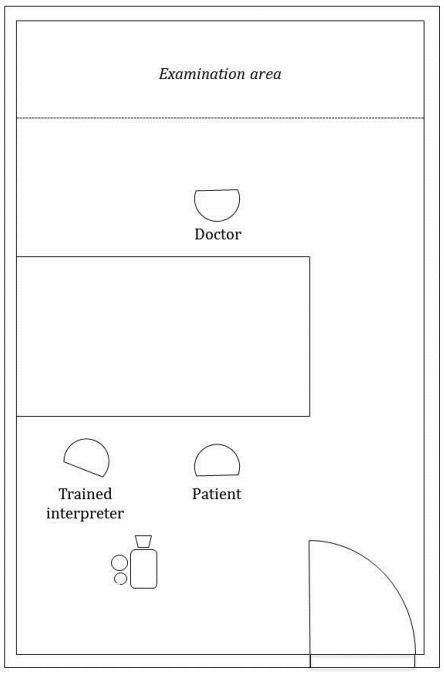


Figure 5.1: Consultation 1 room and positioning of participants

The three participants are sitting around the doctor's desk, with the camera installed behind the trained interpreter and the patient. To the researcher, the positioning of participants enables good communication and a pleasant atmosphere because there is direct eye contact between the doctor and the patient. Throughout consultation 1, the doctor mainly looks at the patient and addresses her directly, which results in the patient also looking back at her and responding to her directly whenever she understands the doctor. However, the patient looks at the interpreter whenever she expresses herself in isiZulu, or when the trained interpreter addresses her. The trained interpreter is not sitting straight towards the desk, she is sitting at an angle that allows her to face the doctor and just slightly turn her head to the patient when she addresses her. Her position allows to participate in the consultation without being invasive or affecting in the relation of trust that the doctor needs to create with the patient to diagnose her better.

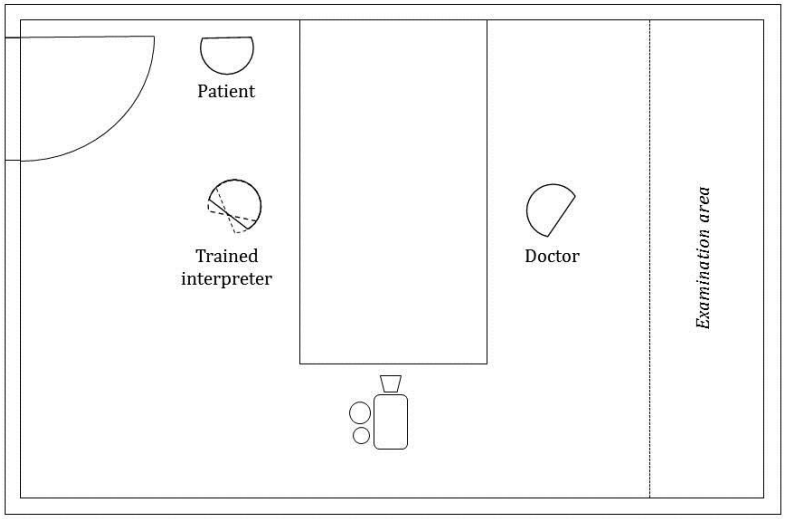


Figure 5.2: Consultation 2 room and positioning of participants

Whereas in consultation 1 the identity of the patient could be kept confidential thanks to the positioning of the camera, in consultation 2 it was not possible to install the camera behind the patient because of the position of the door. Hence the positioning of the camera, which had to be installed quickly so that the doctor could proceed with consulting her numerous patients. The doctor, the patient and the trained interpreter are sitting around the doctor's desk. Nevertheless, the doctor cannot be seen in this recording because she moved out of the

camera's view. The researcher could not see and correct it because she was not allowed to be in the consultation room during consultations. However, it can be seen that the patient was sitting with her back towards the wall, thus facing the trained interpreter and easily able to look at the doctor. The doctor was sitting with her body completely turned towards the patient, whereas the trained interpreter tended to pivot between the doctor and the patient. The positioning of the participants could have been better if the patient had not been facing the camera. The researcher is of the opinion that the fact that the patient was facing the camera hindered her from fully engaging with the other participants and really expressing herself as she constantly looked at the camera and tried to collect herself and her emotions to look good for the camera. It can be noted that the patient looks worried as she hears the side-effects of her treatment and the recommendations as per how to care about her body during the treatment yet, when she looks at the camera, she tries to hide her sadness and concern. Thus, it can be deduced that the limitation of this recording might be due to the researcher's inability to have access to the consultation room and therefore to insure that the camera was viewing participants without invading the patient and affecting the consultation. Had the researcher had access to the consultation room, the change of the camera and the participants positioning would have certainly made a difference. Nonetheless, many elements contributed to the success of the consultation, as it can also be observed that the trained interpreter as well as the doctor used gestures and body language to allow their explanations to carry more meaning for the patient. For instance, when talking about the patient's weight, the doctor shows her the file in which her weight has been recorded so that the patient can see for herself what has been happening with her body over the past weeks; the doctor's hands can be seen at some point when she shows the size of the hat that the patient should purchase to protect herself from the sun. From the eye movements of the patient, it can also be deduced that the doctor shows her the areas that she should wash without using cosmetic products. Similarly, the trained interpreter shows the areas that are likely to be burned by the radiation and explains by touching her face, her mouth and her hands how the skin is likely to change. Furthermore, whereas the doctor's body is completely turned towards the patient and the doctor looks at the patient and addresses her directly, the trained interpreter turns to patient and also looks at her and addresses her directly when interpreting. As a result, throughout the consultation, the patient is involved with the other participants.

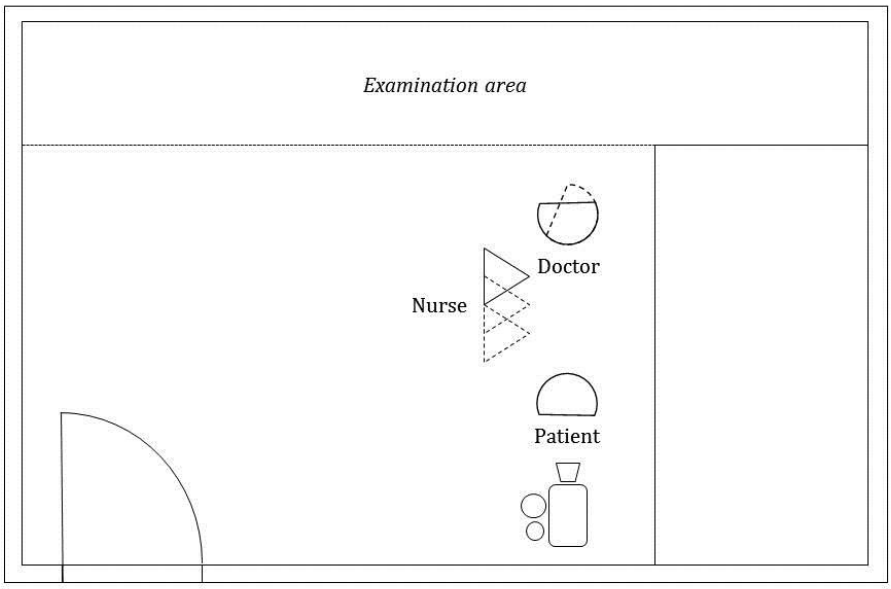


Figure 5.3: Consultation 3 room and positioning of participants

In consultation 3, although there were chairs available at the entrance of the consultation room, when the nurse arrives she does not take a seat, perhaps to avoid delaying the consultation. The nurse arrives and stands by the doctor's right shoulder. It can be argued that she stood by the doctor's shoulder neither to isolate the patient nor as a sign of partnership with the doctor, but rather to avoid standing right in front of the camera since the camera was installed behind the patient. Shortly before the beginning of the consultation, she crosses her arms and starts the consultation that way. She stays in that position for two minutes and thirteen seconds, until she reports the patient's opinion on whether she can already see changes on her skin to the doctor. Then, she unfolds her arms and uses her hands to assist the doctor to visualise what the patient has told her. The fact that she stands and remains with her arms crossed, looking down at the patient with a serious expression in her face while addressing the patient can be interpreted as elements that hindered the success of the consultation, since the patient might have been intimidated by her. As the consultation goes on, the nurse slowly moves towards the patient, probably in order to listen to her better, since the patient has a soft voice. However, although the nurse looks at the patient when she addresses her, she remains standing throughout the consultation. When the patient tells her that she would not like to see what her anus looks like after the radiation treatment, the nurse

laughs; but it does not seem like the patient is amused. Thus, whereas it can be argued that the nurse's reaction was insensitive and disrespectful towards the patient, it can also be defended that the nurse is so used to assisting cancer patients that she has lost some sensitivity towards the illness and neither realised nor understood why the patient would not look at her anus to see whether the treatment is proving to be effective. The doctor, however, has a different body language. The doctor sits in front of the patient. When he needs to consult the patient's file, he turns to the table but when he addresses the patient, he turns to her, looks at her as he addresses her. The doctor looks at the nurse when asking her to report his message to the patient and when she communicates with the patient. He also looks at the patient from time to time while she communicates with the nurse. Nevertheless, there were instances when both the nurse and the doctor were looking at the nurse when she was speaking. This could be intimating to the patient since it looked as if the nurse (standing) and the doctor (sitting) were circling her, without giving her much space. In most African cultures, this closeness would not cause discomfort, but in some other cultures it would. It is therefore important to have participants' feedback on the consultations and the interpreting service rendered.

The next paragraph discusses participants' turn length as well as its impact on consultations. Turn lengths were calculated by using an online time calculator programme *calculator.net*. It is important to stress that in the course of the following analysis, the researcher has highlighted the specific sections of the transcript that are being referred to in the discussion by inserting them into boxes.

Turn length

Consultation 1 takes place in the gynaecologic oncology clinic. In this consultation involving the trained interpreter, the majority of turns are short (average of 6 seconds per turn) since the doctor mostly asks questions of the patient in order to ensure that the treatment is going well. Most of these questions are direct questions with either yes or no answers, as it is the case in the first 2 minutes of the consultation. The back translations are not word for word translations, but close translations that still reflect the meaning of the original message.

> #00:00:00-0# Doctor: ok Mama the last time we saw you [small cough] was that in May were you here in May
> #00:00:06-2# Trained interpreter: *Zulu* isikhathi esaqala ngaso / esagcina ukukubona

ngoMay (*the time we started / we last saw you was in May*)

#00:00:10-2# Patient: yes
#00:00:11-2# Trained interpreter: yes

#00:00:11-7# Doctor: ok hmmm do you remember if you had an operation right at the beginning
#00:00:17-6# Trained interpreter: *Zulu* usakhumbula ukuthi uke waba ne-operation ekuqaleni (*do you remember that you had an operation at the beginning)*

#00:00:22-5# Patient: [no
Doctor: [no operation

#00:00:23-9# [long silence: the doctor is busy reviewing the patient's file]

#00:01:27-9# Doctor: ok Mama are you having any problems now since we saw you in May

#00:01:33-6# Patient: [no

#00:01:34-3# Trained interpreter: [*Zulu* kukhona inkinga onayo manje njengoba sagcina ukukubona ngoMeyi *(end of the Zulu sentence* #00:01:38-3#) (*do you have a problem right now since we last saw you in May)*

#00:01:38-1# Patient: no
#00:01:40-6# Trained interpreter: no I don't have a problem

#00:01:42-1# Doctor: hmm any bleeding from the bottom or discharge
#00:01:45-9# Patient: [he
#00:01:45-9# Trained interpreter: [*Zulu* kukhona okuphumayo ngaphansi (*is there something coming out underneath)*

#00:01:47-8# Patient: no

#00:01:48-4# Doctor: nothing [short pause] hmmm when you're going to pee / is there any burning or pain

#00:01:56-4# Patient: [yes
#00:01:56-4# Trained interpreter: [*Zulu* uma ngabe uchama kukhona okuphumayo noma okushisayo uma ngabe u…(inaudible) uchama (*when you pee is there anything coming out or does it burn when you…(inaudible) pee*)

#00:02:00-5# Patient: *Zulu* yebo kukhona (*yes there is*)
#00:02:01-8# Trained interpreter: yes there is a bur[ning
#00:02:03-2# Doctor: [what is it burning Mum

#00:02:04-7# Patient: yes #00:02:05-1#

Figure 5.4: Direct questions from the doctor requiring yes/no answers from the patient in consultation 1

In consultation 1, the turn length becomes longer either when the doctor asks the patient to elaborate on an answer or when the doctor provides the patient with an explanation. The following extract presents an instance when the doctor would like the patient to be more explicit with her answer. Hence, the patient's answer is no longer reduced to a single response. The turn length is longer when the patient reports on her health.

#00:02:01-8# Trained interpreter: yes there is a bur[ning
#00:02:03-2# Doctor: [what is it burning Mum
#00:02:04-7# Patient: yes #00:02:05-1#
[short silence]
#00:02:06-5# Doctor: how long has the burning been for
#00:02:08-4# Trained interpreter: *Zulu* sekuyisikhathi esingakanani manje ma kushisa (*for how long has it been now burning ma)*

#00:02:11-3# Patient: *Zulu* ukuthi angi- angithi ngesikhathi ngise- ngingena emshinini ngaba nesilonda ngapha ngasha / sahlala unyaka wonke e- base bengithumela e-*gastro* / besihleli sisekhona bafika (inaudible) bangifaka futhi bangiklina bangifaka umuthi / nalapha ngaphambili uma bengifake umuthi / liyaphuma kancane igazi kuba buhlungu kushise (w*hen I got into the machine I had a sore this side I got burnt / it stayed for the whole year and then they sent me to gastro / this sore was there (inaudible) they again cleaned me and put some medicine / also here in front when they put the medicine the blood does come out a little and it becomes painful and it burns*)

#00:02:46-5# Trained interpreter: {Ok} hmm last time hmm they took me to- to- on the machine and I have a- a- a- sore at the back so each time when I- when I pee / the pain is there and I hmm I went there and after- after- that I have just been experiencing the burning sensation

#00:03:06-1# Doctor: so is the burning in front when she pees or in the back when she goes number two
#00:03:11-6# Trained interpreter: *Zulu* ukushisa lokhu kuphuma ngaphambili (*does this burning come from the front)*

#00:03:13-6# Patient: *Zulu* ngaphambili (*from the front*)
#00:03:14-8# Trained interpreter: In the front

Figure 5.5: Example of longer turn lengths in consultation 1 due to the doctor requesting a more elaborate answer from the patient

The following extract presents an instance when the turn is longer because the doctor provides the patient with more explanation:

#00:03:39-4# Doctor: ok hmmmm so she- she mentions that she went to the people at the- the GI clinic
#00:03:46-8# Trained interpreter: *Zulu* uke wakhuluma ngokuthi uke waya e-*GI clinic* (*you said you had been to the GI clinic*)
#00:03:49-8# Patient: e-*gastro*

#00:03:51-9# Trained interpreter: [yes
#00:03:52-0# Doctor: [true it's true
#00:03:52-3# Patient: [yes

#00:03:53-3# Doctor: ok// so is she still seeing them
#00:03:56-1# Patient: [yes
#00:03:56-1# Trained interpreter: [usaya khona (*do you still go there)*
#00:03:57-3# Trained interpreter: yes

#00:03:57-4# Doctor: ok alright so basically hmm- just to explain to her they are treating her for that- that problem is because of the side effect of the radiation so they are treating her for that so she needs to continue following up with them

#00:04:11-2# Trained interpreter: Ok *Zulu* kusabalulekile ukuthi uqhubeke uye *e-gastro* / inkinga leyo bayayilungisa / izogcina isilungile wena kufanele ulokho uqhubeke ulokhu

uhamba khona bazoyilungisa inkinga leyo (*it is still important that you continue to go to gastro / that problem they are sorting it / it will end up solved you need to keep on to continue to keep on going there they will solve that problem*)

Figure 5.6: Example of a longer turn length due to doctor providing the patient with an explanation in consultation 1

Consultation 2 also involves the trained interpreter, but in a different setting. Here, the trained interpreter works in the Head and Neck clinic. During about the first six minutes of the consultations, the turns are relatively short (maximum turn length is about 10 seconds) as the doctor queries about the patient's health since their last meeting. The second part of the consultation takes place behind curtains without the trained interpreter present as the doctor is examining the patient. This lasts for about 3 minutes and 40 seconds. The last part of the consultation has very long turn lengths since the doctor leads the communication and does most of the talking, explaining to the patient how she should look after herself when undergoing radiation treatment. The following extract serves as an illustration of this type of interaction.

#00:15:15-8# Doctor: ok so firstly in term of the chemo it's not a / very big chemo where you...
#00:15:22-2# (door opens making noise as the doctor is speaking)
#00:15:22-8# Doctor: ... (indistinct) there is (indistinct due to the door noise)...
#00:15:25-2# (door closes making a noise)
#00:15:25-3# Doctor: ....all the hair is got to fall out everybody is always worried that all their hair is going to fall out and you know after you get so sick / I'm not going to lie to you the chemo does make your liver a bit sick but just for about three or four days/ you can feel very nauseous / you may even vomit you can feel a little bit high and a little bit weak but what we do is we give you some medication to try and prevent that / ok it may not / work hundred per cent but it'll help with the side effects and within the week you should be back fine ok and the chemo again is only gonna be three weeks / if your blood results are ok #00:16:01-0#

#00:16:01-8# Trained interpreter: {ok} ok *Zulu* indlela esebenza ngayo ama-*side effects* akhona kuyatholakala ukuthi kwesinye isikhathi sengathi ungaba ne... kube sengathi uyahlanza / kwezinye isikhathi kube sengathi umzimba wakho ukhathele // *but* thina siyakwazi ukuthi sikunikeze amaphilisi akwazi ukuthi azivimbe lezozinto / kodwa awazivimbi *hundred per cent //* indlela azivimba ngayo ukuthi uzothola *but* angeke kuze kube kubi kakhulu kubi kangako / *but again* kuzo *diphenda* ngama-*results* egazi lakho ukuthi azobuya enjani *and* nakhona i-*treatment* yakho uzoyithola emva kwamasonto amathathu *everyday* (*the way it works with these side effects it is found that at times you feel as though you want to vomit / at times it is as though your body is tired // but we are able to give you tablets that can stop that / but they don't stop them hundred per cent // the way they stop them is that you will find but they will not be that bad / but again it depends on the blood test results and you will get your treatment after three weeks every day*)

#00:16:39-7# Doctor: ok
#00:16:40-4# Trained interpreter: {yes doctor}

#00:16:40-6# Doctor: now that was the chemo / so radiation has its side effects as well
#00:16:44-9# ?: {oh}

#00:16:45-2# Doctor: ok / the commonest side effects all our patients have some degree of it is tiredness/ you fell very tired you know you feel like at one o'clock two o'clock you wanna go to bed you want to sleep/ and when that happens feel free to do so you mustn't try to be strong you know at home all the washing and all the house work you need some somebody to

help you at home you know for that added support alright you gonna get very tired tiredness can last after the radiation finishes it may even be after ten to six months later you're still feeling tired ok so expect that by about two three weeks a lot of patients start to be tired some patients a bit sooner some of them go to treatment then say not much side effects but there are you know it is a common side effect that many patients complain about/ ok #00:17:36-1#

#00:17:36-1# (short silence)

#00:17:37-9# Trained interpreter: Zulu *i-radiation* ke yona ama-*side effect* akhona ukuthi uzozwa kakhulu ukukhathala, ukukhathala umzimba wakho uzothola ukuthi ngezikhathi zabo 2 emini sewukhathele awusafuni lutho // ungazami ngalesosikhathi ukuthi uzame uziqinise ufune ukuzenzela izinto ezinjengamawashingi nokuklina endlini noku-ayina // kuzofanela ukuthi nje kube khona umuntu ozokusiza but nakhona kuyenzeka ukuthi ilaste *until three to six months after* isikutholile ukuthi *i-radiation* (inaudible) so kufanele nje wazi ukuthi uzoba nokukhathala // amanye ama-*patient* kodwa ayasho ukuthi awezwa lutho kuya ngomuntu ukuthi yena i-*side effect* izoba kanjani (*the radiation itself its side effects is that you will feel very tired you will find that your body is very tired around 2 during the day you are so tired that you don't want anything // at that time don't try to make yourself strong and do things like washing your clothes, cleaning the house and ironing // you will need to have someone to help you but even then it happens that it will last for three to six months after getting radiation (inaudible) so you need to know that you will get tired // but other patients say they don't feel anything // it depends on a person how the side effect would be*)

#00:18:24-3# Doctor: ok am I going at an appropriate pace for you I am not giving too much information to translate

#00:18:30-1# Trained interpreter: {(indistinct)} no it's fine

#00:18:30-9# Doctor: ok the next thing is a common side effect is in the mouth you can get a *mucositis* alright you can get like hmm- the mouth becomes raw and eating may become a huh problem swallowing may become a problem hh- chewing may be difficult and the taste starts to go as well/ right a lot of patients get some degree of it some may be mild some may be much more serious #00:18:59-3#

#00:19:00-7# Trained interpreter: Zulu enye futhi ongakwazi ukuthi uyithole i-*side effect* ejwayelekile ukuthi abantu bayithole yile yokuthi ulimi lwakho njengama- konke uvesane ungakwazi ukuthi uphuze *something* noma udle *something* noma uze ukwazi ukuthola *i-taste* yento olimini ngoba kuvele nje kubi kakhulu // *so* amanye ama-*patients* ayaba nawo akubi *that bad* amanye ama-*patients* kuba yinto enkulu kakhulu (*another side effect you can have that is normal is that people find their tongue like everything you are not able to drink or eat anything or taste it just becomes bad // for other patients it does not get that bad*)

Figure 5.7: Example of doctor's long turn lengths when she leads the consultation and provides the patient with advice and explanation in consultation 2

Correspondingly, as the doctor's turn lengths are longer, so are the trained interpreter's. Nevertheless, it is important to highlight that the trained interpreter had forgotten to take a note pad with her and thus was unable to take notes. This is perhaps the reason why she said that the side-effects could last from three to six months instead of telling the patient that the side-effects could last from ten to six months (which was the correct length of treatment time originally stated by the doctor). By examining the trained interpreter's rendition of the doctor's messages, we can see that she uses many loan words and she either turns medical terms into isiZulu words (e.g: i-radiation, ama-side-effect) or uses plain English terms (e.g: every day, until three to six months after). Although the use of loan words and English terms

can be regarded as a coping strategy, it also shows that the trained interpreter faces difficulties not just with regard to the emotions attached to providing services to patients fighting for their lives, but also with the technicality of the terms that the doctor uses. The following extract highlights the difficulty that the trained interpreter faces with regard to the technical terms that the doctor uses.

#00:10:17-0# Doctor: ok so let's start at the beginning you plan for radiation we are going to take you out to about thirty-one fractions alright thirty one treatment and treatment is Monday to Fridays that's about/ six weeks of treatment #00:10:33-5#

#00:10:33-4# Trained interpreter: ok *so* sizoqala ekuqaleni // i-treatment yakho izoba, izothatha isikhathi esingango-*30 days*// *so* kuzofanele ukuthi uze *Monday to Friday* uhambe i-treatment yakho ye-radiation (*we will start from the beginning // your treatment will be- will take about 30 days // you will have to come Monday to Friday to take your radiation treatment*)

Figure 4.8: Trained interpreter facing difficulties with the medical terms used by the doctor in consultation 2

The above extract shows that the trained interpreter struggled to understand what a fraction is in the technical terminology used in the field of oncology. The doctor states that the patient's radiation will take place in 31 fractions. The trained interpreter interprets this as 30 days instead of 31 set of treatments. Although it can be argued that as a trained interpreter she should have asked the doctor for clarification, this extract shows that the training of interpreters working in such settings should include proper input in basic oncology and in the general jargon used by doctors.

Consultation 3 involves the nurse working as an *ad hoc* untrained interpreter. To the researcher's surprise, she interpreted for a doctor and a female patient in the prostate clinic. In general, the turn lengths in this consultation are short. The longest turn in the course of that consultation is 44 seconds, when the nurse explains to the patient why she has mucous coming from the anus.

#00:03:55-8# Doctor: So when it / there is nothing to come out then that mucous will come out #00:03:59-7# (end of doctor's message)

#00:04:00-8# Nurse: Zulu Uthi udokotela ngikuchazele ukuthi njengoba kuye kwavulwa ukuthi ukake ngapha ufakwe isikhwama ngapha kwavalwa (the doctor says I must explain to you that since it was opened for you to excrete on this side the bag was put in and the other side was closed)

#00:04:07-4# Patient: hm hm

#00:04:08-1# Nurse: So Zulu angithi umuntu uma ezoya ethoyilethi enza unamba thu kuba ukuthi amakaka vele aphuma egcobisekile so ke njengoba kuvaliwe kungaphumi amkaka akusho ukuthi lendawo ayisasebenzi (*when a person goes to the toilet to do number two the faeces come out smeared / Now as this part is closed it does not mean it is not working*)

#00:04:27-8# Patient eeee

#00:04:28-1# Nurse: so Zulu lawo mafinyila layo aphumayo enziwa yingoba vele abevele ephuma ngesikhathi noma ukaka so azolibele ephuma vele ngoba lendawo isasebenza kodwa ayisebenzi ukuthi iphume amakaka isebenza ukuthi sekuphuma leyonto nje engamafinyila (*the mucous that is coming out is caused by the fact that it was going to come out when you excreted / the mucous will still come out because this part is still working although it does not work as the faeces now it only excretes this mucous thing*) #00:04:44-9# (end of nurse's message)

Figure 5.9: Longest turn during consultation 3

The analysis of the above extract points out that there is a difference between the organisation of turns in consultation 1 and 2, and in consultation 3. In consultation 1 and 2, the trained interpreter took her turn, or attempted to take her turn, after each participant. However, this extract indicates that the nurse did not interpret everything the doctor said as the doctor was saying it. The following extract illustrates that instead of interpreting what the doctor was saying, the nurse engaged in a discussion with the doctor as a co-diagnostician rather than working as an interpreter.

#00:03:15-6# Nurse: before she started treatment

#00:03:17-3# Doctor: hmmm

#00:03:17-7# Nurse: [yeah] there was blood coming out

#00:03:17-7# Doctor: [so that's what I was thinking]

#00:03:19-5# Nurse: and since she's started the treatment / so it's [this (indistinct)] (the nurse stops her sentence and listens to the doctor)

#00:03:22-4# Doctor: [the blood] dried out but hmm there is [still...
#00:03:24-6# Nurse: [yeah...

#00:03:25-0# Doctor: ...the mucous
#00:03:25-2# Nurse: there is this mucous thing

#00:03:27-1# Doctor: [ok
#00:03:27-2# Nurse: [that is co[ming out

#00:03:28-3# Doctor: [hmmm / just tell her that eee // the mucous is because the rectum is still working
#00:03:35-8# Nurse: ok

#00:03:36-7# Doctor: she has a e bag outside here
#00:03:39-5# Nurse: hm h[m

#00:03:40-1# Doctor: [everything is coming through here
#00:03:42-0# Nurse: hm hm

#00:03:42-5# Doctor: But the the *kaka* /
#00:03:44-4# Doctor: i[s not coming that side because is the (inaudible) / ...
#00:03:44-6# Nurse: [hmm

#00:03:46-8# Nurse: hmm[mm

#00:03:47-2# Doctor: [coming outside [here
#00:03:48-1# Nurse: [hm hm

#00:03:48-8# Doctor: but the rectum is still working / so it produces the mucous / to lubricate your caca
#00:03:55-1# Nurse: hm hmmm

#00:03:55-8# Doctor: so when it / there is nothing to come out then that mucous will come out
#00:03:59-7#

Figure 5.10: Extract illustrating the nurse engaging in a discussion with the doctor as a co-diagnostician in consultation 3

In the above extract, though the doctor's turns are short, the nurse does not interpret what the doctor says. Instead she discusses the patient's case with the doctor as a co-diagnostician. She speaks simultaneously with the doctor (e.g.: Nurse: [yeah]/Doctor: [so that's what I was thinking]; Nurse: [this (indistinct)]/Doctor: [the blood]); and gives her approval of what the doctor says (e.g. hm hm (yes yes); yeah). In the meantime, the patient is alienated, excluded from the communication and is talked about as if she was not in the room.

The next paragraph presents the cases of overlapping turns that take place in the three consultations.

Overlapping turns

In consultation 1 involving the trained interpreter, there are 17 instances of overlapping turns in the course of the interpreted doctor-patient consultation. Seven of them occur when the patient understands and answers in English without waiting for the trained interpreter's turn. In the following extract, the patient answers back to the doctor in English under two different circumstances:

- In figure 5.11, the patient understands the trained interpreter's rendition into Zulu and answers directly to the doctor in English. This situation creates a sort of 'complicity' between the doctor and the patient since the two of them have an understanding and leave the trained interpreter out of their exchange.
- In figure 5.12, the patient understands what the doctor says in English and answers directly to the doctor in English. In this instance, the trained interpreter nonetheless finishes her turn. However, the fact that the patient reiterates her answer in English disrupts the flow of communication by taking away the trained intrepreter's turn. This is most probably why, when it is her turn, the trained interpreter feels obliged to make a more elaborate sentence: "No, I don't have a problem".

#00:00:00-0# Doctor: ok Mama the last time we saw you [small cough] was that in May where you here in May

#00:00:06-2# Trained interpreter: *Zulu* isikhathi esaqala ngaso/ esagcina ukukubona ngo-*May* (*the time we started/ we last saw you was in May*)

#00:00:10-2# Patient: yes
#00:00:11-2# Trained interpreter: yes
#00:00:11-7# Doctor: ok hmmm do you remember if you had an operation right at the beginning

#00:00:17-6# Trained interpreter: *Zulu* usakhumbula ukuthi uke waba ne-*operation* ekuqaleni (*do remember that you had an operation at the beginning)*

#00:00:22-5# Patient: no

Doctor: [no operation

Figure 5.11: Patient responding directly to the doctor in English after hearing the trained interpreter's rendition into isiZulu in consultation 1

#00:00:23-9# [long silence: the doctor is busy reviewing the patient's file]

#00:01:27-9# Doctor: ok Mama are you having any problems now since we saw you in May

#00:01:33-6# Patient: [no

#00:01:34-3# Trained interpreter: [*Zulu* kukhona inkinga onayo manje njengoba sagcina ukukubona ngoMeyi #00:01:38-3# (*do you have a problem right now since we last saw you in May*

Figure 5.12: Patient responding directly to the doctor in English after hearing the doctor's question in consultation 1

#00:01:38-1# Patient: no
#00:01:40-6# Trained interpreter: no I don't have a problem

In consultation 1, overlapping turns also occur when the doctor does not allow for the trained interpreter to either take her turn or to finish her turn. The two following extracts serve as an illustration for these instances.

#00:01:48-4# Doctor: nothing [short pause] hmmm when you're going to pee / is there any burning or pain
#00:01:56-4# Patient: [yes
#00:01:56-4# Trained interpreter: [*Zulu* uma ngabe uchama kukhona okuphumayo noma okushisayo uma ngabe u…(inaudible) uchama (*when you pee is there anything coming out or does it burn when you…(inaudible) pee*)
#00:02:00-5# Patient: *Zulu* yebo kukhona (*yes there is*)

#00:02:01-8# Trained interpreter: yes there is a bur[ning
#00:02:03-2# Doctor: [what is it burning Mum

#00:02:04-7# Patient: yes #00:02:05-1#

Figure 5.13: Example of overlapping turn taking place when the doctor does not let the trained interpreting finishing her turn in consultation 1

In the above example, the doctor does not wait for the trained interpreter to finish her turn when she addresses the patient. Consequently, the patient replies directly to the doctor in English without allowing for the trained interpreter to interpret. Once again, there is a sort of 'complicity' or understanding between the doctor and the patient, and the trained interpreter is left out of that dynamic. The next extract illustrates the second instance during which there is an overlap due to the doctor's intervention.

#00:09:05-4# Doctor: Hmmm mama do you what tablets you're taking now
#00:09:08-3# Trained interpreter: *Zulu* uyawazi amaphilisi owathathayo njengamanje (*Do you know the tablets you are taking at the moment)*

#00:09:11-7# Patient: (shakes her head) Zulu [cha angiwazi (*no I don't know them*)

#00:09:11-9# Trained interpreter: No doc[tor
#00:09:13-3# Doctor: You don't know ok hmmm how old are you

#00:09:16-7# Trained interpreter: *Zulu* uneminyaka emingaki (*how old are you?)*
#00:09:18-1# Patient: thirty-eight

#00:09:18-8# Trained interpreter: [thirty-eight
#00:09:18-8# Doctor: [thirty-eight

#00:09:19-9# Doctor: are you still using the cream
#00:09:21-6# Patient: [yes
#00:09:22-2# Trained interpreter: [yes she is using the cream

Figure 5.14: Example of overlapping resulting from the patient answering directly to the doctor in English, in consultation 1

In the above extract, the doctor does not let the trained interpreter taking her turn; this is why there is an overlap as they both say "thirty-eight" at the same time. However, here the overlapping turn is likely to be due to the fact that the patient once again did not consistently speak isiZulu for all her turn, as is expected in an interpreted doctor-patient consultation. Instead, the patient code switched and gave her age in English.

There is a last instance during which there is an overlapping turn in this consultation. Overlapping also takes place in consultation 1 when all participants commonly agree on an answer in a common language. The follow extract illustrates this assertion:

#00:03:39-4# Doctor: ok hmmmm so she- she mentions that she went to the people up at the GI clinic
#00:03:46-8# Trained interpreter: *Zulu* uke wakhuluma ngokuthi uke waya eGI clinic (*you said you have been to the GI clinic*)
#00:03:49-8# Patient: e- e- *gastro* e-*gastro*

#00:03:51-9# Trained interpreter: [yes
#00:03:52-0# Doctor: [gastro yes
#00:03:52-3# Patient: [yes

#00:03:53-3# Doctor: ok [pause] so is she still seeing them
#00:03:56-1# Patient: yes

#00:03:56-1# Trained interpreter: Zulu usaya khona (do you still go there)
#00:03:57-3# Trained interpreter: yes

Figure 5.15: Example of overlapping turn when the three participants in consultation 1 agree all together in one language

The above extract shows that there is a common agreement between the three parties concerning the right answer, and they all agree in English. This extract also reiterates the fact that the trained interpreter's turn is overlooked when the doctor and the patient manage to understand each other in English.

In consultation 2, there are 14 instances of overlapping turns, although none of them hinders the dynamic of the communication as the consultation seems well organise. All participants seem to respect each other's turns and there is a spirit of collaboration between the doctor and the trained interpreter as per whether each participant feels comfortable with the consultation proceedings. The following extract serves as an illustration of the collaborative relation between the doctor and the trained interpreter:

#00:18:24-3# Doctor: ok am I going at an appropriate pace for you I am not giving too much information to translate
#00:18:30-1# Trained interpreter: {(indistinct)} no it's fine

Figure 5.16: Extract illustrating the collaborative relation between the doctor and the patient in consultation 2

In consultation 2, as in the following extracts, the instances of overlapping turns take place either when one the participants is being addressed and she shows signs of understanding, when there is an agreement between the doctor and the trained interpreter as per whether their turn is over, or when there is an understanding between the doctor and the patient as per whether the patient has understood the doctor.

#00:02:49-3# Patient: no kwesinye isikhathi ngidla amahewu ngidle nepapa nenkomazi or i-*pasta* e-*dry* / Eyi ngiyakhetha nje izinto engizidlayo (*sometimes I eat mahewu I eat pap and maas (nkomazi) or dry pasta / I am very choosy with what I eat*)

#00:03:01-4# Trained interpreter: i don't really eat hmmm a lot of of things I eat pap [hmm
#00:03:05-1# Doctor: [hm hm (nodding)

Figure 5.17: Overlapping turn in consultation 2 due to positive response from the participant who is being addressed

The extract above shows that the overlapping turn of the doctor does not aim at interrupting the trained interpreter rather, it aims at showing understanding and encouraging the trained

interpreter to say more. The next extract serves as an illustration of the collaborative relation between the doctor and the trained interpreter when it comes to turn taking.

#00:14:08-6# Trained interpreter: Zulu okubalulekile kakhulu ukuthi kufanele ukuthi lungadluli usuku lwakho lokuthi uthole i-treatment / uma kungukuthi mhlawumbe unenkinga nge-transport siyakwazi ukuthi thina sikubhalele incwadi / leyo ncwadi leyo siyakwazi ukuthi siyise emaklinikhi aseduze nawe / kwezinye izikhathi siyakwazi ukuthi uthole i-treatment khona endlini/ but kubalulekile kakhulu ukuthi ungaphuthwa yi-treatment ngoba uma ngabe usuyiphuthile ngeke ize isebenze / so kufanele ukuthi izinsuku esizozisho ukuthi ufike ngazo / ufike ngazo ngempela (*what is important is that you must not skip a day of your treatment / if perhaps you have a transport problem we are able to write you a letter / that letter we can take it to clinics near you / at other times we can make you get treatment in a house / but it is very important that you must not miss your treatment because if you miss it it will not work / when we tell you the days that you must come on those days*)

#00:14:39-6# (door opens making a lot of noise while the interpreter is at work)
#00:14:43-6# (door makes a lot of noise as it is being closed, while the interpreter is still at work)

#00:14:43-6# Doctor: [ok #00:14:43-6# Trained interpreter: [ok doctor

#00:14:44-4# Doctor: you understand up to now ehh in terms of what we discussed

Figure 5.18: Overlapping turn in consultation 2 due to understanding between the doctor and the trained interpreter as per turn taking

The following extract presents an instance of an understanding between the doctor and the patient as per whether the patient has understood the doctor.

#00:33:28-1# Doctor: ok I'll show you where in the chemo room / every time you need to take any blood for chemo / it's the chemo room just two doors down but I'll show it to you now [ok #00:33:36-3# Patient: [ok

#00:33:37-0# Trained interpreter: Zulu [ngizokutshengisa ukuthi kumele uye kuphi / uma kungukuthi uthatha amagazi ekhimo uya iminyango emibili ukusuka lapha / but ngizokutshengisa (*i will show you where to go / when you take chemo blood tests you go two doors from here / but I will show you*)

#00:33:37-4# Patient: [so Zulu ngizoqala ngothatha ifayile… (*must I start by taking the file…*)

Figure 5.19: Overlapping turn in consultation 2 due to understanding between the doctor and the patient

Figure 5.16 indicates that although there is an understanding between the doctor and the patient, the trained interpreter's turn has been taken by the patient. This extract also indicates that since the patient understood the doctor, she does not let the trained interpreter finish her turn because she has something else in mind; she wants to know whether she should start by taking the file or going for a blood test.

In consultation 2, there are two instances during which there is an overlapping turn due to the doctor answering a question before the trained interpreter is done interpreting the question. The following extract illustrates one of these instances.

#00:33:49-6# Trained interpreter: do I start by getting the pink file or [do I

#00:33:51-6# Doctor: [(indistinct) you'll start by getting the pink file for me / and there's something that I'd just like to chat to chat to you off camera / about the blood test as well alright and then the next the last thing is hmm hmmm don't look so worried alright...

Figure 5.20: Overlapping turn in consultation 2 due to the doctor interrupting the trained interpreter before the latter has fully formulated her question.

The last type of instance of overlapping turn that could be observed in consultation 2 is the common agreement between the doctor and the trained interpreter following the patient's answer not verbally, but physically as the patient shook her head as an answer.

#00:23:07-3# (Patient shakes her head)

#00:23:08-1# Trained interpreter: no [doctor

#00:23:08-5# Doctor: [no ok so this is very important right our machines are very good / it's very good to burn the cancer / but it's not a clever machine / it can't say that this is the good [skin

Figure 5.21: Overlapping turn in consultation 2 due to the patient answering using body language instead of verbal language

The extract above shows that the doctor and the trained interpreter spoke at the same time because they both understood what the patient's body language meant. However, it is important to highlight that the trained interpreter interpreted the patient's body language into English possibly as a way to maintain the organisation of the turn-taking, or also probably with the view to render the message she understood regardless of whether the message was in isiZulu or expressed physically.

There are 48 instances of overlapping turns in Consultation 3 involving the *ad hoc* nurse interpreter. The majority of them might be due to a lack of organisation as per how the consultation should take place. In other words, unlike consultation 1 and 2 during which the trained interpreter had briefed the other participants regarding her role and the organisation of the consultation, in consultation 3 neither the doctor, nor the patient had been briefed concerning how the interpreted consultation would take place. The following extract illustrates how consultation 3 started.

#00:00:00-0# Doctor: so they will will they brief her about/ this/ or the've the have they already
#00:00:06-7# Nurse: I don't know/ I don't know

#00:00:08-5# Doctor: or they'll do it after
#00:00:09-8# Nurse: Zulu uthi udokotela *nenimbrifile* na/ (the doctor says did you brief/)
#00:00:12-0#

#00:00:12-5# Researcher's assistant (standing outside by the door): yes
#00:00:13-5# Nurse: i-patient (the patient)

#00:00:14-2# Researcher's assistant (standing outside by the door): {yes}
#00:00:14-3# Nurse: yes she has been briefed

#00:00:16-4# Doctor: ok
#00:00:17-5# Nurse: so what's happening #00:00:18-2#

#00:00:20-3# Doctor: alright / no I was just reading my / my part #00:00:23-9#
(long silence)
#00:00:53-9# Doctor: ask her if she's been told about this hand-out if she's been told about this and she agreed.

Figure 5.22: Extract illustrating the beginning of consultation 3 (absence of briefing)

In the above extract, it can be noticed that neither the doctor nor the nurse takes responsibility for informing the patient with respect to how the interpreted consultation will take place. They might have thought that it is the researcher's responsibility to do so. However, in order to ensure that the patient has been briefed, the doctor asks the nurse to check that the patient has given consent to be recorded. Thus, it can be deduced that to the doctor and the nurse, their understanding of briefing the patient means having the patient's consent to be recorded, to take part in the study. Whereas in interpreting jargon and in the context of an interpreted consultation, briefing a patient means that the interpreter should introduce his or herself, explain his or her role and inform the patient of the procedures in the course of the consultation. The extract in figure 5.22 also indicates that after ensuring that the patient has given consent to be recorded, the nurse does not know how to proceed, and that might be the reason why she asks the doctor "what is happening?"

At the beginning of consultation 3, as per the extract below (figure 5.23), there are instances of overlapping turns between the nurse and the patient because the patient tends to answer the doctor directly in English.

#00:01:20-5# Doctor: I see you're on treatment almost for sevenden- seventeen days now huh
#00:01:25-9# Patient: hmm- hmm

#00:01:27-3# Doctor: how is our treatment hmmm going
#00:01:30-4# Patient: *eish* I don't know about / it[…

#00:01:32-4# Nurse: [Zulu he- e- he- e- umshini // uthi udokotela njengoba usemshinini sekuphele u-*17 days*, uzizwa unjani khona manje / uyawubona umehluko noma awuwuboni umehluko (*mmm-mmm the machine // the doctor says as you are in the machine for 17 days how do you feel right now / do you see the difference or you don't see the difference*)
#00:01:33-6# Patient: o- ngiyawubona wona (*oh I can see it*)

Figure 5.23: Extract illustrating an overlapping turn due to the nurse interrupting the patient in the middle of her sentence as she answers the doctor directly in English

By interrupting and taking over the patient's turn, the nurse stops the patient from expressing how she feels about her treatment. Furthermore, the nurse changes the meaning of the doctor's question and rather tells the patient that the doctor does not mean to know how she feels about her treatment; he rather means to know whether she can see a change on her body since she has started the radiation treatment 17 days ago. In this case, the researcher is rather of the opinion that the doctor was interested in knowing the patient's feeling and opinion with respect to her treatment, and not whether she could see some changes on her body. Consequently, it can be deduced that by trying to make the doctor's message more explicit to the patient, the nurse changed the meaning of the doctor's question.

The nurse seems to be aware that as an interpreter, her role is to render the doctor's messages to the patient from English into isiZulu, and vice versa. However, she has not made that role clear to the patient who, at the beginning of the consultation, consistently addresses the doctor back in English or through mimics. To make sure that the patient waits for her rendition from English into isiZulu, the nurse undertakes to speak louder than the patient until she keeps quiet when the latter wants to respond directly to the doctor. The nurse does it twice. As a result, the patient never addresses the doctor directly again.

#00:02:14-5# Doctor: hmmm / ok any- any problem
#00:02:18-4# Patient, (nurse speaks at the same time) Nurse: inkinga enye ekhona njengoba uqalile ukuya emshinini (any other problem since you started going to the machine)

#00:02:18-8# (voice of the nurse takes over the patient's) Zulu kuphuma izinsila so / kuphuma izinsila / angazi ukuthi kusho kusengathi zihlangene negazi nokungathi amafinyila so (there is dirt coming out / dirt is coming out / I don't know it is like it is mixed with blood and also something like mucous)

#00:02:18-7# Doctor: [during this period

#00:02:19-9# Nurse: (patient and nurse are still speaking at the same time) [Zulu ziphuma kuphi / ngaphambili noma ngemuva (where do these come out in front or at the back)

#00:02:20-4# Patient: [Zulu ngapha emuva (here at the back)
#00:02:20-4# Nurse: [Zulu (voice of the nurse takes over the patient's)

#00:02:22-4# Nurse: aaaaahhhh

Figure 5.24: Extract illustrating the nurse speaking louder than the patient so that she listens to her.

The fact that the nurse speaks louder than the patient to silence her can be an indication that the nurse is not in control of the interpreted consultation, and she might be thinking that in order to take control of the consultation, she has to suppress the patient's voice. This assumption is also motivated by the fact there are numerous overlapping turns taking place between the doctor and the nurse. Both the nurse and the doctor keep interrupting each other when the other one is speaking. These interruptions seem to take place either when the nurse

act as a co-diagnostician (Cf. figure 5.25), or when the doctor thinks that the nurse's turn is over and wants to take his turn but she takes over a second time. This latter example is illustrated in the following extract:

#00:02:01-8# Nurse: alright there was a deep I mean there is a difference because when she was putting a finger she would feel the tumour, now it is decreasing.

#00:02:05-5# Doctor: [hmmm
#00:02:05-8# Nurse: [eeee because when he was putting in the finger she could feel the tumor there

#00:02:10-8# Doctor: hmm[m
#00:02:10-9# Nurse: [but now it's decreasing [so there is a difference
#00:02:13-2# Doctor: [decreasing in size

#00:02:14-5# Nurse: [yeah

Figure 5.25: Extract illustrating overlapping turns between the doctor and the nurse due to a possible miscommunication as per whose turn is next.

The extract above also shows that just as in consultation 1 and 2, overlapping turns take place when the participant addressed uses facial expressions, nodding and other markers of agreement to indicate that he or she is listening and understanding what is being said to him or her.

The next paragraph provides a discussion on the interruptions that took place during the recorded consultations.

Interruptions during consultations

As per the extract below, in consultation 1, there is an interruption of about 90 seconds as a woman enters the consultation room and engages in small talk with the doctor.

#00:10:59-5# [A woman (woman 1) comes inside the consultation room and starts addressing the doctor]

#00:11:03-8# Woman 1: [She greets the doctor by her name]
#00:11:04-7# Doctor responds

#00:11:05-2# Woman 1: how are you darling
#00:11:06-0# Doctor: good how are you

#00:11:06-7# Woman 1: ok [short pause] be ok *né*
#00:11:09-9# Doctor: thank you my dear

#00:11:10-5# Woman 1: things- things will go
#00:11:12-4# Doctor: [thank you [pause]

#00:11:12-4# Woman 1: [ok yeah just [be strong yeah
#00:11:14-5# Doctor: [I appreciate it thank you

#00:11:15-8# [long silence]

#00:11:26-0# Patient: (addresses woman 1 in Zulu):
#00:11:26-7# Woman 1 (adresses patient back in Zulu)
#00:11:28-2# Patient: oh-[oh [laughing]

#00:11:28-6# Woman 1: [eeee #00:11:29-1#
[silence]
#00:11:32-6# Woman 1: (Addresses the patient in Zulu)
#00:11:34-2# Patient [bursts in laughter and replies in Zulu]
[laughter]

Figure 5.26: Extract of the interruption occurring during consultation 1 involving Woman 1

The above extract shows that the patient might be acquainted with the first woman since she engages in a conversation with her and laughs together with her. The next extract shows that another woman might have entered the consultation room. It was not possible for the researcher to ascertain whether it was a different woman who came into the consultation room because the camera was standing in front of the door to record the patient and the trained interpreter from their back so as keep the patient's identity confidential. Thus, it was impossible to see who was at the door. Nonetheless, it is possible to deduce that a second person entered the consultation room because of that second person's reaction at the view of the recording installation.

#00:11:44-7# Woman 1: (Possibly says something as the patient is still laughing. The door creaks. Apparently, Woman 1 goes out and someone else comes in, Woman 2) #00:11:54-1#

#00:11:49-5# Woman 2: what the fuck? (speaking simultaneously with the door closing)
#00:11:49-8# Doctor: oh shame we- they told you they are making a movie [laughter]

#00:11:53-0# Woman 2: what kind of movie
#00:11:54-1# Doctor: we are making a movie [laughter]

#00:11:55-3# Woman 2: really
#00:11:56-0# Doctor: no it's the people from the language school
#00:11:58-9# Woman 2: [yeah
#00:11:59-0# Doctor: [hmm she is an interpreter

#00:12:00-8# Woman 2: yes
#00:12:01-3# Doctor: so she's interpreting for me to see if we can improve the communication and we can help the patients better
#00:12:07-7# Woman 2: ok

#00:12:08-3# Doctor: so that's why they are film[ing so have to [sign...
#00:12:09-7# Woman 2: [ok #00:12:10-7# [ok

#00:12:11-1# ...to say that it is ok
#00:12:11-8# Woman 2: ok [Everybody laughs as the door is closing]
#00:12:14-6# Doctor: that's what we are doing we are making a movie [laughter]
#00:12:18-7# [short pause]

Figure 5.27: Extract of the interruption occurring during consultation 1 involving Woman 2

Consultation 2 has the most instances of interruptions compared to consultation 1 and 3 as there are 10 instances of interruption including the telephone ringing twice for a maximum duration of one 90 seconds, and a minimum duration of 37 seconds; one person entering the consultation room and walking through the room and walking out again, and unknown people opening the creaky door six times. The following extract illustrates the instance when the telephone rang during the interpreted consultation, and as it was ringing, a woman introduced herself in the room. The door was opened three times at different intervals.

#00:00:54-4# [Phone rings while the trained interpreter interprets]

#00:00:55-8# [doctor moved her chair to the table where the telephone lies]

#00:00:56-1# Doctor: [not clearly understood because the phone is ringing]

#00:00:58-3# Trained interpreter: yes ngikhona (*I am fine*)
#00:00:59-0# Doctor: Excellent #00:00:59-7# (end of doctor's turn)

[No one speaks. The phone still rings]

#00:01:02-4# Doctor: ok you're currently on radiation how is your treatment going
#00:01:06-4# Trained interpreter: Zulu okwamanje uku-radiation/ kuhamba kanjani (*at the moment you are on radiation, how is it going)*
#00:01:10-1# Patient: Zulu (inaudible)

#00:01:12-4# Trained interpreter: so so doctor

#00:01:13-5# Patient: hm

#00:01:13-7# Doctor: what's wrong is it (inaudible) are you having any problems any pain

#00:01:17-2# Trained interpreter [Zulu

#00:01:17-9# Patient: [yeah ya uma ngigwinya la yabona la (inaudible– because of the telephone) kunezilonda kuba dry and so kube ngathi kukhona izilonda phakathi la / that is why ngize la kudoktha (yes when I swallow you see here (inaudible– because of the telephone) there are sores it gets dry and as though there are sores right inside here / that is why I have come to see the doctor)

#00:01:34-4# Trained interpreter: currently doctor when I'm swallowing hmm it's very painful and I have mouth sores as well when I swallow it's very painful the whole side...

#00:01:42-4# Doctor: hm

#00:01:42-5# Trained interpreter: ... is very very painful that is why I am here today

#00:01:45-2# Doctor: ok (inaudible) I just wanna check what pain medication are you currently taking

#00:01:50-5# Trained interpreter: Zulu yimiphi izinto ozithathayo zenhlungu (what are you taking for pain)

#00:01:54-0# Patient: Panado
#00:01:55-3# Trained interpreter: Panado doctor

#00:01:56-3# Doctor: Only Panado
#00:01:57-2# Patient: Only panado
#00:01:57-8# Trained interpreter: Panado doctor

#00:01:58-6# Doctor: are you allergic to any medication

#00:02:00-2# [the door opens as the interpreter starts interpreting. In the meantime, the telephone is still ringing

#00:02:00-5# Trained interpreter: Zulu kukhona into ongazwani nayo (*is there anything you are allergic to*)

[Impossible to determine when the patient speaks because of the noise from the door] Patient: cha (*no*)

#00:02:02-1# Trained interpreter: no doctor
#00:02:02-1# Doctor: ok (to the person at the door) sorry (to the trained interpreter) I am going to give you something much stronger after examining...

#00:02:07-2# [the door is opening again as the telephone is still ringing for the last time]

#00:02:07-6# Doctor: (inaudible) of severe {cardiatric} (inaudible) #00:02:11-4# (end of doctor's turn)

#00:02:11-4# [the door closes]

#00:02:11-5# Doctor: and we will decide on what medication but I will give you something stronger ok (pause) the second thing ah ok

#00:02:18-3# Trained interpreter: (smiling) hmm hmm Zulu ngizokunikeza into ezokwenza ukuthi inhlungu zakho zibe ngconywana kunepanado estronger kakhulu kunePanado / ngizokwazi ukuthi ngikutsheke manje ngibone ukuthi yini ewrong ukuze sikunikeze itreatment ezoba ngconywana (*I will give you something that will ease your pain something better than panado something stronger than panado / I will be able to check you now and see what is wrong so that we can give you better treatment*)

#00:02:26-3# [door opens with a noise while the interpreter interprets]

#00:02:31-6# [door closes with a noise while the interpreter keeps interpreting]

Figure 5:28: Interruptions taking place over the two and half first minutes of consultation 2

The extract above shows that when there are interruptions such as the telephone ringing and the opening and closing of a grinding door, transcribing becomes a very difficult task, the transcription lacks accuracy and consequently, the analysis of the transcription cannot be done thoroughly.

In consultation 3 there are no instances of interruptions. This can be due to the fact that the consultation took place at around 1pm, when all patients had already been consulted and most of the Department's personnel were either at lunch, in seminars or giving radiation treatments to patients who were consulted early in the morning. The patient who took part in

consultation 3 was lucky to be consulted by the doctor at that time of the day. However, although there was no interruption, participants had forgotten to close the door when the consultation had started. As pointed out in the following extract, the doctor only realised it when he was about to examine the patient's genital area.

#00:06:16-0# Nurse: Zulu ucela ke ukuthi udokotela ugibele embhedeni azokubona (*doctor is asking that you get on to the bed for him to see*) #00:06:19-0#

#00:06:25-7# Doctor: eiy (as he realises that the door was opened)
#00:06:28-0# the doctor closes the door

#00:06:39-6# Nurse: so khona akukho into ephumayo yiloku kuluma nje kuphela (*is there nothing coming out is it only the itchiness*)

Figure 5:29: Extract illustrating the doctor closing the door in the middle of the consultation

The next paragraph discusses the use of direct versus indirect speech in the course of the three recorded consultations.

The use of direct versus indirect speech

In consultation 1, the trained interpreter briefed participants about the procedures that would be followed during the consultation. She informed them about the code of ethics of interpreters by which she abides; that is to say that the consultation will remain confidential and everything said will be interpreted. The trained interpreter also advised participants to address one another directly. However, as per the following extracts, in the course of the consultation there are two instances where the doctor addresses the trained interpreter while referring to the patient in the third person.

#00:03:39-4# Doctor: ok hmmmm so she she mentions that she went to the people at the- the GI clinic

#00:03:46-8# Trained interpreter: *Zulu* uke wakhuluma ngokuthi uke waya *e-GI clinic* (*you said you have been to the GI clinic*)
#00:03:49-8# Patient: egastro

#00:03:51-9# Trained interpreter: [yes
#00:03:52-0# Doctor: [true it's true
#00:03:52-3# Patient: [yes

#00:03:53-3# Doctor: ok [pause] so is she still seeing them
#00:03:56-1# Patient: yes
#00:03:56-1# Trained interpreter: usaya khona [(starts to interpret but stops) (do you still go there)
#00:03:57-3# Trained interpreter: yes

#00:03:57-4# Doctor: ok alright so basically hmm just to explain to her they are treating her for that that problem is because of the side effect of the radiation so they are treating her for that so she needs to continue following up with them

#00:04:11-2# Trained interpreter: Ok *Zulu* kusabalulekile ukuthi uqhubeke uye *e-gastro* / inkinga leyo bayayilungisa / izogcina isilungile wena kufanele ulokho uqhubeke ulokhu uhamba khona bazoyilungisa inkinga leyo (*it is still important that you continue to go to gastro / that problem they are sorting it / it will end up solved you need to keep on to continue to keep on going there they will solve that problem)*

Figure 5.30: Doctor using the third person when referring to the patient in consultation 1

The following extract indicates the only instance when the trained interpreter refers to the patient indirectly:

#00:09:19-9# Doctor: are you still using the cream
#00:09:21-6# Patient: [yes
#00:09:22-2# Trained interpreter: [yes she is using the cream
#00:09:24-3# Doctor: Hmm are you taking anything for pain

Figure 5.31: Single instance when the trained interpreter uses the third person to refer to the patient in consultation 1

In the extract above, it is possible to deduce that the trained interpreter refers to the patient indirectly by accident since the patient took her turn and answered the doctor directly. Hence, due to the patient's disregard for her turn, it is likely that the trained interpreter lost her composure and made that professional mistake.

In consultation 2, the whole consultation takes place in the direct speech. There are no instances of indirect speech. However, as per the extract below, in consultation 3, when the doctor or the nurse would like to refer to the patient, they mainly do so in the third person.

#00:03:15-6# Nurse: before she started treatment
#00:03:17-3# Doctor: hmmm

#00:03:17-7# Nurse: [yeah]there was blood coming out
#00:03:17-7# Doctor: [so that's what I was thinking]

#00:03:19-5# Nurse: and since she's started the treatment/ so it's [this (indistinct)] (the nurse stops her sentence and listens to the doctor)
#00:03:22-4# Doctor: [the blood] dried out but hmm there is [still...
#00:03:24-6# Nurse: [yeah...

#00:03:25-0# Doctor: ...the mucous
#00:03:25-2# Nurse: there is this mucous thing

#00:03:27-1# Doctor: [ok
#00:03:27-2# Nurse: [that is co[ming out
#00:03:28-3# Doctor: [hmmm/ just tell her that eee // the mucous is because the rectum is still working

#00:03:35-8# Nurse: ok
#00:03:36-7# Doctor: she has a e bag outside here
Figure 5.32: Doctor and nurse referring to the patient mostly in the third person

It appears that the doctor seems in a state of confusion concerning whether to address the patient in the first or the third person. Although he mainly refers to the patient in the third person, it happens that within the same message he also addresses her directly, in the first person. The following extract serves as an illustration for this example.

#00:08:27-4# Doctor: eh- just tell her that you have a vaginal candida e you have a fungus in the in your vagina #00:08:34-0# (end of doctor's message)
#00:08:34-3# Nurse: hmm

#00:08:35-0# Doctor: and I'm going to give her some a hmmm antifungal for it
#00:08:40-1# Nurse: hm hm

#00:08:40-3# Doctor: as well as disinfectant as well so I'm gonna give you antifungal and antibiotic
#00:08:45-7# Nurse: ok
#00:08:46-3# Doctor: and- and a pain medicine
Figure 5:33: Example illustrating the doctor mixing the first and the third person in consultation 3

From the above extract, it can be deduced that the doctor mixes both the first and the third person in the course of a sentence perhaps because he has never been trained to work with interpreter. Thus, though he would like to address the patient directly, he is conscious of the language barrier and therefore asks the nurse to transmit the message on his behalf.

The nurse also behaves the same way. Whenever she addresses the patient, most of the time, she reports the doctor's speech, as illustrated in the following extract.

#00:04:00-8# Nurse: Zulu uthi udokotela ngikuchazele ukuthi njengoba kuye kwavulwa ukuthi ukake ngapha ufakwe isikhwama ngapha kwavalwa (The doctor says I must explain to you that since it was opened for you to excrete on this side, the bag was put in and the other side was closed)
#00:04:07-4# Patient: hm hm

#00:04:08-1# Nurse: so Zulu angithi umuntu uma ezoya ethoyilethi enza unamba thu kuba ukuthi amakaka vele aphuma egcobisekile so ke njengoba kuvaliwe kungaphumi amkaka akusho ukuthi lendawo ayisasebenzi (When a person goes to the toilet to do number two the faeces come out smeared. Now as this part is closed it does not mean it is not working)
#00:04:27-8# Patient eeee

#00:04:28-1# Nurse: so lawo mafinyila layo aphumayo enziwa yingoba vele abevele ephuma ngesikhathi noma ukaka so azolibele ephuma vele ngoba lendawo isasebenza kodwa ayisebenzi ukuthi iphume amakaka isebenza ukuthi sekuphuma leyonto nje engamafinyila (*The mucous that is coming out is caused by the fact that it was going to come out when you excreted. The mucous will still come out because this part is still working although it does not work as the faeces 'excretion now it only excretes this mucous thing*) #00:04:44-9# (end of nurse's message)

#00:04:46-1# Nurse and patient: {hmmm}

#00:04:47-3# Doctor: e any change of the skin colour

#00:04:50-3# Nurse: Zulu la uthola khona ukwelashwa umshini lapho ushisa khon isikhumba sakho sinjani (where you are getting the treatment, where the machine is used, how is your skin like)

#00:04:51-7# Doctor: [where we are to treat

#00:04:52-6# Nurse: ... Zulu umshini la ushisa khona isikhumba singani (where the machine is used, how is your skin)

#00:04:56-8# (end of nurse's turn)

#00:04:57-6# Patient: hash zulu angisiboni (I don't see it)

#00:04:59-5# Nurse: Zulu awusibheki (you don't look at it)

#00:05:00-5# Patient: hin hin

#00:05:01-6# Nurse: Zulu yini indaba ungasibheki (why don't you look at it)
#00:05:02-4# (end of nurse's turn)

#00:05:03-5# Patient: Zulu angikhoni ukusibheka (I am not able to look at it)

#00:05:05-2# Nurse: Zulu hawu noma ume esibukweni awukwazi ukuthi ungazibheka (even when you stand at the mirror you are not able to see it)
#00:05:07-6# (end of nurse's turn)

#00:05:09-8# Patient: hm Zulu sengizozibheka (I will now look at it)

#00:05:11-1# [Nurse bursts in laughter]

#00:05:12-0# Doctor: hm hm

Figure 5.34: Extract illustrating the nurse using the third person to refer to the doctor and engaging in a personal consultation with the patient

The above extract indicates that the nurse does not just refer to the doctor in the third person, but she also engages in a personal consultation with the patient during which she asks questions which have not been formulated by the doctor (e.g.: you don't look at it? Why don't you look at it? Even when you stand at the mirror you are not able to see it?) The nurse is amused by the patient's replies and burst out laughing. The doctor's reaction to the laughter can be interpreted as a way of reminding her of his presence in the room and the fact that he is alienated from the conversation taking place between the nurse and the patient. The feeling of alienation always takes place when the third participant is referred to in the third person. When the doctor and the nurse discuss about the patient, the latter is alienated because she is not addressed directly and in the meantime, the doctor and the nurse discuss about her case

without including her in the conversation. The above extract supports that the doctor is also put in the same position when the nurse discusses with the patient.

The next paragraph reports on participants' feedback on the success or the failure of the consultations as well as their opinion of the interpreting service rendered and the usefulness of interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital.

5.4. Analysis of participants' feedback on the consultations

As the pilot study indicated that there is a substantial educational gap between the doctors and patients, three feedback forms were designed for each group of participants. The aim was to suit the level of education of each group. Whereas doctors and interpreters were required to rate their perception of the interpreting performance on a scale of 1 to 10 with 1 being very bad and 10 being excellent, patients were rather required to rate their perception of the interpreting performance they received from "very bad" to "very good". The researcher was of the view that these terms would not be complex to the patients. Although prior to filling the forms participants were briefed as per these categories and how to rate their consultations, patients were assisted by trained interpreters who sight translated the form to them while they were filling it in and the researcher was available to respond to participants' questions, it is important to stress that participants' rating was purely subjective and based on their perceptions of their consultation. The feedback forms are attached as an appendix.

5.4.1 Feedback from the doctors

In consultation 1, the doctor rated the interpreting service 8/10. She was contented to have benefited from the trained interpreter's interpreting service and stated that the communication with the patient was successful and the trained interpreter gave her satisfaction due to her professionalism and her ability to go straight to the point and convey pertinent information to the patient. The doctor added that there was nothing she thought the interpreter should improve on; therefore she would be delighted to work again with the trained interpreter. The doctor in consultation 1 declared that she had received interpreting service with an *ad hoc* untrained nurse interpreter and the difference with working with the trained interpreter was the professionalism and the ability to convey pertinent information. The doctor was also of

the opinion that medical practitioners would benefit from working with trained interpreters because it would improve their work satisfaction. She did not make any additional comments.

In consultation 2, the doctor rated the interpreting service 10/10. She was happy to have benefited from the trained interpreter's interpreting service and stated that the communication with the patient was successful and the trained interpreter gave her satisfaction because she was very efficient and she could understand that the trained interpreter explained what she said accurately. The doctor also stated that there was nothing she thought the interpreter should improve on; therefore she would be delighted to work again with the trained interpreter. The doctor in consultation 2 stated that she had received interpreting service with an *ad hoc* untrained nurse interpreter and she believe that the service the nurse rendered and the one rendered by the trained interpreter were very similar. The doctor was also of the opinion that medical practitioners would benefit from working with trained interpreters when consulting some patients, and if receiving interpreting services when working with those patients, their work satisfaction would improve. As an additional comment, the doctor stated that she believed that the patient became tired of or had lost interest in the consultation perhaps because her English was satisfactory overall; although she was impressed with the trained interpreter's interpreting service.

In consultation 3, the doctor rated the interpreting service 9/10. The doctor was contented to have benefited from the nurse's interpreting service and stated that the communication with the patient was successful and the nurse gave him satisfaction because she listened to him first and then interpreted. The doctor also added that there was nothing he thought the interpreter should improve on; therefore he would be delighted to work again with the nurse. The doctor in consultation 3 admitted that he had only received interpreting service from a nurse; however he stressed that the service he had received during the study was better than ever before. The doctor was of the opinion that medical practitioners would benefit from working with interpreters especially when they have to consult patients who speak languages such as French and Portuguese. His additional comment was that it is difficult to interact with patients when there are language barriers.

5.4.2 Feedback from the patients

The patient from consultation 1 rated the interpreting service as being "good". She was content to have benefited from the trained interpreter's interpreting service and stated that the

communication with the doctor was successful and the trained interpreter gave her satisfaction because she helped her to explain herself to the doctor. She did not make an additional comment. However, she is of the opinion that it would benefit her and other patients to have access to interpreting services when consulting with the doctor.

The patient from consultation 2 only managed to write that she was contented to have benefited from the trained interpreter's interpreting service. She did not manage to fill in the form completely because she had to resume her consultation with the doctor and go for a blood test. She did not make any comments concerning whether there are some areas on which the trained interpreter could have done better. She added that she would be delighted to work again with the trained interpreter, and admitted that she had received interpreting service from an *ad hoc* untrained nurse interpreter before and commented that consulting with the trained interpreter was easier than with the *ad hoc* nurse interpreter.

The patient from consultation 3 rated the interpreting service as being "very good". She was contented to have benefited from the *ad hoc* nurse interpreter's interpreting service and stated that the communication with the doctor was successful and the nurse interpreter gave her satisfaction because she provided her with some explanation. The patient in consultation 3 did not make any suggestions as per what the untrained nurse interpreter could have done better. However, she mentioned that she would enjoy having the same *ad hoc* nurse interpreter interpreting for her again. The patient also declared that she had never received interpreting services before. Thus, she was unable to compare the nurse's service with the one of another *ad hoc* interpreter. She did not make an additional comment related to her experience, besides that she does not think that doctors and patient would benefit from having access to interpreting services.

5.4.3 Feedback from the interpreters

Concerning the interpreters, in consultation 1, the trained interpreter rated the service she provided 7/10. She was of the opinion that the communication between the doctor and the patient was successful and she added that she was satisfied with the service she had provided although she was lacking the right terminology so she applied elaboration as a coping strategy. Thus, she stressed that she was not satisfied with her lack of terminology, so if she had received more information that would have helped her understanding how the

Department functions and what the jargon used by the doctor means, it would have increased her satisfaction towards her overall performance. During consultation 1, to the trained interpreter, her role was deemed to articulate both parties' points. The trained interpreter believed that the doctor understood her role because she was speaking slowly and clearly. She also believe that the patient understood her role because she was comfortable speaking in her native language. The trained interpreter suggested that more information be provided to trained interpreters who are called to work in such a setting.

In consultation 2, the trained interpreter rated the service she provided 7/10. She was of the opinion that the communication between the doctor and the patient was successful and she mentioned that she was satisfied with the service she had provided because the patient understood what was expected from her. The trained interpreter added that the consultation gave her satisfaction because the doctor-patient relationship was maintained throughout the consultation. However, she stressed that more information are needed in order to tackle conveying accurate messages when facing that type of cancer. Thus, to the trained interpreter, receiving input that would enable her to understand head and neck cancer would increase her level of satisfaction when working in such a setting. To the trained interpreter, her role was deemed to ensure understanding between the doctor and the patient. The trained interpreter believed that the doctor understood her role because she was not using abstruse medical terms; she spoke softly and very well. She also believe that the patient understood her role because she was comfortable requesting more information to the doctor. The trained interpreter suggested that more information about head and neck cancer be provided to trained interpreters who are called to work in such a setting.

In consultation 3, the *ad hoc* untrained nurse interpreter rated the service she provided 8/10. She was of the opinion that the communication between the doctor and the patient was successful and she mentioned that she was satisfied with the service she had provided because as a nurse, she communicates with patients before they meet doctors so as a nurse she should gain patients' trust and confidence. The nurse did not make comments related to what gave her satisfaction and what did not give her satisfaction in her performance. Neither did she make a writing comment about her perception of her role. Nevertheless, she told the researcher that she owes loyalty to the patients before the doctors since the care they provide as nurses is targeted at the patients. Thus, if patients are unsatisfied with their nurses' services, they may to complain to higher offices and these nurses may be sanctioned.

However, the nurse believed that the doctor understood her role since he received all the information he needed. The nurse also believed that the patient understood her role because she was able to address all her problems to the doctor, including whether they are on the right track with respect to her treatment.

5.5. Report on the interview with the trained interpreter

Three weeks after recording the consultations, the Head of the Department of Radiation Oncology at Charlotte Maxeke Johannesburg Academic Hospital, Prof. Sharma, was kind enough to grant a lecture interview to the researcher during which he provided an input on basic oncology. Prof. Sharma's lecture included a straightforward explanation of what cancer is, what is likely to be at the origin of cancer, the different type of cancers as well as the different treatments available for types of cancer that we named. Prof. Sharma also discussed the staging of the disease as well as how the patient's performance would affect his or her treatment. He explained what a fraction is and provided an overview of the different fractions that can be applied according to the patient's state. He also clarified the importance of the patient's weight during the treatment and closed the lecture by providing advice as per how to avoid cancer. The researcher recorded the interview, showed it to the trained interpreter and interviewed the trained interpreter. The goal of the interview was firstly to understand why the trained interpreter faced difficulties with the terminology while she had been given a glossary of medical terms released by the Department of Health of South Africa; secondly, to determine whether that lecture was useful and effective to the trained interpreter and whether she believed that she would have performed better if she had had that lecture before interpreting and lastly, to provide her with advice to improve her interpreting service.

Concerning the first question which was to understand why the trained interpreter had great difficulties with the terminology whereas she was given a glossary, she responded that the glossary had terms which in her opinion no patient or Zulu speaker would have understood. She argued that it is mainly the reason why she used loan words. The researcher asked why she did not ask for clarification although she did not know what a fraction is and she therefore used it as a loan word when interpreting. The trained interpreter responded that she believed that the patient knew what a fraction is.

With reference to Prof. Sharma's lecture, the trained interpreter stated that it was useful, she remembered some of the examples that Prof. Sharma had given during the lecture and she

definitely was of the opinion that she would have felt more confident, she would have performed better should she have received that input prior to interpreting in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital.

The researcher ended the interview with some recommendations among which to never interpret a message that has not been fully understood; thus to always ask for clarifications when she does not understand a term. The researcher also stressed the importance of briefing both parties before starting to interpret in order to limit overlapping turns. The trained interpreter was reminded to always bring a block note and a pen to take notes and to politely stop the speaker with a hand gesture or any other polite gesture when his or her turn is too long. This would prevent her short term memory to be overloaded, which will naturally affect the quality of her rendition.

5.6. Conclusion

The main study was conducted using various methods: audio and video recording of interpreted doctor-patient consultations, transcription of the consultations and analysis of the consultation using conversation analysis (CA). The analysis of the transcription using CA constitutes the main method used. It focused on features such as: kinesic elements including participants' positioning, turn length, overlapping turns, the interruptions during consultations and the use of direct versus indirect speech in the course of the consultations. The analysis aimed primarily at elucidating the research question of whether nurses' interpreting performance compares favourably to that of trained interpreters as well as determining which consultation was the most successful. All participants provided a positive review on the interpreting services they received, especially doctors who received interpreting services from the trained interpreter. However, it is vital to stress that the high level of satisfaction expressed by participants in consultation 3 provided an interesting insight into the perceptions of participants who receive services from *ad hoc* untrained interpreters. These participants seem to be satisfied if even a low level of communication is achieved, and do not seem to realise that quality wise, interpreted communication involving *ad hoc* untrained interpreters is very poor. Furthermore, the fact that they had no experience with working with professionally trained interpreters biased their judgement, which can possibly be noted as part of the limitations of this study.

CHAPTER 6: FINDINGS AND RECOMMENDATIONS

"[…] [R]esearch into the quality of mediated communication could still benefit from a more socioculturally and context-sensitive function-oriented approach" (Pöchhacker, 2006:151)

6.1. Introduction

This part of the thesis will present the findings and recommendations from the data collected for the purpose of this study. A comparison with the researcher' presuppositions will be provided.

6.2. Pilot study findings

6.2.1. Patients' interviews

The analysis of the data collected from patients during the pilot study shows that women constitute the majority of the interviewees by 77 % as opposed to 23% of male interviewees. With reference to patients' social profiles, it has been found that the majority of patients are pensioners (33 out of 100) followed by unemployed patients (30 out of 100). The table providing this data (Cf. Chapter 4 Figure 4.1) shows that the majority of patients are from the working class. It is thus expected that they have a limited income.

IsiZulu is the first language of the majority of the population interviewed (19 out of 100) as part of the pilot study focusing on patients, followed by Sesotho (18 out of 100), Afrikaans, English and Setswana, with the same number of native speakers (10 out of 100) followed by isiXhosa (5 out of 100), Xitsonga (5 out of 100) Sepedi (4 out of 100), isiNdebele (3 out of 100) Tshivenda (2 out of 100), Xitsonga from Mozambique (2 out of 100) and one speaker out of 100 for the respective languages: Italian, Kirundi, Lingala, Portuguese and Siswati. Several patients claiming to be bilingual native speakers were reported: 3 out of 100 assert that their first languages are Afrikaans and English, whereas 1 out of 100 claimed to be bilingual English and Afrikaans. On initial analysis, these two groups are almost identical; however, the researcher took into account the fact that one group stated Afrikaans first and the other stated English first as a possible indication of which of the two languages they relate to best, linguistically and/or culturally speaking.

Patients also indicated which language they would prefer to use when consulting with the doctor in the interview. Unexpectedly, English is the language preferred by the majority of patients when consulting with the doctor (54% of patients), followed by isiZulu (18% of patients) (Cf. Chart in chapter 4 Figure 4.8). This result is even more surprising because on the one hand, the majority of patients are Zulu speakers (19 out of 100 patients). The researcher thus expected the patients' preferred language to use with the doctor to be isiZulu. On the other hand, only 14 patients out of 100 have English as a first language. It is also important to mention that 48% of patients declared that they possessed first-language competence in English (classified as A language in the graphs). Of the patients who stated that they would prefer to speak English with the doctor, six of them do not classify themselves as highly proficient in English, and five of them do not have English as first language.

50% of the patients interviewed prefer speaking a language different from their first language with the doctor. 20 patients showed no preference between speaking their first language or another language with the doctor (Cf. Table chapter 4 Figure 4.7). The data shows that patients who prefer to speak a language different from their first language with the doctor seem to be shifting to a language that carries more status than their first language, since 23 out of 50 patients did not wish to communicate in their first languages with the doctor, but chose another language as preferred language of communication. Among these patients, 5% of Afrikaans first language speakers, 5% of Sesotho first language speakers, 3% of isiNdebele first language speakers, 7% of isiZulu first language speakers, 2% of isiXhosa first language speakers and 1% of Tshivenda first language speakers chose English exclusively as their preferred language of communication with the doctor. 3% of patients shifted from their first language to preferring to speak isiZulu with the doctor. Among them, 2% are Sesotho first language speakers and 1% is a Setswana first language speaker. One Setswana first language patient preferred to use Sesotho with the doctor, and was neither English proficient nor literate. Her daughter acted as an *ad hoc* interpreter, and she explained that although her mother was a Setswana first language speaker, she spent most of her life in a Sesotho speaking community, which was why she felt more at ease speaking Sesotho with the doctor instead of Setswana. The data also shows that one patient preferred to shift from his first language Lingala to exclusively speaking French with the doctor, whereas another one preferred to shift from Xitsonga (Maputo) to exclusively speaking Portuguese.

Patients gave a self-assessment of their level of literacy and proficiency in the languages they claimed to know. Consequently, it is possible that their self-assessment does not reflect their actual level of literacy and proficiency in these languages. Furthermore, whereas 93% of patients provided information with respect to their level of literacy in their first language, fewer patients provided information about their level of literacy with respect to the additional languages they claimed to know. Besides, the majority of patients either did not disclose their level of literacy in the additional languages they claimed to know, or admitted that their level of literacy was very low and sometimes insignificant. Thus, it was established that patients' level of literacy in their first language was higher than their level of literacy in the additional languages they claimed to know (Cf. Chapter 4 Figure 4.9 and 4.10). The fact that the majority of patients, including second language speakers, preferred to speak English with the doctor was surprising, since many of these patients categorised themselves as English B or C. The researcher assumed that patients would grasp the opportunity of having a professionally trained interpreter at their service to speak their first language with the doctor. Nevertheless, it was also evident that the results of the pilot study on patients would have been vastly different if all participants had been formally tested on their level of literacy in all the languages they claimed to know. It is very possible that such a test would have proven that patients' level of literacy in the languages they claimed to know would have been lower than their stated level of proficiency. Such a study could be a fruitful area for further research.

Having provided the main findings on the part of the pilot study focusing on patients, the next paragraph provides the main findings on the questionnaire distributed to the medical staff.

6.2.2. Medical staff questionnaire

The study on the medical staff proves that although each staff member who participated in the study was at least bilingual, the majority of the medical staff (16%) has English as first language. Hence, there is a discrepancy of most popular first language between patients and the medical staff, since the majority of patients who took part in this study were Zulu speaking (19%). Furthermore, it was also highlighted that the majority of doctors are from a different linguistic, social and cultural background compared to the patients (Cf. Chapter 4). Most patients are either pensioners or jobless or have low income employments, thus a social difference exists between the doctors and most of the patients. All these disparities are at the

heart of language and cultural barriers between patients and doctors, hence the need for interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic hospital.

However, when examining the perception of the medical staff towards interpreting, the study conducted revealed that 85% of staff members are of the view that the hospital expects them to provide *ad hoc* interpreting services although none of them is trained to do so (except two student radiation therapists who claimed to have received training in interpreting). 69% of medical staff also declared that though such a clause is not part of their contract with the hospital, they feel obliged to use their additional languages to cater for patients and to assist colleagues with *ad hoc* interpreting services whenever needed (Cf. Chapter 4 Figure 4.14). Thus, whereas 73% of staff members have admitted that they have provided *ad hoc* interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital (Cf. Chapter 4 Figure 4.15), 75% of staff members have admitted that they benefited from *ad hoc* interpreting services. This finding stresses the need for professional interpreting service in the Department. Nevertheless, as much as there is a need for professional interpreting services, given that 88% of staff stated that professional interpreting services are needed in the Department (Cf. Chapter 4 Figure 4.18), the study also revealed that the medical staff is used to working with *ad hoc* untrained interpreters; only two staff members stated that they had worked with professionally trained interpreters.

Thus, concerning the overall pilot study, it is important to emphasise that the results of the patient study seemed to indicate that the majority of patients are English literate. This, coupled with the fact that 58% of patients stated that they prefer to consult with doctors in English, is misleading, given that 88% of the medical staff members acknowledge that they need interpreting services, as they are aware that the messages they transmit to their patients are not being understood effectively. The next section provides the findings on the main study.

6.3. Main study findings

6.3.1 Kinesic elements

The analysis of the recorded consultations indicates that the positioning of participants as well as the positioning of the camera influence the success of an interpreted doctor-patient

consultation. The comparison between consultation room 1, involving the professionally trained interpreter (Cf. Chapter 5 Figure 5.1) and consultation room 3, involving the nurse acting as an interpreter (Cf. Chapter 5 Figure 5.3) makes it clear that in consultation room 1, the positioning of participants contributed to the success of the consultation because the doctor and the patient were facing each other and could therefore have eye contact. The doctor could therefore build a relationship with the patient and gain her trust. The trained interpreter did not intrude in that relationship. She rather ensured that the doctor reached her goal by interpreting the communication between the doctor and the patient as accurately and faithfully as she could. Whenever the patient was unsure of the doctor's message or did not understand the doctor's message, she looked at the trained interpreter. The presence of the trained interpreter also allowed the patient to express herself comfortably in her first language as it could be noticed that the patient was quick to provide yes or no answers to the doctor but when she had to elaborate some on answers, she felt more comfortable doing so in her first language. The positioning of the camera also contributed to the success of the consultation because the camera was positioned behind the patient and the trained interpreter. The patient could therefore interact with the doctor and to a certain extent, with the trained interpreter without feeling invaded by the camera.

In comparison with consultation room 3, the analysis of the recording reveals that the positioning of participants was not ideal for the success of the consultation. Whereas the doctor was sitting on a rotating chair and would turn to the patient whenever he wanted to address her, listen to her or attempt to understand her facial expressions, the *ad hoc* nurse interpreter was standing throughout the consultation. The fact that she was standing and looking at the patient and the doctor from above created a mismatch in power relations towards the latter. The patient was intimidated by the *ad hoc* nurse interpreter. The nurse's positioning is not the only factor that intimidated the patient. At the beginning of the consultation, the nurse addressed the patient with her arms crossed over her chest, which suggests the establishment of a position of power or authority over the patient; this position also suggests the creation of a distance that the *ad hoc* nurse interpreter established between the patient and herself. The fact that the *ad hoc* nurse interpreter crossed her arms suggests that she was perhaps feeling uncomfortable and was attempting unconsciously to protect herself, or she was reluctant to communicate. Furthermore, the patient was intimidated by the *ad hoc* nurse interpreter because whenever she addressed the doctor directly, the *ad hoc* nurse interpreter spoke louder than she did, to the extent that the patient stopped addressing the

doctor until the end of the consultation. Thus, the nurse's positioning and behaviour towards participants and especially towards the patient has hindered the full success of the interpreted doctor-patient consultation. The positioning of the doctor was not ideal either because it created a sense of connection and disconnection with the other participants and especially with the patient, since when the doctor wanted to address the patient or to listen to the patient and the *ad hoc* nurse interpreter, he turned to them and connected with them, and when at times the doctor was waiting for the nurse to report back to him, he turned towards the desk and examined the patient's file in the meantime, thus disconnecting with the other participants.

Although it could be argued that if participants had been exposed to permanent filming over a long period of time, they would have been familiar with that practice, the time allocated for the completion of this exploratory study did not allow the researcher to undertake such a trial. Hence, it is important to point that none of the participants was used to be filmed. Nonetheless, albeit the positioning of the camera did not hinder the success of consultation 3, it might have affected participants at different levels. The camera was located behind the patient (Cf. Chapter 5 Figure 5.3) so the patient tended not to be aware its presence. However, at the beginning of the consultation, the *ad hoc* nurse interpreter stared at the camera (possibly because she was standing right in front of it. If she had been sitting, perhaps she would not have been too conscious of the camera at that moment). However, throughout the consultation, she was focused and engaged in communicating with both the doctor and the patient. The doctor did not seem to be particularly affected by the camera as he was mostly staring at the patient when the latter was speaking or when he was addressing her, or turning to the table when he wanted to report to the patient's file.

Consultation room 2 (Cf. Chapter 5 Figure 5.2) illustrates the instance when the camera hindered the success of the consultation because the patient, unlike the two other participants, was staring at the camera almost throughout the consultation. Consequently, it was evident that the patient was collecting herself and suppressing her emotions when she looked the camera. It is however important to stress that this incident happened because the patient changed her position when the researcher was no longer in the consultation room. The patient was first sitting with the camera looking at her from her profile; her face was supposed to be hidden by the interpreter's face which was closer to the camera. But when the researcher left the room and the consultation began, the patient sat towards the wall, thus facing the camera. But she is not the only person who changed her position. The doctor also changed her

position and consequently, she was not in the view of the camera, only her hands could be seen from time to time. Hence, it can be concluded that the absence of the researcher in the consultation and the fact that the participants changed their positions affected the consultation. Nevertheless, the consultation was still successful, thanks to the dynamics between participants. The doctor turned her chair in order to be able to face the patient, have eye-contact with her and build a relationship with her, whereas the trained interpreter would turn to each participant when addressing them. The doctor also built a relationship with the trained interpreter. In the course of the consultation, she asked the interpreter whether her turn-lengths were manageable and she also waited for the trained interpreter to give her a sign when she had finished her turn, so as to avoid overlapping turns as much as possible. Furthermore, both the doctor and the trained interpreter used body language and hand gestures extensively to help the patient visualising their explanation. All these factors contributed to the success of consultation 2. The next section provides the findings relating to turn-lengths in the course of the consultations.

6.3.2. Turn length

During consultation 1, the doctor's turn lengths are relatively short (average of 6 seconds per turn). The turn lengths become longer when the doctor would like the patient to elaborate on an answer, or when she would like to provide the patient with some explanation. One of the longest turn-lengths in consultation 1 has an average of 36 seconds (Cf. Chapter 5 Figure 5.5). This turn-length is still relatively short compared to the long turn-lengths maintained by doctor consulting in consultation 2 after examining the patient. In consultation 2, one of the doctor's longest turn-lengths is 46 seconds (Cf. Chapter 5 Figure 5.7). The analysis of these recordings revealed that the trained interpreter was very accurate when the turn-lengths were short. However, she missed some details when the turn-lengths were longer or when she faced medical terms she was unfamiliar with (Cf. Chapter 5 Figure 5.7). Nevertheless, turn-lengths had a different effect in consultation 3, which involving the *ad hoc* nurse interpreter. In consultation 3, the turn-lengths were as short as in consultation 1. The longest turn in the course of that consultation is 44 seconds, when the nurse explains to the patient why she has mucous coming from the anus (Cf. Chapter 5 Figure 5.9). The shortness of the turn-lengths did not have an impact in the *ad hoc* nurse interpreter's performance, because she was not interpreting each message uttered by either the doctor or the patient. Instead, she was

engaging in conversations with participants; she was almost assuming the two roles: the role of the co-diagnostician when reporting the patient's message to the doctor, and the role of the doctor in asking questions on her own initiative to the patient (Cf. Chapter 5, Figure 5.10 and Figure 5.34).

The fact that the *ad hoc* nurse interpreter did not interpret accurately hindered the success of consultation 3, because the doctor reported that he felt excluded from the conversation when the nurse-interpreter was engaging in further conversations with the patient. The doctor even cleared his throat while the *ad hoc* nurse interpreter was engaging in further discussion with the patient and was laughing. In the researcher's view, he did this in order to remind her that he was still in the room (Cf. Chapter 5 Figure 5.34). In comparison with the trained interpreter's performance in consultation 1 and 2, the fact that the trained interpreter accurately and consistently interpreted everything that was said contributed to the success of the consultations, because each participant was not just kept involved in the consultation, but also maintained his/her role. In other words, the doctor remained in charge by leading the consultation, and receiving answers for the precise questions that she asked, the patient was only accountable to the doctor and the trained interpreter remained the interpreting service provider between the two of them. Figure 5.23 (Cf. Chapter 5) serves as an additional illustration for the fact that the *ad hoc* nurse interpreter assumed the doctor's role during the consultation when she told the patient that she was not providing the correct answer to the doctor's question. In explaining to the patient what the doctor's question was, the *ad hoc* nurse interpreter actually changed the meaning of the doctor's question, which is a factor that hindered the success of consultation 3. Furthermore, still with reference to Figure 5.23, the *ad hoc* nurse interpreter interrupts the patient in the middle of her sentence when the latter is addressing the doctor. It can be observed that the *ad hoc* nurse interpreter takes over the doctor's role, which is to lead the consultation. If the doctor was not satisfied with the patient's answer, he should have been the one to address it. The next section provides the findings in terms of the factors that either contributed in the success of the consultations or hindered such success, following the analysis of overlapping turns in the course of the three recorded consultations.

6.3.3. Overlapping turns

In the course of the three recorded interpreted doctor-patient consultations, overlapping turns take place. However, these overlapping turns are motivated by different determinants. Whereas in consultation 1 there are 17 instances of overlapping turns, in consultation 2 there are 14 instances of overlapping turns and in consultation 3, there are 48 instances of overlapping turns.

In consultation 1, overlapping turns take place for four reasons:

- when the patient understood the doctor and replied directly to the doctor in English (Cf. chapter 5 fFgure 5.12);
- when the patient understood what the trained interpreter had said and replied directly to the doctor in English (Cf. chapter 5 Figure 5.11)';
- when the doctor does not wait for the trained interpreter to have her turn because the patient replied either verbally in English or through the patient's body language (Cf. Chapter 5 Figure 5.13) and
- when the three participants commonly agreed on a matter (Cf. Chapter 5 Figure 5.15)

The first three reasons can be motivated by the fact that neither the doctor nor the patient has been trained to work with professionally trained interpreters. It can also be argued that perhaps the patient replies directly in English to the doctor not just because she understands English to a certain extent, but also because she takes pride in addressing the doctor directly and demonstrating that she has a certain degree of English literacy. The researcher is of the opinion that in the course of consultation 1, the patient's direct replies to the doctor in English did not hinder the success of the consultation, since the patient's answers were limited to yes/no and to short answers. The researcher believes that addressing the doctor directly in that way somehow helped the patient to communicate better with the doctor. If the patient had spoken English during the whole consultation or part of the consultation, the interpreted consultation would have been pointless because the patient would have demonstrated that her level of English literacy was high enough so she does not need interpreting services. Thus, it is important that interpreting services be provided to patients who need it, although as revealed by the pilot study on patients, not many patients would easily admit that they need interpreting services since most the patients take pride in claiming that they can speak English and believe that their level of English literacy is high enough to consult with the doctor.

The last reasons for overlapping turns in consultation 1 could be categorised as a natural occurrence in the course of a conversation. When in the course of a conversation participants commonly agree, it can naturally happen that they express that agreement simultaneously, which is the case in consultation 1 (Cf. Chapter 5 Figure 5.15). Nevertheless, it is important to stress that in Figure 5.15, the common agreement is also motivated by the fact that the doctor understood what the patient had said since she used a loan word *gastro, e-gastro*. In Consultation 2, the majority of overlapping turns were caused when all participants were in agreement. There is a collaborative relationship between the trained interpreter and the doctor (Cf. Chapter 5 Figure 5.16). This is, in the researcher's opinion, the reason why consultation 2 has the fewest instances of overlapping turns. Figure 5.18 serves as an illustration of an overlapping turn that takes place in consultation 2 due to a common agreement between the doctor and the interpreter. This extract also demonstrates that the doctor and the trained interpreter are working together as a team, since the doctor is in fact making sure that the trained interpreter is following her as she leads the consultation. In other words, the doctor is making sure that the trained interpreter is not experiencing any problems, and at the same time, she is receiving consent from the trained interpreter that they can proceed with the consultation. This dynamic between the doctor and the trained interpreter highly contributes to the success of consultation 2 because it maintains a turn organisation between participants. As a result, only two instances of overlapping turns can be observed, when the doctor takes over the trained interpreter's turn , as observed in consultation 2 (Cf. Chapter 5 Figure 5.21). It is important to stress that these two instances of overlapping turns are due to the fact that the patient did not reply to the doctor verbally. She shook her head instead of saying *cha* (no).

In contrast to consultations 1 and 2 , consultation 3 counts the highest number of instances of overlapping turns, although it was the shortest recorded consultation (10min) compared to consultation 2 (35min) and consultation 1 (13min). And, in contrast to consultation 1 and 2, where the overlapping turns were caused by simultaneous agreement between participants or the trained interpreter's turn was taken over because the doctor and the patient had a common understanding, in consultation 3, the majority of overlapping turns are motivated by a lack of organisation as to how the consultation should take place and a power struggle between the *ad hoc* nurse interpreter and the other participants (Cf. Chapter 5 Figure 5.23 and Figure 5.25). These two factors hindered the full success of consultation 3. Contrary to the way the trained interpreter proceeded in consultation 1 and 2, in consultation 3 the *ad hoc* nurse interpreter did not brief participants to inform them of the interpreted consultation procedures

(Cf. Chapter 5 Figure 5.22). This is certainly due to the fact that the *ad hoc* nurse interpreter had never been trained to interpret professionally. Besides, no participant had ever been trained to work with a professionally trained interpreter. Thus, none of them could suggest a more effective organisation of the consultation.

The power struggle that took place between the *ad hoc* nurse interpreter and the other participants could be ascribed to the fact that the nurse was caught in between her function of nurse (thus the tendency to co-diagnose with the doctor and to ask further questions to the patient) and her *ad hoc* function of interpreter. The nurse is so exposed to cancer patients and to the effects of the different types of cancers that she seems to have lost touch with how sensitive some patients might be, and to their inner suffering. Figure 5.34 reveals how the nurse asks the patient questions on her own initiative, and ends up laughing at the patient when the latter insists that she would not look at her anus to see whether the treatment is effective. A professionally trained interpreter would not have invaded the patient's privacy and would certainly have not have laughed at the patient's sufferings by virtue of the deontology of the profession that requires impartiality from professionally trained interpreters (Cf. Roberts (1995) in Chapter 2). Hence, the invasive behaviour of the nurse, her lack of sensitivity towards the patient's expression of sufferings and the power struggle between the *ad hoc* nurse interpreter and the other participants hindered the full success of consultation 3. The next paragraph presents how the interruptions affected the recorded consultations.

6.3.4. Interruptions during consultations

Whereas two instances of interruptions were recorded in consultation 1 (Cf. Chapter 5 Figure 5.26 and Figure 5.27), ten instances of interruptions were recorded in consultation 2 (Cf. Chapter 5). In consultation 1, two individuals introduced themselves in the consultation room during the interpreted doctor-patient interview. While the first individual introduced herself in the consultation room, walked through and engaged in a personal conversation with the doctor and later, with the patient (Cf. Chapter 5 Figure 5.26), the second individual was surprised to see the recording equipment in the consultation room and engaged in a joking interaction with the doctor (Cf. Chapter 5 Figure 5.27). Hence, the recording activity did not distract the participants; it rather distracted the intruders who did not just interrupt the consultation and somehow violated the patient's privacy, but also diverted participants'

attention away from the consultation. Furthermore, such interruptions prolong the consultation time and delay the next consultations. Consequently, these interruptions are factors that hindered the full success of consultation 1.

In consultation 2, the interruptions ranged from:

- individuals opening and closing the creaking door to look at the participants during the interview,
- an individual introducing herself and walking through the consultation room, and
- the telephone ringing twice at first for 90 seconds, and the second time, for 37 seconds.

It was highlighted that in consultation 2, these interruptions happened simultaneously (Cf. Chapter 5 Figure 5.28). Whereas it could be argued that the intrusion of the woman who walked through the consultation room aimed at increasing the success of consultation 2 because she went into the room to pick up the telephone and therefore stop it from ringing, it can equally be supported that the telephone ringing and her presence in the consultation room were nonetheless intrusive and distracting to the participants. Thus, these interruptions hindered the full success of consultation 2.

Contrary to consultation 1 and 2, consultation 3 did not record any interruptions from outsiders. However, it appeared that the consultation room door was open throughout the first part of the consultation, until the doctor realised that he was about to examine the patient with the door open, and closed it (Cf. Chapter 5 Figure 5.29). It was also highlighted that perhaps no interruption happened because consultation 3 took place after consultation hours, when all patients had already been consulted and all medical staff were already either out for lunch or attending other activities in the Department. Nevertheless, the fact that the door was open during the consultation is a factor that hindered the full success of consultation 3 since the patient's privacy was breached. Thus, the interruptions observed in the three consultations confirmed Nayak et al.'s (2005) statement that departments of Oncology are exposed to real problems of absence of patients' privacy and constant interruptions during consultations; and these problems definitely hinder good communication in oncology departments (Cf. Chapter 2 and chapter 5). The next section provides findings on the use of direct versus indirect speech in the course of the three recorded consultations.

6.3.5. The use of direct versus indirect speech by participants

Whereas no use of indirect speech was recorded in consultation 2, consultation 1 had few instances of use of the indirect speech (Cf. Chapter 5 Figure 5.30 and Figure 5.31), contrary to consultation 3 which mainly took place in the indirect speech (Cf. Chapter 5).

As per figure 5.31 in chapter 5, in consultation 1, the trained interpreter accidentally refers to the patient in the third person when the latter disregarded her turn and answered the doctor directly. As a result, the trained interpreter lost her composure and referred to the patient in the third person. Contrary to this isolated case, in consultation 3, the *ad hoc* nurse interpreter and the doctor mainly refer to the patient indirectly (Cf. Chapter 5 Figure 5.32). However, it can be noticed that both the doctor and the *ad hoc* nurse interpreter were in a state of confusion, as they constantly switched between reporting a speech, requesting for a message to be reported and addressing the patient directly (Cf. Chapter 5 Figure 5.33 and Figure 5.34). Hence, with regard to the norms used by each interpreter, it can be concluded that whereas the trained interpreter follows the norms set by scholars within Interpreting Studies (Cf. Dubslaff and Martinsen (2005) in Chapter 5), the *ad hoc* nurse interpreter follows the norms of natural interpreters or lay interpreters whom, as stated by Dubslaff and Martisen (2005) use the indirect speech (third person) in liaison interpreting. Concerning which norm contributes to the success of the consultations, it was revealed that the use of the third person tends to alienate the participant who is not addressed. When the nurse addressed the patient, the doctor was isolated and vice versa (Cf. Chapter 5 Figure 5.34). Furthermore, the lack of briefing, in other words, the lack of organisation as to how the consultation would be conducted led to a lack of focus in consultation 3, since the *ad hoc* nurse interpreter asked questions on her own initiative, at the expense of causing discomfort to the patient (Cf. Chapter 5 Figure 5.34). In contrast, the fact that consultation 2 took place with a briefing at the beginning of the consultation and the use of direct speech throughout the consultation kept all participants involved in the consultation; it also contributed in keeping eye contact between participants and it allowed the doctor to reach her goal, which was to consult the patient efficiently.

The fact that the doctor and the patient in consultation 3 stated that the consultation was a success only describes the perception that individuals who receive service from an *ad hoc* untrained interpreter have since they are satisfied to have been able to communicate at all. Doctors are satisfied because they believe that they have achieved some sort of understanding

with the patient, having succeeded in consulting with the patient and providing some relief. Patients are also happy because they go home with a prescription that will alleviate their pain. Nevertheless, because they have no experience with working with a professionally trained interpreter, they lack a basis for comparison.

In consultation 2, although the doctor gave the highest rating to the trained interpreter, she stated that she did not perceive a difference between the service provided by the professionally trained interpreter and the one she used to receive from the *ad hoc* nurse interpreter. The researcher is of the of the view that the doctor's answer is not accurate because the *ad hoc* nurse interpreter would never have briefed the patient and the doctor since she does not have any professional training that would have inclined her to do so; she would not have addressed the other participants in the direct speech throughout the consultation, and she would not have preserved the organisation of the consultation the way the professionally trained interpreter did. Hence, to the researcher, it is not possible to state that there is no difference between the services received from the professionally trained interpreter, and the one received from the *ad hoc* nurse interpreter. Furthermore, the doctor from consultation 1 highlighted these differences. She affirmed that the professionally trained interpreter was more accurate and very professional (Cf. Chapter 5). Nonetheless, the doctor from consultation 2 made an important statement, which was that it is vital for professional interpreting services to be provided not to all patients, but to the patients who really need them. Her statement will form part of the recommendations made by the researcher in the next section.

6.4. Review of the researcher's presuppositions and contrast with the findings

The overarching researcher's hypothesis was that by weighing the cost of using *ad hoc* untrained interpreters against using professional interpreting services, public hospitals may realise that their expenses will be reduced as a result of more efficient communication with patients: they will need to run fewer tests on patients thanks to better diagnosis, and they will conduct better consultations which will result in having more satisfied patients and medical staff. The more patients are satisfied and are aware that their satisfaction matters to the hospital, the more people will go to the hospital for services. However, given the constraints of the present study, it was impossible to provide a clear answer to this overarching

hypothesis. Hence, the research question that was formulated to test aspects of the hypothesis at in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital was:

- Would providing trained interpreters to the Department of Radiation Oncology improve the quality of consultations compared to consultations where *ad hoc* untrained interpreters are used - will patients be more satisfied?

Owing to the scope of the present research report, this question cannot be answered accurately. It is not possible to tell whether this research has had a positive impact on patients' the level of satisfaction because only three patients took part in this study. For the research to be more conclusive, more patients should be involved. However, the patients who took part in this study shown a high level of satisfaction, although the researcher questions whether the patient who took part in consultation 3 was genuinely satisfied since in agreement with Herselman (1996), Mullin, Cooper and Eremenco (1998:75) stress that Black patients tend to

> be polite and deferential, which lead to miscommunication if patients withhold information or out of politeness, distort their situation. Politeness behaviors may cause patients to appear to agree with a health professional even when they do not agree because in such cultures patients cannot question or challenge an authority figure such as a physician (Chick, 1990; Herselman, 1996). For example, one breast cancer patient said she did not want to complain about discomfort because of feeling "ashamed of bothering the nurses

Thus, the researcher is of the view that perhaps the patient in consultation 3 did not report dissatisfaction towards the *ad hoc* nurse interpreter laughing at her for not wanting to look at her anus, and stopping her from communicating directly with the doctor on the one hand because she did not want to look impolite and on the other hand, because she has no previous experience working with an interpreter so she had no basis of comparison.

As was outlined in the literature review, it is evident that public hospitals already face a serious shortage of health care providers. It is therefore unrealistic to ask nurses to interpret as they already have a significant workload. In addition, nurses' attitudes towards interpreting are not always positive. In this regard, Levin (2006: 1077) reports that in the course of his research, he found that "forty per cent of nurses said that they were not willing to help doctors with interpreting and 35% of patients said nurses do not want to speak African languages other than their own". Nonetheless, although nurses are not trained interpreters, some nurses claim to be the best interpreters due to the fact that on the one hand, they can culturally relate to patients and on the other hand, as medical staff, they know the jargon, they

are familiar with patients' conditions and treatments therefore they can interpret better. Thus, our second research question aims at verifying this presupposition:

- How does the interpreting performance of nurses compare to that of trained interpreters? In the specific case of this study, trained interpreters refer to individuals who have undergone general interpreting training.

The present study has unveiled that in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital, although the nurses know the terminology used by the doctors and they are familiar with patients' conditions, they do not interpret better than professionally trained interpreters in the consultations that were recorded. According to the criteria set by Pöchhacker (2002:96-97) in agreement with Gile (1991) (Cf. Chapter 2 and Chapter 5), the present research report has shown that the *ad hoc* nurse interpreter was less accurate, less clear and she did not "represent fully the original speaker in his/her interests and intentions" compared to the trained interpreter. Furthermore, the *ad hoc* nurse interpreter intimidated the patient to the extent of stopping her from addressing the doctor directly, asked questions out of own interests, intruded in the patient's intimacy, laughed at the patient and did not managed to keep both the doctor and the patient involved in the consultation. All these factors hindered the full success of consultation 3. Although the trained interpreter lacked the terminology and consequently made several wording mistakes, as per the criteria set by Pöchhacker (2002:96-97) she managed to well "represent the doctors in their interests and intentions" by using body language and gestures that facilitated the patients' understanding of their conditions and to keep both doctors and patients involved and engaged in the consultations. Hence, it can be concluded that the trained interpreter provided more elements that contributed in the success of the consultations, although it is primordial to ensure that in the future, trained interpreters receive basic input in cancer and the terminology used by the medical staff in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital.

In Chapter 1, quoting Schlemmer and Mash (2006), I mentioned the consequences of the absence of a professionally trained interpreter to break the language and cultural barriers between doctors and patients: tensions between the medical staff and dissatisfaction of the medical staff towards their own service delivery, patients avoiding doctors until they reach a critical stage of illness, "errors in diagnosis and treatment" and the "non-compliance and defaulting of medication" from patients (Deumert, 2010:54). All these factors result in very poor service delivery. Hence, my third set of research questions were the following:

- Would the provision of trained interpreters to the Department of Radiation Oncology improve doctors' satisfaction with their service delivery?
- Would the provision of trained interpreters to the Department of Radiation Oncology improve nurses' work satisfaction?

Owing to the scope of the present research report, this question cannot be answered accurately. It is not possible to tell whether this research has had a positive impact on the doctor or the nurse level of satisfaction because only two doctors and one nurse took part in this study. For the research to be more conclusive, more medical staff should be involved. However, the three doctors who took part in this study also expressed high level of satisfaction with receiving interpreting services. Nevertheless, it was again noticed that the doctor in consultation 3 had no experience with working with professionally trained interpreter so he did not have a basis of comparison. One of the two doctors who could compare the service provided by the *ad hoc* nurse interpreter and the trained interpreter, the doctor in consultation 1, stated that she was highly satisfied and could see a difference in terms of accuracy and professionalism. However, although the doctor in consultation 2 gave the highest mark to the trained interpreter (10/10), she stated that there was no difference with the performance of the trained interpreter and the one of the *ad hoc* nurse interpreter; which is an answer that the researcher does not agree with since when comparing the performance of the *ad hoc* nurse interpreter in consultation 3 with the one of the trained interpreter in consultation 1 and 2, it is evident that the *ad hoc* nurse interpreter would not have briefed the participants and might not have been as accurate and impartial as the trained interpreter.

Concerning the level of satisfaction of the nurse, during the pilot study, some medical staff including several nurses informed the researcher that they did not want professionally trained interpreters to come to the Department because they were concerned about who will pay the trained interpreters, and where the funds to pay them will come from. They added that they had been interpreting in the Department for years so they could still handle that task. However, when requested to rather write down that concern in the questionnaire, very few expressed their anxiety since only one medical staff voiced that financial concern and another one rather stated that she was worried about patients' confidentiality (Cf, Chapter 4 and reports in the Appendix section). Hence, the researcher is of the opinion that some medical staff might not see the presence of professionally trained interpreters in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital as an advantage, an innovative measure to bridge communication barriers between medical staff and patient and a

solution to allow each medical staff to focus on his or her duty so as to have a faster and more efficient service delivery. At the contrary, it appears that some medical staff might feel threatened by innovation, by the presence of a new professional body within the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital. Perhaps they feel threatened because they believe that the presence of professionally trained interpreters will impede on their wage. The next section provides recommendations the provision of professional interpreting services in the Department based of the findings made in the course of this study.

6.5. Recommendations

The researcher's recommendations for the provision of professional interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Academic Hospital are the following:

1. Professional interpreting services should be provided in the Department of Radiation Oncology on a permanent basis, since this will boost the quality of the services provided in the Department (Cf. Schlemmer and Mash (2006) Leanza (2007) etc.);
2. The medical staff should be trained to work with professionally trained interpreters. The majority of the medical staff acknowledged that professional interpreting services are needed in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital; however, they have no experience with professionally trained interpreters (Cf. Tebble (2001); Angelelli (2005) etc.)
3. The medical staff members who are concerned about the presence of professionally trained interpreters being employed to bridge language and cultural barriers between the medical staff and patients could be invited to take part in a professional development workshop. This could create a platform where they can address their concerns and receive appropriate answers to their queries; and on the other hand it may give them a sense of acknowledgement so that they feel proud to be part of a positive process;
4. As part of their training to work in a setting such as the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Hospital, professionally trained interpreters must receive input as to what to expect in the Department and at least a basic lecture on cancer and the terminology frequently used in the Department.

Ideally, these interpreters should be fully trained in medical interpreting before being employed in these contexts, but this can only happen in the long term in South Africa;

5. Only professionally trained interpreters should work in the Department, as they will have a better understanding of their role and the importance of accuracy and the respect for privacy than an *ad hoc* interpreter would. Professionally trained interpreters will be sensitive and aware that they should avoid by all means hurting patients' feelings and violating their intimacy. Furthermore, there is a shortage of medical staff in South African public hospitals (Cf. Chapter 1). Using nurses, doctors and other staff members to provide *ad hoc* interpreting services whereas they should be attending to patients slows the work dynamic of the Department and may create tensions between medical staff (Cf. Chapter 1); furthermore, medical staff are unable to provide as high quality services as professionally trained interpreters can;
6. The Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital should address the cases of interruptions in order to improve on patient's privacy and doctor-patient and/or interpreted doctor-patient communication (Cf. Nayak et al. (2005) etc); and
7. Professional interpreting services should target patients who will fully benefit from these services.

6.6. Conclusion

In this chapter, I have presented the findings and recommendations from the data collected for this study. I have also reviewed the hypotheses and contrasted them with the findings. Owing to the scope of this research report, three of the hypotheses could not be verified, namely: whether the level of satisfaction of the patients, the doctors and the nurses had been improved upon in the course of this study. Only one research question could be verified, which was to determine how the interpreting performance of nurses compares to that of trained interpreters, and whether as they claimed, nurses interpret better than trained interpreters. The findings revealed that the *ad hoc* nurse interpreter did not interpret better than the trained interpreter in the sample under analysis. Thus, the researcher made seven recommendations for the provision of professionally trained interpreters and for a possible improvement of service delivery in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital.

CHAPTER 7: CONCLUSION

"Coming from a part of the world where people's willingness and ability to understand one another is at an all-time low, and breakdowns in communication between nations and cultures and religions seems to be hurtling out of control – I cannot help wishing that translators and interpreters might be more conspicuous and outspoken, and play a more active role. Then perhaps – by some miracle – they might even prove instrumental in bringing about a change." (Shlesinger, 2009:14)

This research report has explored the communication problems experienced by medical staff and patients alike in the health care sector internationally and more specifically in South Africa, a multicultural and multilingual country. It was established that in South African public hospitals, communication barriers between the medical personnel and patients lead to several problems such as very poor and even inexistent communication between the medical staff and patients, tensions rising between members of the medical staff, breaching of patients' confidentiality, cross-cultural misunderstandings, ethical dilemmas, patients turning to traditional witchdoctors or *sangomas*, only to come back to the hospital at an advanced stage of illness (Schlemmer and Mash, 2006:1076-1079 in Chapter 1), "inappropriate diagnostic investigation, lower adherence to treatment, lower rates of following up (appointment proposed and kept), poor referrals, incomplete investigations and lower rates of preventive interventions by physicians" (Leanza, 2007:11-12 in Chapter 1) to name just a few. To bridge the language barriers, public hospitals generally resort to using the services of *ad hoc* untrained interpreters namely patients' relatives including children, other medical staff members such as cleaners, security guards, fellow doctors and nurses. Occasionally, patients themselves are used as *ad hoc* untrained interpreters (Cf. Deumert (2010), Penn (2007), Kilian, Swartz and Joska (2010) etc. in Chapter 1). As a result, even more problems are encountered: breach of confidentiality, the remaining risks of misdiagnosis of patients owing to mistranslations, omissions, distortion of information in *ad hoc* untrained interpreters' interpreting renditions (Cf. Penn, Watermeyer and Evans (2011), Penn (2007) etc. in Chapter 1). Hence, numerous scholars are in agreement that professionally trained interpreters should be part of the medical team and both the medical team and trained interpreters should be trained to work together as a team to improve service delivery (Cf. Tebble (2001), Lubrano di Ciccone et al. (2009), Roy (1993) etc. in Chapter 1 and Chapter 2). Nevertheless, it became clear that the role and expectations of interpreters working in statutory services are ill-defined since some medical staff members and institutions expect interpreters to randomly and simultaneously assume the role of translator, cultural informant,

cultural mediator, advocate, bilingual professional, research assistant, counsellor, patient advocate, institutional gatekeeper, co-diagnostician, manager, coordinator of communication between patient and health professional, clarifier and/or conduit (Cf. Penn (2007), Watermeyer (2011) etc. in Chapter 1). The lack of scope of the interpreter's role, rights and duties is among others motivated by the fact that some interpreters are considered as helpers rather than professionals because in countries where the profession of interpreters working in statutory services has not been institutionalised, as in South Africa, interpreters are often untrained. Hence, for interpreters to work efficiently in the medical setting, they need to receive formal training in interpreting as well as formal training targeting the specific medical setting they are called upon to service; their role, rights and duties as well as the role, rights and duties of the institution they work with should be clarified; and finally, interpreters' status should be acknowledged and made official. It is vital that professionally trained interpreters be respected as professionals (Cf. Roberts (1997), Angelelli (2005), Niska (2002) etc. in Chapter 2).

The purpose of this research was to provide professional interpreting services to the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital. In order to achieve this goal, the first step undertaken was to review health care communication in the oncology field as well as language management in four countries where interpreting services in hospitals is an institutionalised activity. The literature review on interpreted communication in the oncology setting disclosed that in oncology departments, communication between patients and the medical staff often lacks effectiveness owing to the shortage of individual offices to ensure patients' privacy and the constant interruptions during consultations, the high rate of bad news that has to be communicated to patients which hinders medical staff from relating to patients and often, from discussing clinical trials (Cf. Butow et al. (2011), Beach et al. (2007), Nayak et al. (2005) etc. in Chapter 2). Besides, it was also revealed that interpreters working in the oncology setting are exposed to constant burnout because of their exposure to emotional distress, the absence of a working dynamic based on collaboration and cooperation with doctors which, as a result, put them in the front line to face and manage patients' distress, and the absence of debriefing at the end of interpreted consultations (Cf. Chapter 2). There is little literature available on interpreted consultations in the oncology setting in South Africa. However, the available literature pointed to the importance of folk medicine within the Black South African population, the lack of proper means of communication with the exposed populations (e.g. lack of translated

flyers in indigenous languages) as well as the weight of traditional beliefs and cultural divergences between doctors and patients (e.g. husbands deciding on their wives' treatment options within South African Black communities) (Cf. Mullin, Cooper and Eremenco (1998), Truter (2007) etc. in Chapter 2).

In order to suggest a language management model that could suit the South African oncology setting, language management and health care interpreting training in Australia, Belgium, Switzerland and the United States was reviewed. After comparison with the South African situation as regards health care, it became evident that unlike in these four countries, no professional interpreting service exists in South Africa, and there is no proper training in health care interpreting in the country either. Furthermore, unlike the National Accreditation Authority for Translators and Interpreters Ltd (NAATI) in Australia, the South African Translators' Institute (SATI) not only does not consider academic qualifications in the granting of accreditation, but also does not provide accreditation in health care interpreting in particular and in liaison interpreting in general (Cf. Chapter 3). This situation may change in future after the passing of the Council for Language Practitioners Bill (Jamal et al., 2014).

The second step that was undertaken in order to provide professional interpreting services to the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital was to conduct a pilot study that would inform the main study. The pilot study was conducted on 100 patients and 78 medical staff members. The research methodology used in the course of the pilot study consisted in: on-site observation, interview on patients and the distribution of a questionnaire to the medical staff. The goal was to profile both the patients and the medical staff linguistically and socially. The goal of the pilot study was also to determine whether the medical staff had experience with receiving interpreting services from professionally trained interpreters and to gather their opinion regarding the implementation of professional interpreting services in the Department (Cf. Chapter 4). The pilot study revealed that the majority of patients attending the Department are from the working class, with many of them being either retired or unemployed. Although the patients were mainly of African origin, when asked what language they would prefer to speak with the doctors during an interpreted consultation, to the surprise of the researcher, the pilot study disclosed that the majority of patients preferred to speak English with the doctors, though some of them did not have a level of English literacy that would have allowed them to communicate effectively with doctors in English. In other words, the pilot study disclosed that the majority of patients shifted from speaking their first language to a language that seems to carry more social value.

One of the limitations of this study was the fact that patients' level of literacy in the language they claimed to know could not be formally evaluated. Most patients claimed to have a first language level of literacy in English and were therefore rated as English A speakers based on this perception. Nonetheless, the researcher is of the view that should a formal language test have been conducted on patients, the results regarding patients' English literacy would have been radically different, which would have made a substantial difference to this study (Cf. Chapter 4 and Chapter 6).

The part of the pilot study focusing on the medical staff confirmed that the linguistic profiles of the majority of doctors are different linguistically, culturally and socially from patients' linguistic profiles, as most of the medical staff is English speaking, contrary to the majority of patients who were Zulu speaking (Cf. Chapter 4 and Chapter 6). The pilot study confirmed that the medical staff has extensive experience with working with *ad hoc* untrained interpreters; only two of the staff members who took part in the pilot study claimed to have previously consulted with a professionally trained interpreter. The pilot study also revealed that the majority of the medical staff is of the opinion that professional interpreting services are needed in the Department. However, many nurses did not share that opinion as they verbally informed the researcher that they had been interpreting in the Department for years and they were better interpreters than professionally trained interpreters, therefore they were not in favour of interpreters working in the Department. Some of them were also anxious that the presence of interpreters in the Department would negatively affect their wage and queried who would be in charge of remunerating the interpreters working in the Department. When asked to report their views in the distributed questionnaire, very few nurses and medical staff raised these concerns in writing. Nonetheless, the pilot study was conclusive: professional interpreting services were requested by the majority of the medical staff, so the researcher could undertake the main study. But since some nurses had claimed to be better interpreters than trained interpreters, the researcher undertook to verify that assertion as part of her main study. Hence, one of the research questions of this research report was to ascertain whether nurses interpret better than professionally trained interpreters.

The methodology used as part of the main study consisted of: video and tape recording three interpreted doctor- patient consultations, transcribing the recordings, analysing the transcription with Conversation Analysis (CA) and analysing the feedback questionnaires distributed to participants. The questionnaires were designed for the three clusters of participants involved in the main study: the doctors, the patients and the interpreters. Two of

these recordings included a trained interpreter who had received introductory training in liaison interpreting at Wits Language School. She first interpreted in the gynaecological cancer clinic and then in the head and neck cancer clinic of the Department. The last recording included an *ad hoc* nurse interpreter, one of the nurses who is usually called upon to interpret for doctors from and into Zulu. The third consultation took place in the prostate cancer clinic, although ironically, the patient was a woman (Cf. Chapter 5 and Chapter 6).

The video and tape recording of these three consultations was followed by a transcription of the three recordings with the transcription software *f4 2012*. The researcher was assisted by a Zulu transcriber who transcribed the Zulu messages and provided back translations into English. The transcriptions were then analysed using CA as the main method of analysis (Cf. Chapter 5). The analysis of the interpreted doctor-patient consultations using CA focused on six specific aspects: turn length, overlaps, interruptions during consultations, the use of direct versus indirect speech in the consultation, and the kinesic elements which include the positioning of participants. The video recordings enabled the analysis of the kinesic elements (Cf. Chapter 5).

With regard to turn length, it was found that in the consultations involving the trained interpreter, turns were short when the doctors were querying about patients' state of health but they were longer when doctors when giving guidance and recommendations. In the consultation involving the *ad hoc* nurse interpreter, in general, turns were short. It is plausible to believe that when turns are short, interactions are smoother and overlapping turns are unlikely to happen. However, the study revealed that although the consultation involving the *ad hoc* nurse interpreter had short turns it also recorded the highest instances of overlapping turns (48 instances of overlapping turns in 10 min of consultation), whereas consultation 2 involving the trained interpreter in the head and neck cancer clinic had the longer turns but recorded the lowest instances of overlapping turns (14 instances of overlapping turns in about 35 min of consultation). The reason for this dichotomy is that whereas consultation 3 involving the *ad hoc* nurse interpreter was filled with interruptions mostly motivated by the fact that the nurse was acting as a co-diagnostician to the doctor and often interrupted the doctor and the patients as they were speaking, in consultation 2, the trained interpreter and the doctor worked together in a spirit of collaboration and partnership as the doctor was waiting for a sign from the trained interpreter indicating that her turn was over, and vice versa (Cf. Chapter 5 and Chapter 6). Consultation 1 involving the trained interpreter working in the gynaecological cancer clinic recorded 17 instances of overlapping turns in about 13 min of

consultation, and these overlapping turns were mostly motivated by the fact that the doctor and the patient often took over the trained interpreter's turn. The trained interpreter's turns were taken over when the patient answered directly to the doctor in English and when the doctor understood the patient's answer (either because she answered in English, or because she nodded) and thus did not let the trained interpreter speak (Cf. Chapter 5 and 6). It was found that the patient and the doctor tend to take over the trained interpreter's turn because on the one hand they don't know how to work with a trained interpreter and on the other hand, the patient understood English to a certain extent and enjoyed connecting with the doctor whenever she had understood the question and she felt that her level of English could allow her to provide an answer. Her direct answers in English to the doctor were usually limited to yes or no answers. When she had to elaborate more, the patient switched to Zulu as it became easier for her to express herself in her first language (Cf. Chapter 5 and 6).

Concerning the cases of interruptions during consultations, Nayak et al.'s (2005) (Cf. Chapter 2, Chapter 5 and Chapter 6) statement that doctor-patient communication in the oncology setting is hindered by frequent interruptions was confirmed to be true, since all consultations were interrupted either by the door being frequently opened by some unidentified intruders, by some medical staff introducing themselves in the consultation room during the interviews, by the telephone constantly ringing or by the medical staff forgetting to close the door before starting the consultation (Cf. Chapter 5 and Chapter 6). It is therefore vital that the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital address these interruptions in order to improve on patient privacy and on doctor-patient communication as well as interpreted doctor-patient communication.

With regard to the use of direct versus indirect speech, it was found that whereas the doctor and the *ad hoc* nurse interpreter mostly used indirect speech, the trained interpreter mostly used the direct speech. Whereas consultation 2 entirely took place in the direct speech in consultation1, there were few instances during which the trained interpreter used the indirect speech, although they were mostly motivated by the fact that her turn had been taken over and she lost her composure. The consequences of using indirect speech in consultation 3 involving the *ad hoc* nurse interpreter was that whenever the nurse was addressing one participant, the other participant was alienated and felt almost isolated. Contrary to the consultations involving the trained interpreter, in consultation 3 where the *ad hoc* nurse interpreter was interpreting, the participants were not all equally involved in the communication process. This factor was found to hinder the full success of consultation 3.

With respect to the analysis of the kinesic elements, the main study revealed that the nurse's positioning also hindered the full success of consultation 3, since she was standing throughout the consultation while the doctor and the patient were sitting, she started the consultation with her hands crossed over her chest, she spoke louder than the patient so as to silence her when the latter wanted to address the doctor directly in English and she laughed at the patient when the latter told her that she would not look at the change of skin on her anus as she was undergoing radiation in that area (Cf. Chapter 5 and 6). By contrast, in consultation 1 involving the trained interpreter, the doctor faced the patient and could therefore have eye contact with her and build a personal relation with the patient. The trained interpreter was sitting next to the patient, but not in a way that could impact on the relationship that was built between the doctor and the patient. The camera was standing behind the patient not just to keep her identity confidential, but also not to impede her. However, in consultation 2, the doctor and the patient changed their position after the camera had been installed. As a result, the doctor was not in the camera view and the patient was facing the camera. Consequently, the patient was visibly trying to collect her emotions because she saw that she was being recorded. This factor hindered the full success of the consultation, although the consultation did succeed thanks to the fact that both the doctor and the trained interpreter used body language and visual aid to assist the patient in understanding their messages, and the turn-taking order of the consultation was very well organised.

Hence, the main study provided an answer to whether in the setting in which this research was conducted; nurses interpret better than trained interpreters. This research helped to shed light on the fact that *ad hoc* untrained nurse interpreters are unlikely to interpret better than trained interpreters, since as reflected in this study, although the trained interpreter was lacking the oncology terminology and knowledge, her interpersonal skills, linguistic skills, kinesic awareness and interpreting skills helped her to ensure a good communication dynamic between all participants; whereas the *ad hoc* nurse interpreter had the oncology terminology and knowledge, but she lacked all these skills that were primordial for the success of an interpreted doctor-patient communication (Cf. Chapter 5 and 6).

The other research questions which could not be fully answered given the scope of this research were as follows:

- To determine whether the provision of trained interpreters to the Department of Radiation Oncology would improve the quality of consultations compared to

consultations where *ad hoc* untrained interpreters are used - will patients be more satisfied;

- To determine whether the provision of trained interpreters to the Department of Radiation Oncology would improve doctors' satisfaction with their service delivery; and
- To determine whether the provision of trained interpreters to the Department of Radiation Oncology would improve nurses' work satisfaction

These research questions could not be fully answered given the constraints of this research report, although all participants provided a positive review on the interpreting services they received, especially doctors who received interpreting services from the trained interpreter (Cf. Chapter 5 and Chapter 6). The researcher highlighted that the high level of satisfaction expressed by participants in consultation 3 provided an interesting insight into the perception of those who receive services from *ad hoc* untrained interpreters, as they seem to be satisfied with even a low level of communication and they do not seem to realise that quality wise, interpreted communication involving *ad hoc* untrained interpreters is very poor. Furthermore, the fact that they had no experience in working with professionally trained interpreters biased their judgement, which is possibly also part of the limitations of this study.

This study was also limited not only by the inability to test formally patients' level of literacy in the numerous languages they had claimed to know, but also by the African etiquette which possibly prohibited African patients and medical staff including the nurses from expressing their complaints in writing (Cf. Mullin, Cooper and Eremenco (1998:75) in Chapter 2 and Chapter 6). These areas therefore call for further research.

To conclude, this study provides a first attempt and a small step forward to determine possible solutions to miscommunication in the South African health care setting in general and an oncology setting in particular, from the perspective of Interpreting Studies.

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APPENDIX A



Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital

Interview conducted during the pilot study on patients

(6-11 December 2012)

Questions asked:

- What is the patient's mother tongue
- How would the patient describe his/her level of literacy in his/her mother tongue
- What are the additional language(s) s/he knows
- What is his/her level of literacy in the language(s) listed
- What is the patient's preferred language during consultations
- What is his/her occupation and
- In which cancer clinic where s/he was admitted in

- The patient was asked for his/her origin when the researcher was not familiar with his/her mother tongue.

APPENDIX B



Wits Language School
Expert Language Solutions



Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital

Staff Questionnaire used during pilot study

1- Interviewee's name[31]

_____

2- You are a

□ Hospital porter □Radiation therapist □Medical physicist □Doctor
□ Cleaner □consultant □Clerk □ Registrar

□ Nurse □ Manager

If your function is not listed, please state what it is: _____

3- Mother tongue: _____

4- Do you speak some other languages? □Yes □No

If yes, please which one(s)?

_____

_____

5- Have you ever used the other languages you know to consult, treat or receive a patient? □Yes □No

6- Is it something that the hospital expects of you to do? □Yes □No

7-Is it part of your contract with the hospital? □Yes □No

8-Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient? □Yes □No

[31] The interviewee's name is not compulsory and will neither be used by the researcher nor in any of her documents. It is required to assist the Department building a database of the languages spoken by staff members.

9- Have you ever interpreted for a doctor or a patient? □Yes □No

If yes, have you ever received a training in interpreting? □ Yes □No

If yes, was it part of your medical training? □Yes □No

10-Has a colleague or another staff of the hospital ever helped as an interpreter for you? □Yes □No

If yes, did the outcome give you satisfaction? □Yes □No

Why?

11-Has an interpreter ever assisted you in consulting, treating or receiving a patient?

□Yes □No

If the answer is "Yes"

11. a- How often? □Once □Twice □A couple of times □Very often □Many times

11. b- Was the interpreter provided by the hospital? □ Yes □No □Sometimes

If yes,

Was it a professional interpreter? □Yes □No □Sometimes

If the answer is "No", who was that interpreter?

_____

Were you satisfied with the consultation? □Yes □No □Sometimes

Please state why

12. Do patients bring their interpreters? □Yes □No □Sometimes □Always

12.a-Are they professional interpreters? □Yes □No □Sometimes □Always

If the answer is "No" or "Sometimes"

Who are these interpreters to patients?

_____

12.d-Were you satisfied with the consultation? □Yes □No □Sometimes

Please state why

13- Have you ever been trained to work with an interpreter? □Yes □No

14-Does the hospital have a database of interpreters it works with?

□Yes □No □I do not know □I am not allowed to tell

15-How long does it take you to consult, record or attend a patient?

_____

Are you satisfied with that timing? □Yes □No

Please state why

16- What are the languages that hinder the dynamism of your work?

17- Studies have shown that working with professional interpreters is financially rewarding to institutions. What do you think?

18-Will it be useful for hospitals to work with interpreters?

□Yes □No

Why?

19-Is the hospital applying any language policy?

□Yes □No □ I do not know

If yes, please could you indicate which one(s)?

Thank you very much for your time! ☺

Your signature Date and time:

APPENDIX C

Providing health care interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital.

Participant Information Sheet

Dear participant,

My name is Mbwéli Ndachi. I am a Masters student in Interpreting at the University of the Witwatersrand. I am inviting you to take part in the present research study. It is part of the research report supported by the University of the Witwatersrand for Masters Program. Before you decide whether or not to take part, I would like to explain why the research is being conducted and what it involves. Please take time to read the following information carefully.

What is the purpose of the study?

The purpose of this study is to create a partnership between Wits Language School (WLS) and the Department of Radiation Oncology at Charlotte Maxeke Johannesburg Academic Hospital. The main goal is that WLS may provide trained interpreters (mostly interpreting students) so that patients coming to the Department consult with doctors in the language they feel more comfortable with. The Department of Radiation Oncology may give basic medical courses so that trained interpreters familiarise themselves with what the medical team does.

I hope that through this study, patients will be empowered. They will be able to communicate better with the medical team; the medical team will be able to better assist patients and students will gain experience.

Why I am invited to participate in this research?

You are invited to participate in this research because as

- the patient
- the escort assisting the patient
- the relative assisting the patient
- the friend assisting the patient or
- a member of the medical team

You play an important role in the consultation. It is therefore thanks to you that I will be able to identify the possible communication challenges that happen during consultations; and it is through you that I will be able to identify the possible solutions. This is why I am asking you permission to videotape your consultation.

Are there any exclusion criteria?

No, there are no exclusion criteria. This information sheet will be read to participants who would like it to be read to them. It will also be sight translated/explained to those who would like to understand its content in the language they best understand, provided that they can be assisted in that language.

Once I take part, can I change my mind?

Yes! There are no immediate benefits to you from participating in this study. Your participation is voluntary. Your refusal to participate involves no penalty from the Department or denial to receive services from the Department.

The decision to take part in this study or not is entirely yours. If you do decide to take part, this information sheet will be given to you to keep and you will be asked to sign a consent form. Please be aware that afterwards, if any misunderstanding or ambiguity arises, the research does not involve treatment and/or payment. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

Will what I say in this study be kept confidential?
This research treats participants anonymously. Records that identify you will be available only to people working on the study. All the information that you will provide will strictly be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly. (All of these people are required to keep your identity confidential.)

What personal information will be required from me?
Your participation contributes in improving the quality of communication between the medical team and patients. For that I need your permission to videotape your consultation with the medical practitioner. Please note that you might feel discomfort due to consulting in front of a video camera. This is why I guarantee you that all shared information will be strictly kept confidential.

How long will it take?
Just the time of your consultation. Please keep in mind that you can withdraw from the study any time.

What will happen to the results of this research study?
The results of this research study will be used in my Masters Research report. Wits dissertations and theses are available on the world-wide-web. A summary of the research will be made available to you should you request it.

I have some more questions who should I contact?
Should you have any question, please contact me:
Mbwéli Ndachi
Tel: 011 717 5488
Email: mbwelindachi@yahoo.fr
Or my supervisor:
Dr Kim Wallmach
Tel: 011 717 3771
Email: Kim.Wallmach@wits.ac.za

What if I am not happy with how the research was conducted?
If you have any concern or dissatisfaction with the way the research was conducted, please contact Ms Anisa Keshav, Wits research office.
Tel: 011 717 1.234
Email: anisa.keshav@wits.ac.za

Thank you 23 January 2013

APPENDIX D





INFORMED CONSENT FORM

I hereby agree to participate in research on *Providing health care interpreting services in the Department of Radiation Oncology, Charlotte Maxeke Johannesburg Academic Hospital.*

I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term. I understand that my participation will remain confidential.

……..
Signature of participant Date:……..

CONSENT FOR VIDEOTAPING

I hereby agree to the videotaping of my participation in the study.

……..
Signature of participant Date:……..

I understand that the information that I provide will be stored electronically and will be used for research purposes now or at a later stage.

……..
Signature of participant Date:……..

APPENDIX E

Interview to be conducted with patients after having received interpreting services during a medical consultation:

1- Are you happy that you received interpreting services during your consultation?

2- How would you rate/describe the interpreting service you just received?

□Very good □good □average □ bad □very bad

3- Was the communication with the doctor successful as regards understanding each other's language?

4- Are you satisfied with the way the interpreter worked?

5- What did you like about the way the interpreter worked?

6-What do you think the interpreter could have done better?

7-Would you be happy for the same interpreter to provide his/her service to you again next time?

8- Have you ever received interpreting services before today by a) a family member b) a nurse c) a trained interpreter?

9- If yes, how would you compare the interpreting service you received today to your previous experience(s)?

10-Do you think that it will benefit you or other patients to have access to interpreting services when you consult with the doctor?

11- Would you like to make any additional comments about your experience?

APPENDIX F

Interview to be conducted with medical practitioners after having received interpreting services during a medical consultation:

1- Are you satisfied that you received interpreting services during your consultation with the patient?

2-, How would you rate the interpreting service you just received? On a scale of 1 to 10, 1 being disappointing and 10 being excellent?

3- Was the communication with the patient successful in removing the language barrier?

4- Are you satisfied with the way the interpreter worked?

5- What did you like about the way the interpreter worked?

6-What do you think the interpreter could have done better?

7-Would you be happy for the same interpreter to provide his/her service to you again next time?

8- Have you ever received interpreting services before today by a) a family member b) a nurse c) a trained interpreter?

9- If yes, how would you compare the interpreting service you received today to your previous experience(s)?

10-Do you think that it will benefit you or other medical practitioners to have access to interpreting services when you consult with the patient?

11-Do you think that it will improve your work satisfaction to have access to interpreting services when you consult with the patient?

12- Would you like to make any additional comments about your experience?

APPENDIX G

Interview to be conducted after an interpreter has provided his/her service to a doctor and patient:

1- How would you rate/describe the interpreting service you just provided? On a scale of 1 to 10, 1 being very bad and 10 being excellent?

2- In your opinion, was the communication between the doctor and the patient successful?

3- Are you satisfied with the service you rendered? Please justify

4- What are the points you are satisfied about?

5- What are the points you are not satisfied about?

6- What would have increased your satisfaction with your overall performance?

7-What do you think your role was during the consultation?

8-Do you think that the doctor understood your role? Please justify.

9-Do you think that the patient understood your role? Please justify.

10- How do you think that consultations could be improved when your service is requested?

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
1	F	English	A	A	English	A	A	English Afrikaans, German and Spanish	C, B, B	XXX	San 0003	XXX (looked Middle class)	Gynae
2	F	English	A	A	English	A	A	English and Afrikaans	A	A	San 0003	Unemployed	Breast
3	M	Afrikaans	A	A	English	F	F	Afrikaans and English	F	F	San 0003	Unemployed	Head and Neck
4	F	Sesotho	A	A	English	C	C	Sesotho and English	C	C	San 0001	Babysitter	Breast
5	F	isiNdebele	A	A	English	A	A	isiNdebele and English	A	A	San 0001	Part time worker-Any job	Breast
6	F	Sesotho	A	A	English	C	C	Sesotho and English	C	NA	San 0001	Unemployed	Breast
7	F	Sesotho	A	A	Sesotho	A	A	Sesotho and Setswana, English	A,A	C,C	San 0001	Student	Breast
8	F	SiSwati	A	A	XXX	XXX	XXX	SiSwati, English and isiZulu, isiXhosa (only speak)	A,A		San 0001	Pensioner	Gynae
9	F	isiXhosa	A	A	English (A/A) and isiXhosa			isiXhosa, isiZulu and English; Sepedi (only speak)	A,A		San 0001	Unemployed	Breast
10	F	isiZulu	A	A	English	A	A	isiZulu, Sesotho, English and isiXhosa; Setswana (only speak);Xitsonga (Speak and read only)	A,A		San 0001	Unemployed	Breast
11	F	Lingala	XXX	XXX	French	XXX	XXX	Lingala, French and English	F,F		Congolese 0001	Unemployed	Breast
12	M	Afrikaans	A	A	Setswana and Afrikaans	A	A	Afrikaans, English, Setswana	A,A		San 0003/0001	Pensioner (used to work in bank)	Head and Neck

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
13	F	Portuguese	A	A	Portuguese			Only portuguese	A	A	Portuguese/San 0002	Pensioner	Breast
14	F	Setswana	A	A	English (A/A) and Setswana			Afrikaans (read and speak only), Setswana, English and isiZulu (A/A)			San 0001	Unemployed	Gynae
15	F	isiZulu	A	A	English (A/A) and isiZulu			isiZulu and English (A/A) Sesotho (F/F)			San 0001	Unemployed	Gynae
16	F	isiZulu	A	C	English	A	A	Sesotho (speak but cannot write) Afrikaans (write do not speak much), isiZulu (A/C), English (A/A)			San 0001	Student	Breast
17	F	Sesotho	A	A	English but Sesotho would be better	B-	B-	isiXhosa (fair in writing and speaking), Sesotho (A/A), English (B-/B-)			San 0001	Unemployed	Gynae
18	F	Sesotho	A	A	Sesotho			Sesotho (A/A) English (C/C)			San 0001	Unemployed	Leg
19	F	Setswana	A	Not anymore	Setswana			English (understand and can respond to a certain extend), isiZulu (but not that much) Setswana (A/NA)			San 0001	Pensioner	Breast
20	F	English	A	A	English			Afrikaans (can understand, not speak)			San 0002	Pensioner	Breast

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
21	F	Italian	A	A	Italian			Italian (A/A) and English (F/F)			Italian/ maybe San 0002	Pensioner	Breast
22	F	Sepedi	A	B-	English (A/A) and Sepedi			isiZulu (fair), isiXhosa (only spoken), Afrikaans (cannot write), Setswana (hear and speak), SiSwati (speak only), Sesotho (Speak only), Xitsonga (only speak), Sepedi (A/B-) and English (A/A)			San 0001	Student	Breast
23	F	isiZulu	A	A	isiZulu			isiZulu (A/A), isiXhosa (fair) English (good)			San 0001	Unemployed	Breast
24	F	Afrikaans	A	A	Afrikaans			Afrikaans and English	A	A	San 0002	Housewife	Gynae
25	F	isiNdebele	A	A	English	A	A	isiNdebele and English (A/A), Shona (speak only)			Zimbabwe 0001	Nurse	Gynae
26	F	Afrikaans	B	B-	English	B	B	Afrikaans and English			San 0003	Unemployed	Gynae
27	F	Sesotho	A	NA	isiZulu	A	A	Sesotho and isiZulu			San 0001	XXX	Breast
28	M	isiZulu	A	A	English	A	A	Sesotho (speak only), isiZulu, English and isiXhosa (A/A), SiSwati (speak only)			San 0001	Pensioner	Leg
29	F	English	A	A	English			Afrikaans, English and isiZulu (A/A)			San 0001	Pensioner (used to be a clerk in a bank)	Breast
30	F	Setswana	A	A	Setswana			Setswana, English and Northern Sesotho (A/A)			San 0001	Unemployed	Breast

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
31	M	Sesotho	A	A	English (A/A), Afrikaans (A/A) and Sesotho			isiXhosa (speak only), isiZulu&Setswana (write a little), Sepedi (read and write), Sesotho, English and Afrikaans (A/A)			San 0001	Pensioner	Leg
32	F	English	A	A	English			English, Afrikaans, isiZulu and isiXhosa (A/A)			San 0003	Pensioner	Breast
33	F	Afrikaans	A	A	Afrikaans			Afrikaans (A/A) and English (B/C)			San 0002	Pensioner	Breast
34	F	Sesotho	(speak only)		isiZulu (speak only)			Sesotho and isiZulu			San 0001	Pensioner	Breast
35	F	Sepedi	A	A	Sepedi			Only Sepedi			San 0001	Pensioner	Breast
36	F	Afrikaans and English	AA	AA	Either or			Afrikaans and English			San 0002	Invoice clerk in a company	Breast
37	F	Afrikaans	A	A	Afrikaans			Afrikaans and English			San 0002	Pensioner	Breast
38	F	Afrikaans and English	AA	AA	English			English and Afrikaans			San 0003	Pensioner	Breast
39	F	Setswana	A	A	Setswana			Setswana (A/A), isiZulu (speak and write) and English (read and write)			San 0001	Unemployed	Gynae
40	F	isiZulu	A	A	English and isiZulu			isiZulu (A/A), Setswana (can only speak), English (A/C)			San 0001	Unemployed	Children

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
41	F	isiZulu	A	A	isiZulu			Sesotho (can only speak), isiZulu and English (A/A)			San 0001	Part-time waitress	Breast
42	F	English	A	A	English			English and Afrikaans	A	A	San 0002	Pensioner	Breast
43	F	Afrikaans and English	AA	AA	Afrikaans			Sesotho (can only speak), English and Afrikaans			San 0003	Pensioner	Head & Neck
44	F	Sesotho	A	NA	English and isiZulu			Sesotho, English and isiZulu (A/A)			San 0001	Unemployed due to sickness	Gynae
45	M	isiZulu	A	A	English	A	A	isiZulu, Xitsonga and isiXhosa (can only speak)			San 0001	Cleaner	Head & Neck
46	F	Xitsonga	A	A	Xitsonga			Xitsonga, Sesotho and English (A/A)			San 0001	Pensioner	Breast
47	F	isiZulu	A	A	English	A	A	Sepedi and Sesotho (talk and read); Afrikaans (speak only); isiZulu and English			San0001	Domestic worker	XXX
48	F	Xitsonga	Can speak	Blind patient	Xitsonga			Xitsonga, isiZulu and Sesotho (speak only)			San 0001	Pensioner	Gynae
49	M	isiXhosa	A	A	English	A	A	Sesotho and Afrikaans (speak only); isiXhosa and English			San 0001	Recycler	Head and Neck
50	M	English	A	A	English			Only English			San 0002	Pensioner	Head and Neck
51	M	Sepedi	A	A	Sepedi			English (not that well) and Sepedi			XXXX 0001	Cleaner	Head and Neck

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
52	M	isiZulu	A	NA	isiZulu			isiZulu and Sesotho	A	NA	San 0001	Pensioner	Head and Neck
53	F	Xitsonga	A	A	Xitsonga			Xitsonga, English (A/A), Afrikaans (A/A), isiZulu (A/A) and Sesotho (A/A)			San 0001	Recycling	Gynae
54	F	Tshivenda	A	A	Tshivenda			Tshivenda, English (speak& write), Xitsonga, isiZulu, Sepedi (Speak only)			San 0001	School headmaster	Gynae
55	M	English	A	A	English			Afrikaans (not as good as his English) and English			San 0002	Pensioner	Head and Neck
56	F	Sepedi	A	A	Sepedi			Sepedi, Sesotho and English (A/A)			San 0001	General Assistant	Gynae
57	M	Setswana			Setswana			Setswana only			San 0001	Beads artist	Head and Neck
58	F	Afrikaans	A	A	English	A	A	English and Afrikaans			San 0003	Unemployed	Gynae
59	M	English	A	A	English			English and Afrikaans	A	A	San 0002	Pensioner	Head and Neck
60	F	isiZulu			isiZulu			isiZulu only			San 0001	Unemployed	Gynae
61	M	Kegoundi	A	A	Kegoundi/ French (A/A)			French, Swahili (speak only) and Kegoundi			Burundi 0001	Student	Head and Neck
62	M	isiXhosa	A	A	English or isiXhosa			English and isiXhosa	A	A	San 0001	Unemployed	Head and Neck
63	F	Sesotho	A	NA	Sesotho			Sesotho and Afrikaans (speak only)			San 0001	Pensioner	Head and Neck
64	M	isiXhosa	A	A	English	A	A	isiXhosa and isiZulu (A/A) and Sepedi (speak only)			San 0001	Administrator	Spinal

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
65	F	isiZulu	A	A	English and isiZulu	A	A	isiZulu, English, Sesotho (write and speak) Setswana (speak only)			San 0001	Domestic worker	Gynae
66	M	Sesotho	A	A	English	A	A	isiZulu and Setswana (A/A)			San 0001	Pensioner	Head and Neck
67	F	English and Afrikaans	AA	AA	English			English and Afrikaans only			San 0003	Pensioner	Gynae
68	F	English	A	A	English			English and Afrikaans (a little bit)			San 0001	Housewife	Lung
69	F	Xitsonga	A	A	Any of the language the patient can speak			Xitsonga, English, isiZulu, Sesotho and Afrikaans (A/A)			San 0001	Unemployed	Gynae
70	F	Sesotho	A	A	English, Sesotho if available	A	A	Sesotho and Afrikaans (A/A); isiXhosa (a bit)			San 0001	Unemployed	Gynae
71	M	isiZulu	A	A	English	A	A	isiZulu, English and Xitsonga (A/A); Tshivenda, Sesotho amd Setswana (speak only)			San 0001	Pharmacist assistant	Head and Neck
72	F	isiZulu	A	A	English	A	A	isiZulu and English			San 0001	Unemployed due to sickness	Gynae

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
73	F	Setswana	A	NA	Setswana			Setswana; English and Tshivenda (A/A); isiZulu and Xitsonga (only speak)			San 0001	Cleaner	Head and Neck
74	F	isiXhosa	A	A	English	A	A	isiXhosa, English, Sesotho and isiZulu (A/A)			San 0001	Unemployed	Gynae
75	F	Sesotho	A	A	Sesotho			Sesotho and isiZulu (A/A) and English (speak, do not write well)			San 0001	Unemployed	Gynae
76	F	Sesotho	A	A	Sesotho			Sesotho and English (speak only)			San 0001	Unemployed	Gynae
77	F	isiXhosa	A	A	isiXhosa			isiXhosa, English and isiZulu (A/A); Sesotho (can write), Afrikaans (speak only)			San 0001	Pensioner	Gynae
78	F	Sesotho	A	A	English	A	A	Sesotho and English (A/A); Afrikaans (write and speak a bit), isiZulu and isiXhosa (speak only)			San 0001	Domestic worker	Breast
79	F	isiZulu	A	A	isiZulu			isiZulu, English (A/A); Sesotho and Afrikaans (not very well)			San 0001	Domestic worker	Gynae
80	F	Setswana	A	A	Setswana			Setswana and English (A/A)			San 0001	Unemployed	Stomach
81	F	Sesotho	A	A	Sesotho			Sesotho and Setswana (A/A); English and Afrikaans (can understand but hardly speaks)			San 0001	Pensioner	Gynae

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
82	F	Setswana	A	A	Sesotho	A	A	Setswana and Sesotho (A/A); isiZulu and English (not very well; can understand and speak a little bit)			San 0001	Pensioner	Gynae
83	M	Xitsonga (Maputo)	A	XXX	Xitsonga and Portuguese			Xitsonga (Maputo) and Portuguese	A	A	Mozambique 0001	???	???
84	F	Sesotho	A	A	Sesotho			Sesotho; isiZulu, isiXhosa (not well)	C	C	San 0001	Unemployed	Gynae
85	M	isiZulu	A	A	English and isiZulu	A	A	isiZulu and English (A/A); Sesotho and isiXhosa (more or less)			San 0001	Unemployed	Head and Neck
86	F	Afrikaans	A	A	Afrikaans			Afrikaans and English (English not as good as her Afrikaans)			San 0002	Administrator	Gynae
87	M	Xitsonga (Maputo)	A	A	Portuguese	A	A	Portuguese and Xitsonga (Maputo)			Mozambique-Albinos	Unemployed	Head and Neck
88	F	Afrikaans	A	A	English	A	A	Afrikaans and English			San 0002	Pensioner	Gynae
89	F	Tshivenda	A	A	English	A	A	Tshivenda, English Portuguese and Xitsonga (A/A); isiZulu, Sesotho, isiXhosa (speak only)			San 0001	Work in the pharmaceutical industry	Gynae

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
90	F	isiXhosa	A	A	English and isiXhosa			English and isiXhosa			San 0001	Domestic worker	Gynae
91	F	isiXhosa	A	A	English and isiXhosa (both)			isiXhosa and English (A/A); isiZulu and Sesotho (speak only)			San 0001	Nurse	Gynae
92	M	isiNdebele	A	A	English	A	A	isiNdebele and English (A/A) and Sepedi (speak only)			San 0001	Handyman	Head and Neck
93	F	Setswana	A	A	Any of the language the patient can speak			Setswana, isiZulu, English, Sesotho, Xitsonga (a/A)			San 0001	Teacher	Gynae
94	F	Sesotho	A	A	English	A	A	Sesotho and English			San 0001	Unemployed	Breast
95	F	Afrikaans	A	A	English	A	A	Afrikaans and English			San 0003	Housewife	Gynae
96	F	isiZulu	A	A	isiZulu			isiZulu and English (A/A) and Sesotho (speak only)			San 0001	Unemployed	Gynae
97	F	Setswana	A	C-	isiZulu	A	C	Setswana, English, isiZulu, Xitsonga			San 0001	Unemployed	Gynae
98	F	isiZulu	XXX	XXX	isiZulu			isiZulu and English			San 0001	Pensioner	Leg

Appendix H - Patient study: Language Proficiency

Patient number	Gender	First Language	Proficiency	Literacy	Preferred language	Proficiency	Literacy	Additional language(s) known by patient	Proficiency	Literacy	Patient's origin	Income classification	Clinic
99	M	Xitsonga	A	A	English and Xitsonga (if available)	A	A	Xitsonga, Setswana, Sesotho, English (A/A)			San 0001	Pensioner	Head and Neck
100	M	isiZulu	A	A	isiZulu			isiZulu, Afrikaans, Sepedi and English (A/A)			San 0001	Pensioner	Head and Neck

Appendix I - Additional languages known by patients

Patient number	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
1	Y	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N
2	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
4	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
5	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
6	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
7	N	Y	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
8	N	Y	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
9	N	Y	N	N	N	N	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N
10	N	Y	N	N	N	N	Y	N	N	N	N	N	Y	Y	N	N	N	N	N	Y	N
11	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
12	N	Y	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
13	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
14	Y	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
15	N	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
16	Y	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
17	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
18	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
19	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
20	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
21	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
22	Y	Y	N	N	N	N	Y	Y	N	N	N	N	Y	Y	N	Y	N	N	N	Y	N
23	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
24	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
25	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N
26	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
27	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
28	N	Y	N	N	N	N	Y	N	N	N	N	N	Y	N	N	Y	N	N	N	N	N
29	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
30	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
31	Y	Y	N	N	N	N	Y	Y	N	N	N	Y	N	Y	N	N	N	N	N	N	N
32	Y	N	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
33	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
34	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
35	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
36	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
37	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
38	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
39	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
40	N	Y	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
41	N	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
42	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
43	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N

Appendix I - Additional languages known by patients

Patient number	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
44	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
45	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	Y	N
46	N	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
47	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N
48	N	N	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
49	Y	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
50	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
51	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
52	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
53	Y	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
54	N	Y	N	N	N	N	N	Y	N	N	N	Y	N	N	N	N	N	N	N	Y	N
55	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
56	N	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
57	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
58	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
59	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
60	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
61	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N
62	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
63	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
64	N	N	N	N	N	N	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N
65	N	Y	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N	N
66	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
67	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
68	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
69	Y	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
70	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
71	N	Y	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	Y	Y	N
72	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
73	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	Y	Y	N
74	N	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
75	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
76	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
77	Y	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
78	Y	Y	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
79	Y	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
80	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
81	Y	Y	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
82	N	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
83	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N
84	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
85	N	Y	N	N	N	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
86	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Appendix I - Additional languages known by patients

Patient number	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
87	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N
88	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
89	N	Y	N	N	N	N	Y	Y	N	N	Y	N	Y	N	N	N	N	N	N	Y	N
90	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
91	N	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N
92	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
93	N	Y	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	Y	N
94	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
95	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
96	N	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
97	N	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	Y	N
98	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
99	N	Y	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N	N	N
100	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
Tot	**23**	**70**	**2**	**1**	**0**	**0**	**14**	**28**	**0**	**0**	**3**	**8**	**27**	**11**	**1**	**2**	**1**	**1**	**2**	**9**	**0**

Appendix J - Preferred languages

Patient number	Afrikaans	English	French	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
1	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
2	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
4	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
5	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
6	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
7	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
8	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
10	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
11	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
12	Y	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
13	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N
14	N	Y	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
15	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
16	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
17	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
18	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
19	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
20	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
21	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
22	N	Y	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
23	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
24	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
25	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
26	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
27	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
28	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
29	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
30	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
31	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
32	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
33	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
34	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
35	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
36	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
37	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
38	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
39	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
40	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
41	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
42	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
43	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Appendix J - Preferred languages

Patient number	Afrikaans	English	French	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
44	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
45	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
46	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N
47	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
48	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N
49	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
50	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
51	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
52	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
53	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N
54	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N
55	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
56	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N
57	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
58	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
59	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
60	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
61	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N
62	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
63	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
64	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
65	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
66	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
67	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
68	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
69	Y	Y	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N	Y	N
70	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
71	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
72	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
73	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
74	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
75	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
76	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
77	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
78	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
79	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
80	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
81	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
82	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
83	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y
84	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N
85	N	Y	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
86	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Appendix J - Preferred languages

Patient number	Afrikaans	English	French	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
87	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N
88	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
89	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
90	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
91	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
92	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
93	N	Y	N	N	N	N	Y	N	N	N	N	Y	Y	N	N	N	N	N	Y	N
94	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
95	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
96	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
97	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
98	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
99	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N
100	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Tot	**9**	**54**	**2**	**0**	**1**	**5**	**18**	**1**	**0**	**3**	**4**	**13**	**9**	**0**	**0**	**0**	**0**	**1**	**6**	**1**

Appendix K - Language proficiency

Patient number	Mother tongue	Mother tongue proficiency	Mother tongue literacy	Preferred language	Preferred language proficiency	Preferred language literacy
1	English	English A	English A	English	English A	English A
2	English	English A	English A	English	English A	English A
3	Afrikaans	Afrikaans A	Afrikaans A	English	English NA	English NA
4	Sesotho	Sesotho A	Sesotho A	English	English C	English C
5	isiNdebele	isiNdebele A	isiNdebele A	English	English A	English A
6	Sesotho	Sesotho A	Sesotho A	English	English C	English C
7	Sesotho	Sesotho A	Sesotho A	Sesotho	Sesotho A	Sesotho A
8	SiSwati	Siswati A	Siswati A	XXX	XXX	XXX
9	isiXhosa	isiXhosa A	isiXhosa A	English and isiXhosa	English A and isiXhosa A	English A and isiXhosa A
10	isiZulu	isiZulu A	isiZulu A	English	English A	English A
11	Lingala	Lingala XXX	Lingala XXX	French	French NA	French NA
12	Afrikaans	Afrikaans A	Afrikaans A	Afrikaans and Setswana	Afrikaans A and Setswana XXX	Afrikaans A and Setswana XXX
13	Portuguese	Portuguese A	Portuguese A	Portuguese	Portuguese A	Portuguese A
14	Setswana	Setswana A	Setswana A	English and Setswana	English A and Setswana A	English A and Setswana A
15	isiZulu	isiZulu A	isiZulu A	English and isiZulu	English A and isiZulu A	English A and isiZulu A
16	isiZulu	isiZulu A	isiZulu C	English	English A	English A
17	Sesotho	Sesotho A	Sesotho A	English or Sesotho	Sesotho A or English C	Sesotho A or English C
18	Sesotho	Sesotho A	Sesotho A	Sesotho	Sesotho A	Sesotho A
19	Setswana	Setswana A	Setswana- not any longer: blind	Setswana	Setswana A	Setswana- not any longer: blind
20	English	English A	English A	English	English A	English A
21	Italian	Italian A	Italian A	Italian	Italian A	Italian A
22	Sepedi	Sepedi A	Sepedi B	English and Sepedi	English A and Sepedi A	English A and Sepedi B
23	isiZulu	isiZulu A	isiZulu A	isiZulu	isiZulu A	isiZulu A

Appendix K - Language proficiency

Patient number	Mother tongue	Mother tongue proficiency	Mother tongue literacy	Preferred language	Preferred language proficiency	Preferred language literacy
24	Afrikaans	Afrikaans A	Afrikaans A	Afrikaans	Afrikaans A	Afrikaans A
25	isiNdebele	isiNdebele A	isiNdebele A	English	English A	English A
26	Afrikaans	Afrikaans B	Afrikaans B	English	English B	English B
27	Sesotho	Sesotho A	Sesotho XXX	isiZulu	isiZulu A	isiZulu A
28	isiZulu	isiZulu A	isiZulu A	English	English A	English A
29	English	English A	English A	English	English A	English A
30	Setswana	Setswana A	Setswana A	Setswana	Setswana A	Setswana A
31	Sesotho	Sesotho A	Sesotho A	English, Afrikaans and Sesotho	Afrikaans A, English A and Sesotho A	Afrikaans A, English A and Sesotho A
32	English	English A	English A	English	English A	English A
33	Afrikaans	Afrikaans A	Afrikaans A	Afrikaans	Afrikaans A	Afrikaans A
34	Sesotho	Sesotho- no level indicated	Sesotho NA	isiZulu	isiZulu- can only speak	isiZulu 0
35	Sepedi	Sepedi A	Sepedi A	Sepedi	Sepedi A	Sepedi A
36	Afrikaans and English	Afrikaans A and English A	Afrikaans A and English A	Afrikaans or English	Afrikaans A or English A	Afrikaans A or English A
37	Afrikaans	Afrikaans A	Afrikaans A	Afrikaans	Afrikaans A	Afrikaans A
38	Afrikaans and English	Afrikaans A and English A	Afrikaans A and English A	English	English A	English A
39	Setswana	Setswana A	Setswana A	Setswana	Setswana A	Setswana A
40	isiZulu	isiZulu A	isiZulu A	English and isiZulu	English A and isiZulu A	English C and isiZulu A
41	isiZulu	isiZulu A	isiZulu A	isiZulu	isiZulu A	isiZulu A
42	English	English A	English A	English	English A	English A
43	Afrikaans and English	Afrikaans A and English A	Afrikaans A and English A	Afrikaans	Afrikaans A	Afrikaans A
44	Sesotho	Sesotho A	Sesotho NA	English and isiZulu	English A and isiZulu A	English A and isiZulu A
45	isiZulu	isiZulu A	isiZulu A	English	English A	English A
46	Xitsonga	Xitsonga A	Xitsonga A	Xitsonga	Xitsonga A	Xitsonga A

Appendix K - Language proficiency

Patient number	Mother tongue	Mother tongue proficiency	Mother tongue literacy	Preferred language	Preferred language proficiency	Preferred language literacy
47	isiZulu	isiZulu A	isiZulu A	English	English A	English A
48	Xitsonga	Xitsonga XXX	Xitsonga NA	Xitsonga	Xitsonga XXX	Xitsonga NA
49	isiXhosa	isiXhosa A	isiXhosa A	English	English A	English A
50	English	English A	English A	English	English A	English A
51	Sepedi	Sepedi A	Sepedi A	Sepedi	Sepedi A	Sepedi A
52	isiZulu	isiZulu A	isiZulu NA	isiZulu	isiZulu A	isiZulu NA
53	Xitsonga	Xitsonga A	Xitsonga A	Xitsonga	Xitsonga A	Xitsonga A
54	Tshivenda	Tshivenda A	Tshivenda A	Tshivenda	Tshivenda A	Tshivenda A
55	English	English A	English A	English	English A	English A
56	Sepedi	Sepedi A	Sepedi A	Sepedi	Sepedi A	Sepedi A
57	Setswana	Setswana XXX	Setswana XXX	Setswana	Setswana XXX	Setswana XXX
58	Afrikaans	Afrikaans A	Afrikaans A	English	English A	English A
59	English	English A	English A	English	English A	English A
60	isiZulu	isiZulu XXX	isiZulu XXX	isiZulu	isiZulu XXX	isiZulu XXX
61	Kegoundi	Kegoundi A	Kegoundi A	French or Kegoundi	French A or Kegoundi A	French A or Kegoundi A
62	isiXhosa	isiXhosa A	isiXhosa A	English or isiXhosa	English A or isiXhosa A	English A or isiXhosa A
63	Sesotho	Sesotho A	Sesotho NA	Sesotho	Sesotho A	Sesotho NA
64	isiXhosa	isiXhosa A	isiXhosa A	English	English A	English A
65	isiZulu	isiZulu A	isiZulu A	English and isiZulu	English A and isiZulu A	English A and isiZulu A
66	Sesotho	Sesotho A	Sesotho A	English	English A	English A
67	English and Afrikaans	English A and Afrikaans A	English A and Afrikaans A	English	English A	English A
68	English	English A	English A	English	English A	English A
69	Xitsonga	Xitsonga A	Xitsonga A	Afrikaans, English, isiZulu, Sesotho and Xitsonga	Afrikaans A, English A, isiZulu A, Sesotho A and Xitsonga A	Afrikaans A, English A, isiZulu A, Sesotho A and Xitsonga A

Appendix K - Language proficiency

Patient number	Mother tongue	Mother tongue proficiency	Mother tongue literacy	Preferred language	Preferred language proficiency	Preferred language literacy
70	Sesotho	Sesotho A	Sesotho A	English and Sesotho	English A or Sesotho A	English A or Sesotho A
71	isiZulu	isiZulu A	isiZulu A	English	English A	English A
72	isiZulu	isiZulu A	isiZulu A	English	English A	English A
73	Setswana	Setswana A	Setswana NA	Setswana	Setswana A	Setswana NA
74	isiXhosa	isiXhosa A	isiXhosa A	English	English A	English A
75	Sesotho	Sesotho A	Sesotho A	Sesotho	Sesotho A	Sesotho A
76	Sesotho	Sesotho A	Sesotho A	Sesotho	Sesotho A	Sesotho A
77	isiXhosa	isiXhosa A	isiXhosa A	isiXhosa	isiXhosa A	isiXhosa A
78	Sesotho	Sesotho A	Sesotho A	English	English A	English A
79	isiZulu	isiZulu A	isiZulu A	isiZulu	isiZulu A	isiZulu A
80	Setswana	Setswana A	Setswana A	Setswana	Setswana A	Setswana A
81	Sesotho	Sesotho A	Sesotho A	Sesotho	Sesotho A	Sesotho A
82	Setswana	Setswana A	Setswana A	Sesotho	Sesotho A	Sesotho A
83	Xitsonga (Maputo)	Xitsonga (Maputo) A	Xitsonga (Maputo) XXX	Portuguese and Xitsonga	Portuguese A and Xitsonga (Maputo) A	Portuguese A and Xitsonga (Maputo) A
84	Sesotho	Sesotho A	Sesotho A	Sesotho	Sesotho A	Sesotho A
85	isiZulu	isiZulu A	isiZulu A	English and isiZulu	English A and isiZulu A	English A and isiZulu A
86	Afrikaans	Afrikaans A	Afrikaans A	Afrikaans	Afrikaans A	Afrikaans A
87	Xitsonga (Maputo)	Xitsonga (Maputo) A	Xitsonga (Maputo) A	Portuguese	Portuguese A	Portuguese A
88	Afrikaans	Afrikaans A	Afrikaans A	English	English A	English A
89	Tshivenda	Tshivenda A	Tshivenda A	English	English A	English A
90	isiXhosa	isiXhosa A	isiXhosa A	English and isiXhosa	English XXX and isiXhosa A	English XXX and isiXhosa A
91	isiXhosa	isiXhosa A	isiXhosa A	English and isiXhosa	English A and isiXhosa A	English A and isiXhosa A
92	isiNdebele	isiNdebele A	isiNdebele A	English	English A	English A

Appendix K - Language proficiency

Patient number	Mother tongue	Mother tongue proficiency	Mother tongue literacy	Preferred language	Preferred language proficiency	Preferred language literacy
93	Setswana	Setswana A	Setswana A	English, isiZulu, Sesotho, Setswana and Xitsonga	English A, isiZulu A, Sesotho A, Setswana A, Xitsonga A	English A, isiZulu A, Sesotho A, Setswana A, Xitsonga A
94	Sesotho	Sesotho A	Sesotho A	English	English A	English A
95	Afrikaans	Afrikaans A	Afrikaans A	English	English A	English A
96	isiZulu	isiZulu A	isiZulu A	isiZulu	isiZulu A	isiZulu A
97	Setswana	Setswana A	Setswana C	isiZulu	isiZulu A	isiZulu C
98	isiZulu	isiZulu XXX	isiZulu XXX	isiZulu	isiZulu XXX	isiZulu XXX
99	Xitsonga	Xitsonga A	Xitsonga A	English and Xitsonga	English A and Xitsonga A	English A and Xitsonga A
100	isiZulu	isiZulu A	isiZulu A	isiZulu	isiZulu A	isiZulu A

Appendix L - Additional Language proficiency

		Additional Languages known									
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala
1	English	Afrikaans B	NA	NA	German B	NA	NA	NA	NA	NA	NA
2	English	Afrikaans A	NA	NA	NA	NA	NA	NA	NA	NA	NA
3	Afrikaans	NA	English NA	NA	NA	NA	NA	NA	NA	NA	NA
4	Sesotho	NA	English C	NA	NA	NA	NA	NA	NA	NA	NA
5	isiNdebele	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
6	Sesotho	NA	English C	NA	NA	NA	NA	NA	NA	NA	NA
7	Sesotho	NA	English C	NA	NA	NA	NA	NA	NA	NA	NA
8	Siswati	NA	English A	NA	NA	NA	NA	isiXhosa-can only speak	isiZulu A	NA	NA
9	isiXhosa	NA	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
10	isiZulu	NA	English A	NA	NA	NA	NA	isiXhosa A	NA	NA	NA
11	Lingala	NA	English NA	French NA	NA	NA	NA	NA	NA	NA	NA
12	Afrikaans	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
13	Portuguese	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
14	Setswana	Afrikaans XXX	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
15	isiZulu	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
16	isiZulu	Afrikaans NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
17	Sesotho	NA	English C	NA	NA	NA	NA	isiXhosa B	NA	NA	NA
18	Sesotho	NA	English C	NA	NA	NA	NA	NA	NA	NA	NA
19	Setswana	NA	English C	NA	NA	NA	NA	NA	isiZulu C	NA	NA

Appendix L - Additional Language proficiency

		Additional Languages known									
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala
20	English	Afrikaans- can only understand	NA	NA	NA	NA	NA	NA	NA	NA	NA
21	Italian	NA	English NA	NA	NA	NA	NA	NA	NA	NA	NA
22	Sepedi	Afrikaans- can only speak	English A	NA	NA	NA	NA	isiXhosa- can only speak	isiZulu B	NA	NA
23	isiZulu	NA	English A	NA	NA	NA	NA	isiXhosa B	NA	NA	NA
24	Afrikaans	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
25	isiNdebele	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
26	Afrikaans	NA	English B	NA	NA	NA	NA	NA	NA	NA	NA
27	Sesotho	NA	NA	NA	NA	NA	NA	NA	isiZulu A	NA	NA
28	isiZulu	NA	English A	NA	NA	NA	NA	isiXhosa A	NA	NA	NA
29	English	Afrikaans A	NA	NA	NA	NA	NA	NA	isiZulu A	NA	NA
30	Setswana	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
31	Sesotho	Afrikaans A	English A	NA	NA	NA	NA	isiXhosa- can only speak	isiZulu XXX	NA	NA
32	English	Afrikaans A	NA	NA	NA	NA	NA	isiXhosa A	isiZulu A	NA	NA
33	Afrikaans	NA	English B	NA	NA	NA	NA	NA	NA	NA	NA
34	Sesotho	NA	NA	NA	NA	NA	NA	NA	isiZulu- can only speak	NA	NA
35	Sepedi	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
36	Afrikaans and English	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
37	Afrikaans	NA	English XXX	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

		Additional Languages known									
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala
38	Afrikaans and English	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
39	Setswana	NA	English XXX	NA	NA	NA	NA	NA	isiZulu XXX	NA	NA
40	isiZulu	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
41	isiZulu	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
42	English	Afrikaans A	NA	NA	NA	NA	NA	NA	NA	NA	NA
43	Afrikaans and English	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
44	Sesotho	NA	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
45	isiZulu	NA	NA	NA	NA	NA	NA	isiXhosa- can only speak	NA	NA	NA
46	Xitsonga	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
47	isiZulu	Afrikaans- can only speak	English XXX	NA	NA	NA	NA	NA	NA	NA	NA
48	Xitsonga	NA	NA	NA	NA	NA	NA	NA	isiZulu- can only speak	NA	NA
49	isiXhosa	Afrikaans- can only speak	English A	NA	NA	NA	NA	NA	NA	NA	NA
50	English	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
51	Sepedi	NA	English C	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

		Additional Languages known									
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala
52	isiZulu	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
53	Xitsonga	Afrikaans A	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
54	Tshivenda	NA	English XXX	NA	NA	NA	NA	NA	isiZulu- can only speak	NA	NA
55	English	Afrikaans B	NA	NA	NA	NA	NA	NA	NA	NA	NA
56	Sepedi	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
57	Setswana	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
58	Afrikaans	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
59	English	Afrikaans A	NA	NA	NA	NA	NA	NA	NA	NA	NA
60	isiZulu	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
61	Kegoundi	NA	NA	French A	NA	NA	NA	NA	NA	NA	NA
62	isiXhosa	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
63	Sesotho	Afrikaans- can only speak	NA	NA	NA	NA	NA	NA	NA	NA	NA
64	isiXhosa	NA	NA	NA	NA	NA	NA	NA	isiZulu A	NA	NA
65	isiZulu	NA	English XXX	NA	NA	NA	NA	NA	NA	NA	NA
66	Sesotho	NA	NA	NA	NA	NA	NA	NA	isiZulu A	NA	NA
67	English and Afrikaans	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
68	English	Afrikaans C	NA	NA	NA	NA	NA	NA	NA	NA	NA
69	Xitsonga	Afrikaans A	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
70	Sesotho	Afrikaans A	NA	NA	NA	NA	NA	isiXhosa C	NA	NA	NA

Appendix L - Additional Language proficiency

		Additional Languages known									
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala
71	isiZulu	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
72	isiZulu	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
73	Setswana	NA	English A	NA	NA	NA	NA	NA	isiZulu- can only speak	NA	NA
74	isiXhosa	NA	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
75	Sesotho	NA	English XXX	NA	NA	NA	NA	NA	isiZulu A	NA	NA
76	Sesotho	NA	English- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
77	isiXhosa	Afrikaans- can only speak	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
78	Sesotho	Afrikaans C	English A	NA	NA	NA	NA	isiXhosa- can only speak	isiZulu- can only speak	NA	NA
79	isiZulu	Afrikaans C	English A	NA	NA	NA	NA	NA	NA	NA	NA
80	Setswana	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
81	Sesotho	Afrikaans- can understand but hardly speak	English- can only understand but hardly speak	NA	NA	NA	NA	NA	NA	NA	NA
82	Setswana	NA	English C	NA	NA	NA	NA	NA	isiZulu C	NA	NA
83	Xitsonga (Maputo)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
84	Sesotho	NA	NA	NA	NA	NA	NA	isiXhosa C	isiZulu C	NA	NA

Appendix L - Additional Language proficiency

		Additional Languages known									
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian	isiXhosa	isiZulu	Kirundi	Lingala
85	isiZulu	NA	English A	NA	NA	NA	NA	isiXhosa C	NA	NA	NA
86	Afrikaans	NA	English B	NA	NA	NA	NA	NA	NA	NA	NA
87	Xitsonga (Maputo)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
88	Afrikaans	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
89	Tshivenda	NA	English A	NA	NA	NA	NA	isiXhosa- can only speak	isiZulu- can only speak	NA	NA
90	isiXhosa	NA	English XXX	NA	NA	NA	NA	NA	NA	NA	NA
91	isiXhosa	NA	English A	NA	NA	NA	NA	NA	isiZulu- can only speak	NA	NA
92	isiNdebele	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
93	Setswana	NA	English A	NA	NA	NA	NA	NA	isiZulu A	NA	NA
94	Sesotho	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
95	Afrikaans	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
96	isiZulu	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
97	Setswana	NA	English XXX	NA	NA	NA	NA	NA	isiZulu A	NA	NA
98	isiZulu	NA	English XXX	NA	NA	NA	NA	NA	isiZulu XXX	NA	NA
99	Xitsonga	NA	English A	NA	NA	NA	NA	NA	NA	NA	NA
100	isiZulu	Afrikaans A	English A	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

	Additional Languages known										
Patient number	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
1	NA	NA	NA	NA	NA	NA	NA	Spanish B	NA	NA	NA
2	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
4	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
6	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
7	NA	NA	NA	Setswana A	NA	NA	NA	NA	NA	NA	NA
8	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9	NA	Sepedi- can only speak	NA	NA	NA	NA	NA	NA	NA	NA	NA
10	NA	NA	Sesotho A	Setswana- can only speak	NA	NA	NA	NA	NA	Xitsonga XXX	NA
11	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
12	NA	NA	NA	Setswana XXX	NA	NA	NA	NA	NA	NA	NA
13	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
14	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
15	NA	NA	Sesotho NA	NA	NA	NA	NA	NA	NA	NA	NA
16	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
17	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
18	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

	Additional Languages known										
Patient number	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
20	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
21	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
22	NA	NA	Sesotho- can only speak	Setswana XXX	NA	Siswati- can only speak	NA	NA	NA	Xitsonga- can only speak	NA
23	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
24	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
25	NA	NA	NA	NA	Shona- can only speak	NA	NA	NA	NA	NA	NA
26	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
27	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
28	NA	NA	Sesotho- can only speak	NA	NA	Siswati- can only speak	NA	NA	NA	NA	NA
29	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
30	NA	Sepedi A	NA	NA	NA	NA	NA	NA	NA	NA	NA
31	NA	Sepedi XXX	NA	Setswana XXX	NA	NA	NA	NA	NA	NA	NA
32	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
33	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
34	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
35	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
36	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
37	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

	Additional Languages known										
Patient number	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
38	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
39	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
40	NA	NA	NA	Setswana- can only speak	NA	NA	NA	NA	NA	NA	NA
41	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
42	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
43	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
44	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
45	NA	NA	NA	NA	NA	NA	NA	NA	NA	Xitsonga- can only speak	NA
46	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
47	NA	Sepedi XXX	Sesotho XXX	NA	NA	NA	NA	NA	NA	NA	NA
48	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
49	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
50	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
51	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

	Additional Languages known										
Patient number	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
52	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
53	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
54	NA	Sepedi- can only speak	NA	NA	NA	NA	NA	NA	NA	Xitsonga-can only speak	NA
55	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
56	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
57	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
58	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
59	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
60	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
61	NA	NA	NA	NA	NA	NA	Swahili- can only speak	NA	NA	NA	NA
62	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
63	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
64	NA	Sepedi- can only speak	NA	NA	NA	NA	NA	NA	NA	NA	NA
65	NA	NA	Sesotho XXX	Setswana-can only speak	NA	NA	NA	NA	NA	NA	NA
66	NA	NA	NA	Setswana A	NA	NA	NA	NA	NA	NA	NA
67	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
68	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
69	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
70	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

	Additional Languages known										
Patient number	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
71	NA	NA	Sesotho- can only speak	Setswana-can only speak	NA	NA	NA	NA	Tshivenda-can only speak	Xitsonga A	NA
72	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
73	NA	NA	NA	Setswana-can only speak	NA	NA	NA	NA	Tshivenda A	Xitsonga-can only speak	NA
74	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
75	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
76	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
77	NA	NA	Sesotho XXX	NA	NA	NA	NA	NA	NA	NA	NA
78	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
79	NA	NA	Sesotho C	NA	NA	NA	NA	NA	NA	NA	NA
80	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
81	NA	NA	NA	Setswana A	NA	NA	NA	NA	NA	NA	NA
82	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	NA	NA
83	Portuguese A	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
84	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix L - Additional Language proficiency

	Additional Languages known										
Patient number	Portuguese	Sepedi	Sesotho	Setswana	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
85	NA	NA	Sesotho C	NA	NA	NA	NA	NA	NA	NA	NA
86	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
87	Portuguese A	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
88	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
89	Portuguese A	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	Xitsonga A	NA
90	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
91	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
92	NA	Sepedi- can only speak	NA	NA	NA	NA	NA	NA	NA	NA	NA
93	NA	NA	Sesotho A	NA	NA	NA	NA	NA	NA	Xitsonga A	NA
94	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
95	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
96	NA	NA	Sesotho- can only speak	NA	NA	NA	NA	NA	NA	NA	NA
97	NA	NA	NA	NA	NA	NA	NA	NA	NA	Xitsonga XXX	NA
98	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
99	NA	NA	Sesotho A	Setswana A	NA	NA	NA	NA	NA	NA	NA
100	NA	Sepedi A	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix M - Additional Language Literacy

		Additional Languages known					
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian
1	English	Afrikaans XXX	NA	NA	German XXX	NA	NA
2	English	Afrikaans A	NA	NA	NA	NA	NA
3	Afrikaans	NA	English NA	NA	NA	NA	NA
4	Sesotho	NA	English C	NA	NA	NA	NA
5	isiNdebele	NA	English A	NA	NA	NA	NA
6	Sesotho	NA	English C	NA	NA	NA	NA
7	Sesotho	NA	English C	NA	NA	NA	NA
8	Siswati	NA	English A	NA	NA	NA	NA
9	isiXhosa	NA	English A	NA	NA	NA	NA
10	isiZulu	NA	English A	NA	NA	NA	NA
11	Lingala	NA	English NA	French NA	NA	NA	NA
12	Afrikaans	NA	English A	NA	NA	NA	NA
13	Portuguese	NA	NA	NA	NA	NA	NA
14	Setswana	Afrikaans-can only read	English A	NA	NA	NA	NA
15	isiZulu	NA	English A	NA	NA	NA	NA
16	isiZulu	Afrikaans C	English A	NA	NA	NA	NA
17	Sesotho	NA	English C	NA	NA	NA	NA
18	Sesotho	NA	English C	NA	NA	NA	NA
19	Setswana	NA	English 0	NA	NA	NA	NA
20	English	Afrikaans 0	NA	NA	NA	NA	NA
21	Italian	NA	English NA	NA	NA	NA	NA
22	Sepedi	Afrikaans 0	English A	NA	NA	NA	NA
23	isiZulu	NA	English A	NA	NA	NA	NA
24	Afrikaans	NA	English A	NA	NA	NA	NA
25	isiNdebele	NA	English A	NA	NA	NA	NA
26	Afrikaans	NA	English B	NA	NA	NA	NA
27	Sesotho	NA	NA	NA	NA	NA	NA
28	isiZulu	NA	English A	NA	NA	NA	NA
29	English	Afrikaans A	NA	NA	NA	NA	NA

Appendix M - Additional Language Literacy

		Additional Languages known					
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian
30	Setswana	NA	English A	NA	NA	NA	NA
31	Sesotho	Afrikaans A	English A	NA	NA	NA	NA
32	English	Afrikaans A	NA	NA	NA	NA	NA
33	Afrikaans	NA	English C	NA	NA	NA	NA
34	Sesotho	NA	NA	NA	NA	NA	NA
35	Sepedi	NA	NA	NA	NA	NA	NA
36	Afrikaans and English	NA	NA	NA	NA	NA	NA
37	Afrikaans	NA	English XXX	NA	NA	NA	NA
38	Afrikaans and English	NA	NA	NA	NA	NA	NA
39	Setswana	NA	English XXX	NA	NA	NA	NA
40	isiZulu	NA	English C	NA	NA	NA	NA
41	isiZulu	NA	English A	NA	NA	NA	NA
42	English	Afrikaans A	NA	NA	NA	NA	NA
43	Afrikaans and English	NA	NA	NA	NA	NA	NA
44	Sesotho	NA	English A	NA	NA	NA	NA
45	isiZulu	NA	NA	NA	NA	NA	NA
46	Xitsonga	NA	English A	NA	NA	NA	NA
47	isiZulu	Afrikaans 0	English XXX	NA	NA	NA	NA
48	Xitsonga	NA	NA	NA	NA	NA	NA
49	isiXhosa	Afrikaans 0	English A	NA	NA	NA	NA
50	English	NA	NA	NA	NA	NA	NA
51	Sepedi	NA	English NA	NA	NA	NA	NA
52	isiZulu	NA	NA	NA	NA	NA	NA
53	Xitsonga	Afrikaans A	English A	NA	NA	NA	NA
54	Tshivenda	NA	English XXX	NA	NA	NA	NA
55	English	Afrikaans XXX	NA	NA	NA	NA	NA
56	Sepedi	NA	English A	NA	NA	NA	NA
57	Setswana	NA	NA	NA	NA	NA	NA
58	Afrikaans	NA	English A	NA	NA	NA	NA
59	English	Afrikaans A	NA	NA	NA	NA	NA
60	isiZulu	NA	NA	NA	NA	NA	NA
61	Kegoundi	NA	NA	French A	NA	NA	NA
62	isiXhosa	NA	English A	NA	NA	NA	NA

Appendix M - Additional Language Literacy

		Additional Languages known					
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian
63	Sesotho	Afrikaans 0	NA	NA	NA	NA	NA
64	isiXhosa	NA	NA	NA	NA	NA	NA
65	isiZulu	NA	English XXX	NA	NA	NA	NA
66	Sesotho	NA	NA	NA	NA	NA	NA
67	English and Afrikaans	NA	NA	NA	NA	NA	NA
68	English	Afrikaans XXX	NA	NA	NA	NA	NA
69	Xitsonga	Afrikaans A	English A	NA	NA	NA	NA
70	Sesotho	Afrikaans A	NA	NA	NA	NA	NA
71	isiZulu	NA	English A	NA	NA	NA	NA
72	isiZulu	NA	English A	NA	NA	NA	NA
73	Setswana	NA	English A	NA	NA	NA	NA
74	isiXhosa	NA	English A	NA	NA	NA	NA
75	Sesotho	NA	English NA	NA	NA	NA	NA
76	Sesotho	NA	English 0	NA	NA	NA	NA
77	isiXhosa	Afrikaans 0	English A	NA	NA	NA	NA
78	Sesotho	Afrikaans C	English A	NA	NA	NA	NA
79	isiZulu	Afrikaans C	English A	NA	NA	NA	NA
80	Setswana	NA	English A	NA	NA	NA	NA
81	Sesotho	Afrikaans 0	English 0	NA	NA	NA	NA
82	Setswana	NA	English XXX	NA	NA	NA	NA
83	Xitsonga (Maputo)	NA	NA	NA	NA	NA	NA
84	Sesotho	NA	NA	NA	NA	NA	NA
85	isiZulu	NA	English A	NA	NA	NA	NA
86	Afrikaans	NA	English XXX	NA	NA	NA	NA
87	Xitsonga (Maputo)	NA	NA	NA	NA	NA	NA
88	Afrikaans	NA	English A	NA	NA	NA	NA
89	Tshivenda	NA	English A	NA	NA	NA	NA

Appendix M - Additional Language Literacy

		Additional Languages known					
Patient number	Mother tongue	Afrikaans	English	French	German	isiNdebele	Italian
90	isiXhosa	NA	English XXX	NA	NA	NA	NA
91	isiXhosa	NA	English A	NA	NA	NA	NA
92	isiNdebele	NA	English A	NA	NA	NA	NA
93	Setswana	NA	English A	NA	NA	NA	NA
94	Sesotho	NA	English A	NA	NA	NA	NA
95	Afrikaans	NA	English A	NA	NA	NA	NA
96	isiZulu	NA	English A	NA	NA	NA	NA
97	Setswana	NA	English XXX	NA	NA	NA	NA
98	isiZulu	NA	English XXX	NA	NA	NA	NA
99	Xitsonga	NA	English A	NA	NA	NA	NA
100	isiZulu	Afrikaans A	English A	NA	NA	NA	NA

Appendix M - Additional Language Literacy

	Additional Languages known							
Patient number	isiXhosa	isiZulu	Kerundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana
1	NA	NA	NA	NA	NA	NA	NA	NA
2	NA	NA	NA	NA	NA	NA	NA	NA
3	NA	NA	NA	NA	NA	NA	NA	NA
4	NA	NA	NA	NA	NA	NA	NA	NA
5	NA	NA	NA	NA	NA	NA	NA	NA
6	NA	NA	NA	NA	NA	NA	NA	NA
7	NA	NA	NA	NA	NA	NA	NA	Setswana A
8	isiXhosa 0	isiZulu A	NA	NA	NA	NA	NA	NA
9	NA	isiZulu A	NA	NA	NA	Sepedi 0	NA	NA
10	isiXhosa A	NA	NA	NA	NA	NA	Sesotho A	Setswana 0
11	NA	NA	NA	NA	NA	NA	NA	NA
12	NA	NA	NA	NA	NA	NA	NA	Setswana XXX
13	NA	NA	NA	NA	NA	NA	NA	NA
14	NA	isiZulu A	NA	NA	NA	NA	NA	NA
15	NA	NA	NA	NA	NA	NA	Sesotho NA	NA
16	NA	NA	NA	NA	NA	NA	Sesotho 0	NA
17	isiXhosa B	NA	NA	NA	NA	NA	NA	NA
18	NA	NA	NA	NA	NA	NA	NA	NA
19	NA	isiZulu 0	NA	NA	NA	NA	NA	NA
20	NA	NA	NA	NA	NA	NA	NA	NA
21	NA	NA	NA	NA	NA	NA	NA	NA
22	isiXhosa 0	isiZulu XXX	NA	NA	NA	NA	Sesotho 0	Setswana 0
23	isiXhosa XXX	NA	NA	NA	NA	NA	NA	NA
24	NA	NA	NA	NA	NA	NA	NA	NA
25	NA	NA	NA	NA	NA	NA	NA	NA
26	NA	NA	NA	NA	NA	NA	NA	NA
27	NA	isiZulu A	NA	NA	NA	NA	NA	NA
28	isiXhosa A	NA	NA	NA	NA	NA	Sesotho 0	NA
29	NA	isiZulu A	NA	NA	NA	NA	NA	NA

Appendix M - Additional Language Literacy

	Additional Languages known							
Patient number	isiXhosa	isiZulu	Kerundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana
30	NA	NA	NA	NA	NA	Sepedi A	NA	NA
31	isiXhosa 0	isiZulu C	NA	NA	NA	Sepedi XXX	NA	Setswana C
32	isiXhosa A	isiZulu A	NA	NA	NA	NA	NA	NA
33	NA	NA	NA	NA	NA	NA	NA	NA
34	NA	isiZulu 0	NA	NA	NA	NA	NA	NA
35	NA	NA	NA	NA	NA	NA	NA	NA
36	NA	NA	NA	NA	NA	NA	NA	NA
37	NA	NA	NA	NA	NA	NA	NA	NA
38	NA	NA	NA	NA	NA	NA	NA	NA
39	NA	isiZulu XXX	NA	NA	NA	NA	NA	NA
40	NA	NA	NA	NA	NA	NA	NA	Setswana 0
41	NA	NA	NA	NA	NA	NA	Sesotho 0	NA
42	NA	NA	NA	NA	NA	NA	NA	NA
43	NA	NA	NA	NA	NA	NA	Sesotho 0	NA
44	NA	isiZulu A	NA	NA	NA	NA	NA	NA
45	isiXhosa 0	NA	NA	NA	NA	NA	NA	NA
46	NA	NA	NA	NA	NA	NA	Sesotho A	NA
47	NA	NA	NA	NA	NA	Sepedi XXX	Sesotho XXX	NA
48	NA	isiZulu 0	NA	NA	NA	NA	Sesotho 0	NA
49	NA	NA	NA	NA	NA	NA	Sesotho 0	NA
50	NA	NA	NA	NA	NA	NA	NA	NA
51	NA	NA	NA	NA	NA	NA	NA	NA
52	NA	NA	NA	NA	NA	NA	Sesotho 0	NA
53	NA	isiZulu A	NA	NA	NA	NA	Sesotho A	NA
54	NA	isiZulu 0	NA	NA	NA	Sepedi 0	NA	NA
55	NA	NA	NA	NA	NA	NA	NA	NA
56	NA	NA	NA	NA	NA	NA	Sesotho A	NA
57	NA	NA	NA	NA	NA	NA	NA	NA
58	NA	NA	NA	NA	NA	NA	NA	NA
59	NA	NA	NA	NA	NA	NA	NA	NA
60	NA	NA	NA	NA	NA	NA	NA	NA
61	NA	NA	NA	NA	NA	NA	NA	NA
62	NA	NA	NA	NA	NA	NA	NA	NA

Appendix M - Additional Language Literacy

	Additional Languages known							
Patient number	isiXhosa	isiZulu	Kerundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana
63	NA	NA	NA	NA	NA	NA	NA	NA
64	NA	isiZulu A	NA	NA	NA	Sepedi 0	NA	NA
65	NA	NA	NA	NA	NA	NA	Sesotho XXX	Setswana 0
66	NA	isiZulu A	NA	NA	NA	NA	NA	Setswana A
67	NA	NA	NA	NA	NA	NA	NA	NA
68	NA	NA	NA	NA	NA	NA	NA	NA
69	NA	isiZulu A	NA	NA	NA	NA	Sesotho A	NA
70	isiXhosa XXX	NA	NA	NA	NA	NA	NA	NA
71	NA	NA	NA	NA	NA	NA	Sesotho 0	Setswana 0
72	NA	NA	NA	NA	NA	NA	NA	NA
73	NA	isiZulu 0	NA	NA	NA	NA	NA	Setswana 0
74	NA	isiZulu A	NA	NA	NA	NA	Sesotho A	NA
75	NA	isiZulu A	NA	NA	NA	NA	NA	NA
76	NA	NA	NA	NA	NA	NA	NA	NA
77	NA	isiZulu A	NA	NA	NA	NA	Sesotho XXX	NA
78	isiXhosa 0	isiZulu 0	NA	NA	NA	NA	NA	NA
79	NA	NA	NA	NA	NA	NA	Sesotho C	NA
80	NA	NA	NA	NA	NA	NA	NA	NA
81	NA	NA	NA	NA	NA	NA	NA	Setswana A
82	NA	isiZulu XXX	NA	NA	NA	NA	Sesotho A	NA
83	NA	NA	NA	NA	Portuguese A	NA	NA	NA
84	isiXhosa C	isiZulu C	NA	NA	NA	NA	NA	NA
85	isiXhosa C	NA	NA	NA	NA	NA	Sesotho C	NA
86	NA	NA	NA	NA	NA	NA	NA	NA
87	NA	NA	NA	NA	Portuguese A	NA	NA	NA
88	NA	NA	NA	NA	NA	NA	NA	NA
89	isiXhosa 0	isiZulu 0	NA	NA	Portuguese A	NA	Sesotho 0	NA

Appendix M - Additional Language Literacy

	Additional Languages known							
Patient number	isiXhosa	isiZulu	Kerundi	Lingala	Portuguese	Sepedi	Sesotho	Setswana
90	NA	NA	NA	NA	NA	NA	NA	NA
91	NA	isiZulu 0	NA	NA	NA	NA	Sesotho 0	NA
92	NA	NA	NA	NA	NA	Sepedi 0	NA	NA
93	NA	isiZulu A	NA	NA	NA	NA	Sesotho A	NA
94	NA	NA	NA	NA	NA	NA	NA	NA
95	NA	NA	NA	NA	NA	NA	NA	NA
96	NA	NA	NA	NA	NA	NA	Sesotho 0	NA
97	NA	isiZulu C	NA	NA	NA	NA	NA	NA
98	NA	isiZulu XXX	NA	NA	NA	NA	NA	NA
99	NA	NA	NA	NA	NA	NA	Sesotho A	Sesotho A
100	NA	NA	NA	NA	NA	Sepedi A	NA	NA

Appendix M - Additional Language Literacy

Additional Languages known

Patient number	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
1	NA	NA	NA	Spanish XXX	NA	NA	NA
2	NA	NA	NA	NA	NA	NA	NA
3	NA	NA	NA	NA	NA	NA	NA
4	NA	NA	NA	NA	NA	NA	NA
5	NA	NA	NA	NA	NA	NA	NA
6	NA	NA	NA	NA	NA	NA	NA
7	NA	NA	NA	NA	NA	NA	NA
8	NA	NA	NA	NA	NA	NA	NA
9	NA	NA	NA	NA	NA	NA	NA
10	NA	NA	NA	NA	NA	Xitsonga-can only read	NA
11	NA	NA	NA	NA	NA	NA	NA
12	NA	NA	NA	NA	NA	NA	NA
13	NA	NA	NA	NA	NA	NA	NA
14	NA	NA	NA	NA	NA	NA	NA
15	NA	NA	NA	NA	NA	NA	NA
16	NA	NA	NA	NA	NA	NA	NA
17	NA	NA	NA	NA	NA	NA	NA
18	NA	NA	NA	NA	NA	NA	NA
19	NA	NA	NA	NA	NA	NA	NA
20	NA	NA	NA	NA	NA	NA	NA
21	NA	NA	NA	NA	NA	NA	NA
22	NA	Siswati 0	NA	NA	NA	Xitsonga 0	NA
23	NA	NA	NA	NA	NA	NA	NA
24	NA	NA	NA	NA	NA	NA	NA
25	Shona 0	NA	NA	NA	NA	NA	NA
26	NA	NA	NA	NA	NA	NA	NA
27	NA	NA	NA	NA	NA	NA	NA
28	NA	Siswati 0	NA	NA	NA	NA	NA
29	NA	NA	NA	NA	NA	NA	NA

Appendix M - Additional Language Literacy

Additional Languages known

Patient number	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
30	NA	NA	NA	NA	NA	NA	NA
31	NA	NA	NA	NA	NA	NA	NA
32	NA	NA	NA	NA	NA	NA	NA
33	NA	NA	NA	NA	NA	NA	NA
34	NA	NA	NA	NA	NA	NA	NA
35	NA	NA	NA	NA	NA	NA	NA
36	NA	NA	NA	NA	NA	NA	NA
37	NA	NA	NA	NA	NA	NA	NA
38	NA	NA	NA	NA	NA	NA	NA
39	NA	NA	NA	NA	NA	NA	NA
40	NA	NA	NA	NA	NA	NA	NA
41	NA	NA	NA	NA	NA	NA	NA
42	NA	NA	NA	NA	NA	NA	NA
43	NA	NA	NA	NA	NA	NA	NA
44	NA	NA	NA	NA	NA	NA	NA
45	NA	NA	NA	NA	NA	Xitsonga 0	NA
46	NA	NA	NA	NA	NA	NA	NA
47	NA	NA	NA	NA	NA	NA	NA
48	NA	NA	NA	NA	NA	NA	NA
49	NA	NA	NA	NA	NA	NA	NA
50	NA	NA	NA	NA	NA	NA	NA
51	NA	NA	NA	NA	NA	NA	NA
52	NA	NA	NA	NA	NA	NA	NA
53	NA	NA	NA	NA	NA	NA	NA
54	NA	NA	NA	NA	NA	Xitsonga 0	NA
55	NA	NA	NA	NA	NA	NA	NA
56	NA	NA	NA	NA	NA	NA	NA
57	NA	NA	NA	NA	NA	NA	NA
58	NA	NA	NA	NA	NA	NA	NA
59	NA	NA	NA	NA	NA	NA	NA
60	NA	NA	NA	NA	NA	NA	NA
61	NA	NA	Swahili 0	NA	NA	NA	NA
62	NA	NA	NA	NA	NA	NA	NA

Appendix M - Additional Language Literacy

Additional Languages known

Patient number	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
63	NA	NA	NA	NA	NA	NA	NA
64	NA	NA	NA	NA	NA	NA	NA
65	NA	NA	NA	NA	NA	NA	NA
66	NA	NA	NA	NA	NA	NA	NA
67	NA	NA	NA	NA	NA	NA	NA
68	NA	NA	NA	NA	NA	NA	NA
69	NA	NA	NA	NA	NA	NA	NA
70	NA	NA	NA	NA	NA	NA	NA
71	NA	NA	NA	NA	Tshivenda 0	Xitsonga A	NA
72	NA	NA	NA	NA	NA	NA	NA
73	NA	NA	NA	NA	Tshivenda A	Xitsonga 0	NA
74	NA	NA	NA	NA	NA	NA	NA
75	NA	NA	NA	NA	NA	NA	NA
76	NA	NA	NA	NA	NA	NA	NA
77	NA	NA	NA	NA	NA	NA	NA
78	NA	NA	NA	NA	NA	NA	NA
79	NA	NA	NA	NA	NA	NA	NA
80	NA	NA	NA	NA	NA	NA	NA
81	NA	NA	NA	NA	NA	NA	NA
82	NA	NA	NA	NA	NA	NA	NA
83	NA	NA	NA	NA	NA	NA	NA
84	NA	NA	NA	NA	NA	NA	NA
85	NA	NA	NA	NA	NA	NA	NA
86	NA	NA	NA	NA	NA	NA	NA
87	NA	NA	NA	NA	NA	NA	NA
88	NA	NA	NA	NA	NA	NA	NA
89	NA	NA	NA	NA	NA	Xitsonga A	NA

Appendix M - Additional Language Literacy

Additional Languages known

Patient number	Shona	Siswati	Swahili	Spanish	Tshivenda	Xitsonga	Xitsonga Maputo
90	NA	NA	NA	NA	NA	NA	NA
91	NA	NA	NA	NA	NA	NA	NA
92	NA	NA	NA	NA	NA	NA	NA
93	NA	NA	NA	NA	NA	Xitsonga A	NA
94	NA	NA	NA	NA	NA	NA	NA
95	NA	NA	NA	NA	NA	NA	NA
96	NA	NA	NA	NA	NA	NA	NA
97	NA	NA	NA	NA	NA	Xitsonga XXX	NA
98	NA	NA	NA	NA	NA	NA	NA
99	NA	NA	NA	NA	NA	NA	NA
100	NA	NA	NA	NA	NA	NA	NA

Appendix N - Preferred Language Proficiency

Patient number	Preferred language proficiency	Afrikaans A	English A	English B	English C	English N/A	English XXX	French A	French N/A	isiXhosa A	isiZulu A
1	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	English NA	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
4	English C	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
5	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	English C	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
7	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	XXX	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	English A and isiXhosa A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
10	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	French NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A
12	Afrikaans A and Setswana XXX	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
13	Portuguese A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	English A and Setswana A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
15	English A and isiZulu A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
16	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	Sesotho A or English C	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
18	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
19	Setswana A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	Italian A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	English A and Sepedi A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
24	Afrikaans A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix N - Preferred Language Proficiency

Patient number	Preferred language proficiency	Afrikaans A	English A	English B	English C	English N/A	English XXX	French A	French N/A	isiXhosa A	isiZulu A
26	English B	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
28	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30	Setswana A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
31	Afrikaans A, English A and Sesotho A	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
32	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
33	Afrikaans A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
34	isiZulu- can only speak	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
35	Sepedi A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
36	Afrikaans A or English A	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
37	Afrikaans A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
38	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
39	Setswana A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
40	English A and isiZulu A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
41	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
42	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
43	Afrikaans A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
44	English A and isiZulu A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
45	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
46	Xitsonga A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
47	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
48	Xitsonga XXX	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
49	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
50	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
51	Sepedi A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
52	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y

Appendix N - Preferred Language Proficiency

Patient number	Preferred language proficiency	Afrikaans A	English A	English B	English C	English N/A	English XXX	French A	French N/A	isiXhosa A	isiZulu A
53	Xitsonga A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
54	Tshivenda A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
55	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
56	Sepedi A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
57	Setswana XXX	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
58	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
59	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
60	isiZulu XXX	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	French A or Kegoundi A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
62	English A or isiXhosa A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
63	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
64	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	English A and isiZulu A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
66	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
67	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
68	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
69	Afrikaans A, English A, isiZulu A, Sesotho A and Xitsonga A	Y	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
70	English A or Sesotho A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
71	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
72	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
73	Setswana A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
74	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
75	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
76	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
77	isiXhosa A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
78	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix N - Preferred Language Proficiency

Patient number	Preferred language proficiency	Afrikaans A	English A	English B	English C	English N/A	English XXX	French A	French N/A	isiXhosa A	isiZulu A
79	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
80	Setswana A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
81	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
82	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
83	Portuguese A and Xitsonga (Maputo) A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
84	Sesotho A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
85	English A and isiZulu A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
86	Afrikaans A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
87	Portuguese A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
88	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
89	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
90	English XXX and isiXhosa A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	Y	N/A
91	English A and isiXhosa A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
92	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
93	English A, isiZulu A, Sesotho A, Setswana A, Xitsonga A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
94	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	English A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
96	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
97	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
98	isiZulu XXX	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99	English A and Xitsonga A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
100	isiZulu A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y

Appendix N - Preferred Language Proficiency

Patient number	isiZulu XXX	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sesotho A	Setswana A	Setswana XXX	Tshivenda A	Xitsonga A	Xitsonga XXX	Xitsonga (Maputo) A
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
13	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
15	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
18	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
19	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix N - Preferred Language Proficiency

Patient number	isiZulu XXX	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sesotho A	Setswana A	Setswana XXX	Tshivenda A	Xitsonga A	Xitsonga XXX	Xitsonga (Maputo) A
26	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
31	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
32	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
33	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
34	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
35	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
36	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
37	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
38	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
39	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
40	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
41	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
42	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
43	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
44	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
45	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
46	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A
47	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
48	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
49	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
50	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
51	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
52	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix N - Preferred Language Proficiency

Patient number	isiZulu XXX	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sesotho A	Setswana A	Setswana XXX	Tshivenda A	Xitsonga A	Xitsonga XXX	Xitsonga (Maputo) A
53	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A
54	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
55	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
56	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A
57	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
58	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
59	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
60	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
62	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
66	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
67	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
68	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
69	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	Y	N/A	N/A
70	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
71	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
72	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
73	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
74	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
75	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
76	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
77	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
78	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix N - Preferred Language Proficiency

Patient number	isiZulu XXX	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sesotho A	Setswana A	Setswana XXX	Tshivenda A	Xitsonga A	Xitsonga XXX	Xitsonga (Maputo) A
79	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
81	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
82	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
83	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
84	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
85	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
86	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
87	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
88	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
89	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
90	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
91	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
92	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
93	N/A	N/A	N/A	N/A	N/A	Y	Y	N/A	N/A	Y	N/A	N/A
94	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
96	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
97	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
98	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A
100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Preferred language literacy	Afrikaans A	English A	English B	English C	English N/A
1	English A	N/A	Y	N/A	N/A	N/A
2	English A	N/A	Y	N/A	N/A	N/A
3	English NA	N/A	N/A	N/A	N/A	Y
4	English C	N/A	N/A	N/A	Y	N/A
5	English A	N/A	Y	N/A	N/A	N/A
6	English C	N/A	N/A	N/A	Y	N/A
7	Sesotho A	N/A	N/A	N/A	N/A	N/A
8	XXX	N/A	N/A	N/A	N/A	N/A
9	English A and isiXhosa A	N/A	Y	N/A	N/A	N/A
10	English A	N/A	Y	N/A	N/A	N/A
11	French NA	N/A	N/A	N/A	N/A	N/A
12	Afrikaans A and Setswana XXX	Y	N/A	N/A	N/A	N/A
13	Portuguese A	N/A	N/A	N/A	N/A	N/A
14	English A and Setswana A	N/A	Y	N/A	N/A	N/A
15	English A and isiZulu A	N/A	Y	N/A	N/A	N/A
16	English A	N/A	Y	N/A	N/A	N/A
17	Sesotho A or English C	N/A	N/A	N/A	Y	N/A
18	Sesotho A	N/A	N/A	N/A	N/A	N/A
19	Setswana- not any longer: blind	N/A	N/A	N/A	N/A	N/A
20	English A	N/A	Y	N/A	N/A	N/A
21	Italian A	N/A	N/A	N/A	N/A	N/A
22	English A and Sepedi B	N/A	Y	N/A	N/A	N/A
23	isiZulu A	N/A	N/A	N/A	N/A	N/A
24	Afrikaans A	Y	N/A	N/A	N/A	N/A
25	English A	N/A	Y	N/A	N/A	N/A
26	English B	N/A	N/A	Y	N/A	N/A
27	isiZulu A	N/A	N/A	N/A	N/A	N/A
28	English A	N/A	Y	N/A	N/A	N/A
29	English A	N/A	Y	N/A	N/A	N/A
30	Setswana A	N/A	N/A	N/A	N/A	N/A
31	Afrikaans A, English A and Sesotho A	Y	Y	N/A	N/A	N/A
32	English A	N/A	Y	N/A	N/A	N/A
33	Afrikaans A	Y	N/A	N/A	N/A	N/A
34	isiZulu 0	N/A	N/A	N/A	N/A	N/A
35	Sepedi A	N/A	N/A	N/A	N/A	N/A
36	Afrikaans A or English A	Y	Y	N/A	N/A	N/A
37	Afrikaans A	Y	N/A	N/A	N/A	N/A
38	English A	N/A	Y	N/A	N/A	N/A
39	Setswana A	N/A	N/A	N/A	N/A	N/A
40	English C and isiZulu A	N/A	N/A	N/A	Y	N/A
41	isiZulu A	N/A	N/A	N/A	N/A	N/A
42	English A	N/A	Y	N/A	N/A	N/A
43	Afrikaans A	Y	N/A	N/A	N/A	N/A
44	English A and isiZulu A	N/A	Y	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Preferred language literacy	Afrikaans A	English A	English B	English C	English N/A
45	English A	N/A	Y	N/A	N/A	N/A
46	Xitsonga A	N/A	N/A	N/A	N/A	N/A
47	English A	N/A	Y	N/A	N/A	N/A
48	Xitsonga NA	N/A	N/A	N/A	N/A	N/A
49	English A	N/A	Y	N/A	N/A	N/A
50	English A	N/A	Y	N/A	N/A	N/A
51	Sepedi A	N/A	N/A	N/A	N/A	N/A
52	isiZulu NA	N/A	N/A	N/A	N/A	N/A
53	Xitsonga A	N/A	N/A	N/A	N/A	N/A
54	Tshivenda A	N/A	N/A	N/A	N/A	N/A
55	English A	N/A	Y	N/A	N/A	N/A
56	Sepedi A	N/A	N/A	N/A	N/A	N/A
57	Setswana XXX	N/A	N/A	N/A	N/A	N/A
58	English A	N/A	Y	N/A	N/A	N/A
59	English A	N/A	Y	N/A	N/A	N/A
60	isiZulu XXX	N/A	N/A	N/A	N/A	N/A
61	French A or Kegoundi A	N/A	N/A	N/A	N/A	N/A
62	English A or isiXhosa A	N/A	Y	N/A	N/A	N/A
63	Sesotho NA	N/A	N/A	N/A	N/A	N/A
64	English A	N/A	Y	N/A	N/A	N/A
65	English A and isiZulu A	N/A	Y	N/A	N/A	N/A
66	English A	N/A	Y	N/A	N/A	N/A
67	English A	N/A	Y	N/A	N/A	N/A
68	English A	N/A	Y	N/A	N/A	N/A
69	Afrikaans A, English A, isiZulu A, Sesotho A and Xitsonga A	Y	Y	N/A	N/A	N/A
70	English A or Sesotho A	N/A	Y	N/A	N/A	N/A
71	English A	N/A	Y	N/A	N/A	N/A
72	English A	N/A	Y	N/A	N/A	N/A
73	Setswana NA	N/A	N/A	N/A	N/A	N/A
74	English A	N/A	Y	N/A	N/A	N/A
75	Sesotho A	N/A	N/A	N/A	N/A	N/A
76	Sesotho A	N/A	N/A	N/A	N/A	N/A
77	isiXhosa A	N/A	N/A	N/A	N/A	N/A
78	English A	N/A	Y	N/A	N/A	N/A
79	isiZulu A	N/A	N/A	N/A	N/A	N/A
80	Setswana A	N/A	N/A	N/A	N/A	N/A
81	Sesotho A	N/A	N/A	N/A	N/A	N/A
82	Sesotho A	N/A	N/A	N/A	N/A	N/A
83	Portuguese A and Xitsonga (Maputo) A	N/A	N/A	N/A	N/A	N/A
84	Sesotho A	N/A	N/A	N/A	N/A	N/A
85	English A and isiZulu A	N/A	Y	N/A	N/A	N/A
86	Afrikaans A	Y	N/A	N/A	N/A	N/A
87	Portuguese A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Preferred language literacy	Afrikaans A	English A	English B	English C	English N/A
88	English A	N/A	Y	N/A	N/A	N/A
89	English A	N/A	Y	N/A	N/A	N/A
90	English XXX and isiXhosa A	N/A	N/A	N/A	N/A	N/A
91	English A and isiXhosa A	N/A	Y	N/A	N/A	N/A
92	English A	N/A	Y	N/A	N/A	N/A
93	English A, isiZulu A, Sesotho A, Setswana A, Xitsonga A	N/A	Y	N/A	N/A	N/A
94	English A	N/A	Y	N/A	N/A	N/A
95	English A	N/A	Y	N/A	N/A	N/A
96	isiZulu A	N/A	N/A	N/A	N/A	N/A
97	isiZulu C	N/A	N/A	N/A	N/A	N/A
98	isiZulu XXX	N/A	N/A	N/A	N/A	N/A
99	English A and Xitsonga A	N/A	Y	N/A	N/A	N/A
100	isiZulu A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	English XXX	French A	French N/A	isiXhosa A	isiZulu A	isiZulu C	isiZulu XXX	isiZulu 0
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
10	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A
12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
14	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
15	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
16	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
18	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
26	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
28	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
31	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
32	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
33	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
34	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
35	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
36	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
37	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
38	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
39	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
40	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
41	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
42	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
43	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
44	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	English XXX	French A	French N/A	isiXhosa A	isiZulu A	isiZulu C	isiZulu XXX	isiZulu 0
45	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
46	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
47	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
48	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
49	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
50	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
51	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
52	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
53	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
54	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
55	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
56	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
57	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
58	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
59	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
60	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
61	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
62	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
63	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
66	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
67	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
68	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
69	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
70	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
71	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
72	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
73	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
74	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
76	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
77	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
78	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
79	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
80	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
81	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
82	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
83	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
84	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
85	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
86	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
87	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	English XXX	French A	French N/A	isiXhosa A	isiZulu A	isiZulu C	isiZulu XXX	isiZulu 0
88	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
89	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
90	Y	N/A	N/A	Y	N/A	N/A	N/A	N/A
91	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A
92	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
93	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
94	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
96	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A
97	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A
98	N/A	N/A	N/A	N/A	N/A	N/A	Y	N/A
99	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
100	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	isiZulu N/A	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sepedi B	Sesotho A
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	N/A	N/A	N/A	N/A	N/A	N/A	Y
8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10	N/A	N/A	N/A	N/A	N/A	N/A	N/A
11	N/A	N/A	N/A	N/A	N/A	N/A	N/A
12	N/A	N/A	N/A	N/A	N/A	N/A	N/A
13	N/A	N/A	N/A	Y	N/A	N/A	N/A
14	N/A	N/A	N/A	N/A	N/A	N/A	N/A
15	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	N/A	N/A	N/A	N/A	N/A	N/A	N/A
17	N/A	N/A	N/A	N/A	N/A	N/A	Y
18	N/A	N/A	N/A	N/A	N/A	N/A	Y
19	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	N/A	Y	N/A	N/A	N/A	N/A	N/A
22	N/A	N/A	N/A	N/A	N/A	Y	N/A
23	N/A	N/A	N/A	N/A	N/A	N/A	N/A
24	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	N/A	N/A	N/A	N/A	N/A	N/A	N/A
26	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	N/A	N/A	N/A	N/A	N/A	N/A	N/A
28	N/A	N/A	N/A	N/A	N/A	N/A	N/A
29	N/A	N/A	N/A	N/A	N/A	N/A	N/A
30	N/A	N/A	N/A	N/A	N/A	N/A	N/A
31	N/A	N/A	N/A	N/A	N/A	N/A	Y
32	N/A	N/A	N/A	N/A	N/A	N/A	N/A
33	N/A	N/A	N/A	N/A	N/A	N/A	N/A
34	N/A	N/A	N/A	N/A	N/A	N/A	N/A
35	N/A	N/A	N/A	N/A	Y	N/A	N/A
36	N/A	N/A	N/A	N/A	N/A	N/A	N/A
37	N/A	N/A	N/A	N/A	N/A	N/A	N/A
38	N/A	N/A	N/A	N/A	N/A	N/A	N/A
39	N/A	N/A	N/A	N/A	N/A	N/A	N/A
40	N/A	N/A	N/A	N/A	N/A	N/A	N/A
41	N/A	N/A	N/A	N/A	N/A	N/A	N/A
42	N/A	N/A	N/A	N/A	N/A	N/A	N/A
43	N/A	N/A	N/A	N/A	N/A	N/A	N/A
44	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	isiZulu N/A	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sepedi B	Sesotho A
45	N/A	N/A	N/A	N/A	N/A	N/A	N/A
46	N/A	N/A	N/A	N/A	N/A	N/A	N/A
47	N/A	N/A	N/A	N/A	N/A	N/A	N/A
48	N/A	N/A	N/A	N/A	N/A	N/A	N/A
49	N/A	N/A	N/A	N/A	N/A	N/A	N/A
50	N/A	N/A	N/A	N/A	N/A	N/A	N/A
51	N/A	N/A	N/A	N/A	Y	N/A	N/A
52	Y	N/A	N/A	N/A	N/A	N/A	N/A
53	N/A	N/A	N/A	N/A	N/A	N/A	N/A
54	N/A	N/A	N/A	N/A	N/A	N/A	N/A
55	N/A	N/A	N/A	N/A	N/A	N/A	N/A
56	N/A	N/A	N/A	N/A	Y	N/A	N/A
57	N/A	N/A	N/A	N/A	N/A	N/A	N/A
58	N/A	N/A	N/A	N/A	N/A	N/A	N/A
59	N/A	N/A	N/A	N/A	N/A	N/A	N/A
60	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	N/A	N/A	Y	N/A	N/A	N/A	N/A
62	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	N/A	N/A	N/A	N/A	N/A	N/A	N/A
64	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	N/A	N/A	N/A	N/A	N/A	N/A	N/A
66	N/A	N/A	N/A	N/A	N/A	N/A	N/A
67	N/A	N/A	N/A	N/A	N/A	N/A	N/A
68	N/A	N/A	N/A	N/A	N/A	N/A	N/A
69	N/A	N/A	N/A	N/A	N/A	N/A	Y
70	N/A	N/A	N/A	N/A	N/A	N/A	Y
71	N/A	N/A	N/A	N/A	N/A	N/A	N/A
72	N/A	N/A	N/A	N/A	N/A	N/A	N/A
73	N/A	N/A	N/A	N/A	N/A	N/A	N/A
74	N/A	N/A	N/A	N/A	N/A	N/A	N/A
75	N/A	N/A	N/A	N/A	N/A	N/A	Y
76	N/A	N/A	N/A	N/A	N/A	N/A	Y
77	N/A	N/A	N/A	N/A	N/A	N/A	N/A
78	N/A	N/A	N/A	N/A	N/A	N/A	N/A
79	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80	N/A	N/A	N/A	N/A	N/A	N/A	N/A
81	N/A	N/A	N/A	N/A	N/A	N/A	Y
82	N/A	N/A	N/A	N/A	N/A	N/A	Y
83	N/A	N/A	N/A	Y	N/A	N/A	N/A
84	N/A	N/A	N/A	N/A	N/A	N/A	Y
85	N/A	N/A	N/A	N/A	N/A	N/A	N/A
86	N/A	N/A	N/A	N/A	N/A	N/A	N/A
87	N/A	N/A	N/A	Y	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	isiZulu N/A	Italian A	Kegoundi A	Portuguese A	Sepedi A	Sepedi B	Sesotho A
88	N/A	N/A	N/A	N/A	N/A	N/A	N/A
89	N/A	N/A	N/A	N/A	N/A	N/A	N/A
90	N/A	N/A	N/A	N/A	N/A	N/A	N/A
91	N/A	N/A	N/A	N/A	N/A	N/A	N/A
92	N/A	N/A	N/A	N/A	N/A	N/A	N/A
93	N/A	N/A	N/A	N/A	N/A	N/A	Y
94	N/A	N/A	N/A	N/A	N/A	N/A	N/A
95	N/A	N/A	N/A	N/A	N/A	N/A	N/A
96	N/A	N/A	N/A	N/A	N/A	N/A	N/A
97	N/A	N/A	N/A	N/A	N/A	N/A	N/A
98	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99	N/A	N/A	N/A	N/A	N/A	N/A	N/A
100	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Sesotho N/A	Setswana A	Setswana XXX	Setswana N/A	Tshivenda A	Xitsonga A
1	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A	N/A	N/A
4	N/A	N/A	N/A	N/A	N/A	N/A
5	N/A	N/A	N/A	N/A	N/A	N/A
6	N/A	N/A	N/A	N/A	N/A	N/A
7	N/A	N/A	N/A	N/A	N/A	N/A
8	N/A	N/A	N/A	N/A	N/A	N/A
9	N/A	N/A	N/A	N/A	N/A	N/A
10	N/A	N/A	N/A	N/A	N/A	N/A
11	N/A	N/A	N/A	N/A	N/A	N/A
12	N/A	N/A	Y	N/A	N/A	N/A
13	N/A	N/A	N/A	N/A	N/A	N/A
14	N/A	Y	N/A	N/A	N/A	N/A
15	N/A	N/A	N/A	N/A	N/A	N/A
16	N/A	N/A	N/A	N/A	N/A	N/A
17	N/A	N/A	N/A	N/A	N/A	N/A
18	N/A	N/A	N/A	N/A	N/A	N/A
19	N/A	N/A	N/A	N/A	N/A	N/A
20	N/A	N/A	N/A	N/A	N/A	N/A
21	N/A	N/A	N/A	N/A	N/A	N/A
22	N/A	N/A	N/A	N/A	N/A	N/A
23	N/A	N/A	N/A	N/A	N/A	N/A
24	N/A	N/A	N/A	N/A	N/A	N/A
25	N/A	N/A	N/A	N/A	N/A	N/A
26	N/A	N/A	N/A	N/A	N/A	N/A
27	N/A	N/A	N/A	N/A	N/A	N/A
28	N/A	N/A	N/A	N/A	N/A	N/A
29	N/A	N/A	N/A	N/A	N/A	N/A
30	N/A	Y	N/A	N/A	N/A	N/A
31	N/A	N/A	N/A	N/A	N/A	N/A
32	N/A	N/A	N/A	N/A	N/A	N/A
33	N/A	N/A	N/A	N/A	N/A	N/A
34	N/A	N/A	N/A	N/A	N/A	N/A
35	N/A	N/A	N/A	N/A	N/A	N/A
36	N/A	N/A	N/A	N/A	N/A	N/A
37	N/A	N/A	N/A	N/A	N/A	N/A
38	N/A	N/A	N/A	N/A	N/A	N/A
39	N/A	Y	N/A	N/A	N/A	N/A
40	N/A	N/A	N/A	N/A	N/A	N/A
41	N/A	N/A	N/A	N/A	N/A	N/A
42	N/A	N/A	N/A	N/A	N/A	N/A
43	N/A	N/A	N/A	N/A	N/A	N/A
44	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Sesotho N/A	Setswana A	Setswana XXX	Setswana N/A	Tshivenda A	Xitsonga A
45	N/A	N/A	N/A	N/A	N/A	N/A
46	N/A	N/A	N/A	N/A	N/A	Y
47	N/A	N/A	N/A	N/A	N/A	N/A
48	N/A	N/A	N/A	N/A	N/A	N/A
49	N/A	N/A	N/A	N/A	N/A	N/A
50	N/A	N/A	N/A	N/A	N/A	N/A
51	N/A	N/A	N/A	N/A	N/A	N/A
52	N/A	N/A	N/A	N/A	N/A	N/A
53	N/A	N/A	N/A	N/A	N/A	Y
54	N/A	N/A	N/A	N/A	Y	N/A
55	N/A	N/A	N/A	N/A	N/A	N/A
56	N/A	N/A	N/A	N/A	N/A	N/A
57	N/A	N/A	Y	N/A	N/A	N/A
58	N/A	N/A	N/A	N/A	N/A	N/A
59	N/A	N/A	N/A	N/A	N/A	N/A
60	N/A	N/A	N/A	N/A	N/A	N/A
61	N/A	N/A	N/A	N/A	N/A	N/A
62	N/A	N/A	N/A	N/A	N/A	N/A
63	Y	N/A	N/A	N/A	N/A	N/A
64	N/A	N/A	N/A	N/A	N/A	N/A
65	N/A	N/A	N/A	N/A	N/A	N/A
66	N/A	N/A	N/A	N/A	N/A	N/A
67	N/A	N/A	N/A	N/A	N/A	N/A
68	N/A	N/A	N/A	N/A	N/A	N/A
69	N/A	N/A	N/A	N/A	N/A	Y
70	N/A	N/A	N/A	N/A	N/A	N/A
71	N/A	N/A	N/A	N/A	N/A	N/A
72	N/A	N/A	N/A	N/A	N/A	N/A
73	N/A	N/A	N/A	Y	N/A	N/A
74	N/A	N/A	N/A	N/A	N/A	N/A
75	N/A	N/A	N/A	N/A	N/A	N/A
76	N/A	N/A	N/A	N/A	N/A	N/A
77	N/A	N/A	N/A	N/A	N/A	N/A
78	N/A	N/A	N/A	N/A	N/A	N/A
79	N/A	N/A	N/A	N/A	N/A	N/A
80	N/A	Y	N/A	N/A	N/A	N/A
81	N/A	N/A	N/A	N/A	N/A	N/A
82	N/A	N/A	N/A	N/A	N/A	N/A
83	N/A	N/A	N/A	N/A	N/A	N/A
84	N/A	N/A	N/A	N/A	N/A	N/A
85	N/A	N/A	N/A	N/A	N/A	N/A
86	N/A	N/A	N/A	N/A	N/A	N/A
87	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Sesotho N/A	Setswana A	Setswana XXX	Setswana N/A	Tshivenda A	Xitsonga A
88	N/A	N/A	N/A	N/A	N/A	N/A
89	N/A	N/A	N/A	N/A	N/A	N/A
90	N/A	N/A	N/A	N/A	N/A	N/A
91	N/A	N/A	N/A	N/A	N/A	N/A
92	N/A	N/A	N/A	N/A	N/A	N/A
93	N/A	Y	N/A	N/A	N/A	Y
94	N/A	N/A	N/A	N/A	N/A	N/A
95	N/A	N/A	N/A	N/A	N/A	N/A
96	N/A	N/A	N/A	N/A	N/A	N/A
97	N/A	N/A	N/A	N/A	N/A	N/A
98	N/A	N/A	N/A	N/A	N/A	N/A
99	N/A	N/A	N/A	N/A	N/A	Y
100	N/A	N/A	N/A	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Xitsonga XXX	Xitsonga N/A	Xitsonga (Maputo) A
1	N/A	N/A	N/A
2	N/A	N/A	N/A
3	N/A	N/A	N/A
4	N/A	N/A	N/A
5	N/A	N/A	N/A
6	N/A	N/A	N/A
7	N/A	N/A	N/A
8	N/A	N/A	N/A
9	N/A	N/A	N/A
10	N/A	N/A	N/A
11	N/A	N/A	N/A
12	N/A	N/A	N/A
13	N/A	N/A	N/A
14	N/A	N/A	N/A
15	N/A	N/A	N/A
16	N/A	N/A	N/A
17	N/A	N/A	N/A
18	N/A	N/A	N/A
19	N/A	N/A	N/A
20	N/A	N/A	N/A
21	N/A	N/A	N/A
22	N/A	N/A	N/A
23	N/A	N/A	N/A
24	N/A	N/A	N/A
25	N/A	N/A	N/A
26	N/A	N/A	N/A
27	N/A	N/A	N/A
28	N/A	N/A	N/A
29	N/A	N/A	N/A
30	N/A	N/A	N/A
31	N/A	N/A	N/A
32	N/A	N/A	N/A
33	N/A	N/A	N/A
34	N/A	N/A	N/A
35	N/A	N/A	N/A
36	N/A	N/A	N/A
37	N/A	N/A	N/A
38	N/A	N/A	N/A
39	N/A	N/A	N/A
40	N/A	N/A	N/A
41	N/A	N/A	N/A
42	N/A	N/A	N/A
43	N/A	N/A	N/A
44	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Xitsonga XXX	Xitsonga N/A	Xitsonga (Maputo) A
45	N/A	N/A	N/A
46	N/A	N/A	N/A
47	N/A	N/A	N/A
48	N/A	Y	N/A
49	N/A	N/A	N/A
50	N/A	N/A	N/A
51	N/A	N/A	N/A
52	N/A	N/A	N/A
53	N/A	N/A	N/A
54	N/A	N/A	N/A
55	N/A	N/A	N/A
56	N/A	N/A	N/A
57	N/A	N/A	N/A
58	N/A	N/A	N/A
59	N/A	N/A	N/A
60	N/A	N/A	N/A
61	N/A	N/A	N/A
62	N/A	N/A	N/A
63	N/A	N/A	N/A
64	N/A	N/A	N/A
65	N/A	N/A	N/A
66	N/A	N/A	N/A
67	N/A	N/A	N/A
68	N/A	N/A	N/A
69	N/A	N/A	N/A
70	N/A	N/A	N/A
71	N/A	N/A	N/A
72	N/A	N/A	N/A
73	N/A	N/A	N/A
74	N/A	N/A	N/A
75	N/A	N/A	N/A
76	N/A	N/A	N/A
77	N/A	N/A	N/A
78	N/A	N/A	N/A
79	N/A	N/A	N/A
80	N/A	N/A	N/A
81	N/A	N/A	N/A
82	N/A	N/A	N/A
83	N/A	N/A	Y
84	N/A	N/A	N/A
85	N/A	N/A	N/A
86	N/A	N/A	N/A
87	N/A	N/A	N/A

Appendix O - Preferred Language Literacy

Patient number	Xitsonga XXX	Xitsonga N/A	Xitsonga (Maputo) A
88	N/A	N/A	N/A
89	N/A	N/A	N/A
90	N/A	N/A	N/A
91	N/A	N/A	N/A
92	N/A	N/A	N/A
93	N/A	N/A	N/A
94	N/A	N/A	N/A
95	N/A	N/A	N/A
96	N/A	N/A	N/A
97	N/A	N/A	N/A
98	N/A	N/A	N/A
99	N/A	N/A	N/A
100	N/A	N/A	N/A

Appendix P - Comparison between first language and preferred language oral literacy (data that do not match)

Language	First language oral proficiency	Preferred language oral proficiency
Afrikaans A and English A	3	
Siswati A	1	
English A and Afrikaans A	1	
Kirundi A	1	
Xitsonga (Maputo) A	2	
Afrikaans B	1	
Lingala XXX	1	
Sesotho- no level indicated	1	
English A and isiXhosa A		2
Afrikaans A and Setswana XXX		1
Afrikaans A or English A		1
English A and Sepedi A		1
English A and Setswana A		1
English A and Xitsonga A		1
English A or isiXhosa A		1
English A or Sesotho A		1
Portuguese A and Xitsonga (Maputo) A		1
Sesotho A or English C		1
French A or Kirundi A		1
Afrikaans A, English A and Sesotho A		1
Afrikaans A, English A, isiZulu A, Sesotho A and Xitsonga A		1
English A, isiZulu A, Sesotho A, Setswana A, Xitsonga A		1
English B		1
English N/A		1
English XXX and isiXhosa A		1
French N/A		1
isiZulu- can only speak		1
XXX		1
English A and isiZulu A		5
English C		2
isiNdebele	3	

Appendix - Q Comparison between first language and preferred language literacy (data that do not match)

Language	First language Literacy	Preferred language literacy
isiNdebele	3	
Siswati A	1	
Xitsonga (Maputo) A	1	
Afrikaans B	1	
Sepedi B	1	
isiZulu C	1	
Setswana C	1	
Kirundi A	1	
Lingala XXX	1	
Xitsonga (Maputo) XXX	1	
Afrikaans A and English A	3	
English A and Afrikaans A	1	
English B		1
English C		2
English N/A		1
French N/A		1
isiZulu 0		1
isiZulu C		1
English A and isiZulu A		4
English A and isiXhosa A		2
Afrikaans A and Setswana XXX		1
Afrikaans A or English A		1
English A and Sepedi B		1
English A and Setswana A		1
English A and Xitsonga A		1
English A or isiXhosa A		1
English A or Sesotho A		1
English C and isiZulu A		1
English XXX and isiXhosa A		1
French A and Kirundi A		1
Portuguese A and Xitsonga (Maputo) A		1

Appendix R - Staff summary

Staff	Functions	First language	Number of languages known	Additional languages known
staff 1	Radiation therapist	Sesotho	4	English, isiZulu, Sepedi
staff 2	Radiation therapist	isiZulu	2	English
staff 3	Radiation therapist	Sesotho	5	English, isiXhosa, isiZulu, Sepedi
staff 4	Student radiation therapist	English	2	Afrikaans
staff 5	Student radiation therapist	Setswana	5	English, isiZulu, Sepedi, Sesotho
staff 6	Radiation therapist	isiZulu	5	English, isiXhosa, Sesotho, SiSwati
staff 7	Student radiation therapist	isiXhosa	3	English, isiZulu
staff 8	Radiation therapist	isiZulu	5	English, isiXhosa, Sesotho, Setswana
staff 9	Radiation therapist	Tshivenda	6	English, isiZulu, Sepedi, Sesotho, Xitsonga
staff 10	Nurse	Afrikaans	3	English, isiZulu
staff 11	Administrative Clerk	isiXhosa	4	English, isiZulu, Sesotho
staff 12	Porter	Xitsonga	5	English, isiZulu, Sesotho, Tshivenda
staff 13	Radiation therapist	Afrikaans	2	English
staff 14	Student radiation therapist	Sepedi	4	Afrikaans, English, isiZulu
staff 15	Radiation therapist	Sesotho	3	English, isiZulu
staff 16	Research assistant	Afrikaans	2	English
staff 17	Doctor	Hindi	2	English
staff 18	Porter	sepedi	7	English, isiZulu, isiXhosa, Sesotho, Setswana, Tshivenda
staff 19	Cleaner	isiZulu	4	English, Sesotho, Xitsonga
staff 20	Cleaner	isiXhosa	4	English, isiZulu, Sesotho
staff 21	Cleaner	Setswana	3	English, isiZulu
staff 22	Cleaner	XXX	4	English, isiZulu, Sesotho
staff 23	Cleaner	isiZulu	5	English, isXhosa, Sesotho, Xitsonga
staff 25	Cleaner	isiZulu	7	English, isXhosa, Sesotho, Xitsonga
staff 26	Medical physicist	isiZulu	2	English
staff 27	Messenger	isiZulu	6	Afrikaans, English, isXhosa, Sesotho, Setswana
staff 28	Nurse	Setswana	6	Afrikaans, English, isiZulu, Sepedi, Sesotho
staff 29	Nurse	isiZulu	4	English, Sesotho, Setswana
staff 30	Radiation therapist	isiZulu	6	English, isiXhosa, Sepedi, Sesotho, Setswana
staff 31	Nurse	Sesotho	7	Afrikaans, English, isiXhosa, isizulu, Sepedi, Setswana
staff 32	Operator	Xitsonga	11	isiNdebele, isiXhosa, isiZulu, Sesotho, Setswana, Shona, SiSwati, Tshivenda, Shangaan, English
staff 33	Senior operator	Setswana	4	isiNdebele, Sepedi, English
staff 34	Nurse	Setswana	5	Afrikaans, English, isiZulu, Sepedi
staff 35	Radiation therapist	English	2	Afrikaans
staff 36	Radiation therapist	English	4	Afrikaans, Hebrew, isiZulu
staff 37	Consultant	English	2	Afrikaans

staff 38	Registrar	isiXhosa	4	Afrikaans, English, isiZulu
staff 39	Doctor	English	2	Afrikaans
staff 40	Registrar	English	2	Afrikaans
staff 41	Registrar/Doctor	Kikuyu	3	English, Kiswahili
staff 42	Registrar	English	2	Afrikaans
staff 43	Registrar	Kiswahili	3	English, French
staff 44	Registrar	English	3	Afrikaans, isiZulu
staff 45	Doctor	Kiswahili	2	English
staff 46	Registrar	Kikuyu	3	English, Kiswahili
staff 47	Doctor	Punjabi, English	7	Bengali, German, Hindi, Malay, Russian
staff 48	Doctor	English	2	Afrikaans
staff 49	Doctor	Sesotho	3	isiZulu, English
staff 50	Doctor	English	2	Afrikaans
staff 51	Registrar	Afrikaans	2	English
staff 52	Doctor	isiXhosa	4	Afrikaans, English, isiZulu
staff 53	Doctor	Setswana	8	Afrikaans, English, isiXhosa, isiZulu, Sepedi, Tshivenda, Xitsonga
staff 54	Doctor	English	2	Afrikaans
staff 55	Nurse	isiXhosa	11	Afrikaans, English, isiNdebele, isiZulu, Sepedi, Sesotho, Setswana, Swazi, Tshivenda, Xistonga
staff 56	Nurse	Sesotho	7	Afrikaans, English, isiXhosa, isiZulu, Sepedi, Setswana
staff 57	Nurse	Setswana	7	Afrikaans, English, isiXhosa, isiZulu, Sepedi, Sesotho
staff 58	Nurse	XXX	XXX	XXX
staff 59	Nurse	Sesotho	2	XXX
staff 60	Personal Assistant	Setswana	4	English, isiZulu, Sesotho
staff 61	Clerk	isiXhosa	6	Afrikaans, English, isiZulu, Sesotho, Setswana
staff 62	Clerk	Sesotho	5	isiXhosa, isiZulu, Setswana, English
staff 63	Clerk	isiXhosa	5	English, isiZulu, Sesotho, Setswana
staff 64	Medical physicist	SeSwati	5	English, isiNdebele, isiXhosa, isiZulu
staff 65	Consultant	English	2	Afrikaans
staff 66	Medical physicist	Afrikaans	2	English
staff 67	Radiation therapist	isiXhosa	6	Afrikaans, English, isiZulu Sesotho, Setswana
staff 68	Nurse	Xitsonga	6	isiZulu, Sesotho, Sepedi, Tshivenda, English
staff 69	Radiation therapist	Sesotho	3	English, isiZulu (basic)
staff 70	Radiation therapist	English	3	Afrikaans, isiZulu
staff 71	Radiation therapist	English	4	Afrikaans, Hindi, isiZulu (basic)
staff 72	Radiation therapist	isiZulu	2	English
staff 73	Radiation therapist	isiXhosa	5	English, isiZulu, Sesotho, Tshivenda
staff 74	Radiation therapist	Xitsonga	4	English, isiZulu, Tshivenda
staff 75	Radiation therapist	Afrikaans	2	English

staff 76	Radiation therapist	English	3	Afrikaans, Italian
staff 77	Radiation therapist	isiXhosa	4	English, isiZulu, Setswana
staff 78	Radiation therapist	isiZulu	5	English, isiXhosa, Sepedi, Setswana
staff 79	Student radiation therapist	Siswati	5	English, isiNdebele, isiZulu, Setswana

Appendix S - Answers of staff members to questionnaire

	Have you ever used the other languages you know to consult, treat or receive a patient? to receive patients	Is it something that the hospital expects of you to do?	Is it part of your contract with the hospital?	Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient?	Have you ever interpreted for a doctor or a patient?	If yes, have you ever received training in interpreting?	If yes, was it part of your medical training?	Has a colleague or another staff of the hospital ever helped as an interpreter for you?	If yes, was the outcome satisfactory?
staff 1	Y	Y	N	Y	Y	Y	Y	Y	Y
staff 2	Y	XXX	N	Y	Y	N	NA	Y	Y
staff 3	Y	Y	N	Y	Y	N	NA	N	XXX
staff 4	N	N	N	Y	N	N	NA	Y	Y
staff 5	Y	Y	N	Y	Y	N	NA	Y	Y
staff 6	N	Y	N	Y	Y	N	NA	Y	Y
staff 7	Y	Y	N	Y	Y	N	NA	N	Y
staff 8	Y	Y	N	Y	Y	N	NA	Y	Y
staff 9	Y	Y	N	Y	Y	N	NA	Y	Y
staff 10	Y	Y	N	Y	Y	N	NA	Y	Y
staff 11	Y	Y	N	Y	Y	N	NA	N	XXX
staff 12	Y	Y	N	N	N	N	NA	XXX	XXX
staff 13	Y	N	N	Y	Y	N	NA	Y	Y
staff 14	Y	Y	N	Y	Y	N	NA	Y	Y
staff 15	Y	N	N	N	Y	N	NA	Y	Y
staff 16	Y	Y	N	Y	Y	N	NA	Y	Y
staff 17	Y	Y	N	Y	Y	N	NA	Y	Y
staff 18	Y	Y	Y	Y	Y	Y	Y	Y	Y
staff 19	Y	Y	Y	Y	Y	N	NA	Y	Y

Appendix S - Answers of staff members to questionnaire

	Have you ever used the other languages you know to consult, treat or receive a patient? to receive patients	Is it something that the hospital expects of you to do?	Is it part of your contract with the hospital?	Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient?	Have you ever interpreted for a doctor or a patient?	If yes, have you ever received training in interpreting?	If yes, was it part of your medical training?	Has a colleague or another staff of the hospital ever helped as an interpreter for you?	If yes, was the outcome satisfactory?
staff 20	Y	Y	N	Y	N	N	NA	N	NA
staff 21	Y	Y	Y	Y	N	N	NA	Y	Y
staff 22	Y	Y	Y	Y	Y	N	ER Y	Y	Y
staff 23	Y	Y	Y	Y	N	N	NA	N	NA
staff 25	Y	Y	Y	Y	N	N	NA	N	NA
staff 26	XXX	XXX	N	Y	Y	N	NA	N	NA
staff 27	XXX	N	N	XXX	Y	N	NA	N	NA
staff 28	Y	Y	N	Y	Y	N	NA	Y	Y
staff 29	Y	Y	N	Y	Y	N	NA	Y	Y
staff 30	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 31	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 32	Y	Y	N	Y	Y	N	NA	Y	Y
staff 33	Y	Y	N	Y	Y	N	ER Y	N	ER Y
staff 34	Y	Y	Y	Y	Y	N	NA	N	NA
staff 35	Y	XXX	XXX	Y	Y	N	NA	Y	Y
staff 36	Y	N	N	Y	N	N	NA	Y	Y
staff 37	Y	Y	N	Y	N	NA	NA	Y	Y
staff 38	Y	Y	N	Y	Y	N	NA	Y	Y
staff 39	Y	Y	N	XXX	N	N	NA	Y	Y

Appendix S - Answers of staff members to questionnaire

	Have you ever used the other languages you know to consult, treat or receive a patient? to receive patients	Is it something that the hospital expects of you to do?	Is it part of your contract with the hospital?	Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient?	Have you ever interpreted for a doctor or a patient?	If yes, have you ever received training in interpreting?	If yes, was it part of your medical training?	Has a colleague or another staff of the hospital ever helped as an interpreter for you?	If yes, was the outcome satisfactory?
staff 40	Y	Y	XXX	Y	N	NA	NA	Y	Y
staff 41	N	N	N	Y	N	N	NA	Y	Y
staff 42	Y	Y	N	Y	Y	N	NA	Y	Y
staff 43	Y	N	N	Y	N	NA	NA	Y	Y
staff 44	Y	Y	N	N	N	NA	NA	Y	Y
staff 45	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 46	Y	Y	Y	Y	N	N	NA	Y	Y
staff 47	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 48	Y	N	N	Y	Y	N	NA	Y	Y and N
staff 49	Y	Y	N	Y	Y	N	NA	Y	Y
staff 50	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 51	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 52	Y	Y	N	Y	Y	N	NA	Y	Y
staff 53	Y	N	N	Y	Y	N	NA	Y	N
staff 54	Y	Y	N	Y	N	NA	NA	Y	Y
staff 55	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 56	Y	Y	N	Y	Y	N	NA	Y	Y
staff 57	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 58	Y	XXX	N	N	Y	N	NA	Y	Y

Appendix S - Answers of staff members to questionnaire

	Have you ever used the other languages you know to consult, treat or receive a patient? to receive patients	Is it something that the hospital expects of you to do?	Is it part of your contract with the hospital?	Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient?	Have you ever interpreted for a doctor or a patient?	If yes, have you ever received training in interpreting?	If yes, was it part of your medical training?	Has a colleague or another staff of the hospital ever helped as an interpreter for you?	If yes, was the outcome satisfactory?
staff 59	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 60	Y	Y	Y	Y	N	NA	NA	N	NA
staff 61	Y	Y	N	N	Y	N	NA	Y	Y
staff 62	ER: N	XXX	XXX	Y	Y	N	NA	XXX	XXX
staff 63	Y	N	N	Y	N	NA	NA	Y	Y
staff 64	Y	N	N	N	Y	N	NA	N	NA
staff 65	Y	Y	N	Y	Y	N	NA	Y	Y
staff 66	Y	N	N	N	N	NA	NA	Y	Y
staff 67	Y	Y	N	Y	Y	Y	Y	N	NA
staff 68	Y	Y	Y	Y	Y	N	NA	Y	Y
staff 69	Y	N	N	N	Y	N	ER N	Y	Y
staff 70	Y	Y	N	Y	N	NA	ER N	Y	Y
staff 71	Y	Y	N	Y	Y	N	ER N	Y	Y
staff 72	Y	Y	Y	Y	Y	N	ER N	Y	Y
staff 73	Y	Y	N	Y	Y	N	ER N	N	NA
staff 74	Y	N	N	N	N	N	ER N	N	NA
staff 75	Y	Y	N	Y	Y	N	ER Y	Y	Y
staff 76	N	N	N	Y	N	N	NA	Y	Y
staff 77	Y	Y	N	Y	Y	N	ER N	N	NA

Appendix S - Answers of staff members to questionnaire

	Have you ever used the other languages you know to consult, treat or receive a patient? to receive patients	Is it something that the hospital expects of you to do?	Is it part of your contract with the hospital?	Does the hospital expect staff members to help as interpreters when there is language barrier between doctor/nurse and patient?	Have you ever interpreted for a doctor or a patient?	If yes, have you ever received training in interpreting?	If yes, was it part of your medical training?	Has a colleague or another staff of the hospital ever helped as an interpreter for you?	If yes, was the outcome satisfactory?
staff 78	Y	Y	XXX	Y	Y	N	NA	XXX	XXX
staff 79	Y	Y	N	Y	Y	N	ER N	Y	Y

Appendix S - Answers of staff members to questionnaire

	Why?	Has an interpreter ever assisted you in consulting, treating or receiving a patient?	If the answer is "Yes" How often?	Was the interpreter provided by the hospital?	Was it a professional interpreter?	If the answer is "No", who was that interpreter?
staff 1	The patient cooperated and received proper	N	NA	NA	NA	NA
staff 2	The patient cooperated	Y	A couple of times	N	XXX	Patient's relatives
staff 3	XXX	Y	A couple of times	N	XXX	Patient's attendant
staff 4	Understanding with the patient	N	NA	NA	NA	NA
staff 5	The patient followed instructions	N	NA	NA	NA	NA
staff 6	Improved communication	N	NA	NA	NA	NA
staff 7	The patient understood expectations	N	NA	NA	NA	Myself
staff 8	XXX	N	NA	NA	NA	NA
staff 9	XXX	Y	A couple of times	N	N	Patient's
staff 10	Understanding the patient	N	NA	NA	NA	NA
staff 11	XXX	N	NA	NA	NA	NA
staff 12	XXX	XXX	XXX	XXX	XXX	XXX
staff 13	Understanding with the patient	Y	A couple of times	N	N	Patient's relatives
staff 14	XXX	N	NA	NA	NA	NA
staff 15	XXX	N	NA	NA	NA	NA
staff 16	Understanding with the patient	N	NA	NA	NA	NA
staff 17	XXX	Y	A couple of times	Y	N	Nurse
staff 18	Understanding with the patient	Y	Many times	N	XXX	XXX
staff 19	XXX	N	NA	NA	NA	NA

Appendix S - Answers of staff members to questionnaire

	Why?	Has an interpreter ever assisted you in consulting, treating or receiving a patient?	If the answer is "Yes" How often?	Was the interpreter provided by the hospital?	Was it a professional interpreter?	If the answer is "No", who was that interpreter?
staff 20	NA	N	NA	NA	NA	NA
staff 21	I am happy to receive help	Y	A couple of times	XXX	XXX	XXX
staff 22	Understanding with the patient	XXX	XXX	XXX	XXX	XXX
staff 23	NA	N	NA	NA	NA	NA
staff 25	NA	N	NA	NA	NA	NA
staff 26	NA	XXX	XXX	XXX	XXX	XXX
staff 27	NA	XXX	XXX	XXX	XXX	XXX
staff 28	Fluency of the colleage interpreting	Y	Twice	N	Not sure	Patient's attendant
staff 29	Well conveyed message	Y	A couple of times	N	N	Colleague
staff 30	Possibility to communicate with the patient	Y	Many times	N	XXX	XXX
staff 31	XXX	N	NA	NA	NA	NA
staff 32	XXX	N	NA	NA	NA	NA
staff 33	XXX	N	NA	NA	NA	NA
staff 34	NA	Y	A couple of times	N	NA	Patient's relatives
staff 35	???	Y	XXX	XXX	XXX	XXX
staff 36	I reached my goal	N	NA	NA	NA	NA
staff 37	Possibility to communicate with the patient	Y	A couple of times	Y	Y	NA
staff 38	The patient understood expectations	Y	A couple of times	N	N	Patient's relatives
staff 39	XXX	Y	A couple of times	Sometimes	N	Nurse

Appendix S - Answers of staff members to questionnaire

	Why?	Has an interpreter ever assisted you in consulting, treating or receiving a patient?	If the answer is "Yes" How often?	Was the interpreter provided by the hospital?	Was it a professional interpreter?	If the answer is "No", who was that interpreter?
staff 40	Understanding the patient	N	NA	NA	NA	NA
staff 41	Enabled to do my work	N	NA	NA	NA	NA
staff 42	Well conveyed message	Y	A couple of times	N	N	Nurse
staff 43	XXX	N	NA	NA	NA	NA
staff 44	Satisfaction varies with the interpreter	Y	A couple of times	N	N	Nurse
staff 45	The patient receives help	N	NA	NA	NA	NA
staff 46	Effective interpreting	Y	A couple of times	N	XXX	Y
staff 47	XXX	N	NA	NA	NA	NA
staff 48	Sometimes it works well, sometimes it does	N	NA	NA	NA	NA
staff 49	Improved communication	Y	Twice	N	N	Colleague
staff 50	The patient understood expectations	Y	Very often	Y	N	Colleague
staff 51	The employee has a medical background and	Y	A couple of times	N	XXX	Patient's relatives
staff 52	Improved communication	Y	A couple of times	N	N	Escort nurse
staff 53	Messages were summarised	N	NA	NA	NA	NA
staff 54	Enabled to do my work	Y	A couple of times	N	XXX	Nurse
staff 55	Understanding with the patient	N	NA	NA	NA	NA
staff 56	Doctor did not call for a second opinion	Y	A couple of times	N	N	Patient's relatives
staff 57	The patient was happy	Y	Very often	N	N	Nurse from Congo
staff 58	XXX	N	NA	NA	NA	NA

Appendix S - Answers of staff members to questionnaire

	Why?	Has an interpreter ever assisted you in consulting, treating or receiving a patient?	If the answer is "Yes" How often?	Was the interpreter provided by the hospital?	Was it a professional interpreter?	If the answer is "No", who was that interpreter?
staff 59	XXX	N	XXX	XXX	XXX	XXX
staff 60	XXX	N	NA	NA	NA	NA
staff 61	XXX	Y	A couple of times	N	Y	NA
staff 62	XXX	N	NA	NA	NA	NA
staff 63	XXX	Y	A couple of times	N	N	Patient
staff 64	NA	N	NA	NA	NA	NA
staff 65	Understanding with the patient	Y	Very often	Y	N	Department staff
staff 66	Understanding the patient	N	NA	NA	NA	NA
staff 67	NA	Y	Twice	N	XXX	XXX
staff 68	The patient understood and answers were	N	NA	NA	NA	NA
staff 69	The patient understood expectations and	Y	A couple of times	N	N	Colleagues
staff 70	The patient understood expectations	Y	A couple of times	Y	N	Escort nurse
staff 71	The patient understood radiotherapy	Y	Very often	Y	N	Colleague/Nurse
staff 72	XXX	Y	A couple of times	Sometimes	N	Colleague
staff 73	NA	Y	A couple of times	N	N	XXX
staff 74	NA	N	NA	NA	NA	NA
staff 75	I knew what was been interpreted	Y	A couple of times	Sometimes	N	Staff
staff 76	The patient understood	Y	A couple of times	N	N	Friends/Relatives
staff 77	NA	N	NA	NA	NA	NA

Appendix S - Answers of staff members to questionnaire

	Why?	Has an interpreter ever assisted you in consulting, treating or receiving a patient?	If the answer is "Yes" How often?	Was the interpreter provided by the hospital?	Was it a professional interpreter?	If the answer is "No", who was that interpreter?
staff 78	XXX	XXX	XXX	XXX	XXX	XXX
staff 79	We could resume the treatment as patient got	Y	A couple of times	N	XXX	Colleague

Appendix S - Answers of staff members to questionnaire

	Were you satisfied with the consultation?	Please state why	Do patients bring their interpreters?	Are they professional interpreters?	If the answer is "No" or "Sometimes" Who are these interpreters to patients?	Were you satisfied with the consultation?	Please state why
staff 1	NA	NA	XXX	XXX	XXX	XXX	XXX
staff 2	Y	Facilitates communication	Y	N	Relatives	Y	Faster communication than usual
staff 3	N	XXX	Y	N	Attendants	N	As the service provider, it's better
staff 4	NA	NA	XXX	XXX	XXX	XXX	XXX
staff 5	NA	NA	XXX	XXX	XXX	XXX	XXX
staff 6	NA	NA	Sometimes	N	Relatives	N	Unsure that the information is
staff 7	Y	I conveyed the information	N	N	Myself	Y	I conveyed the information to the
staff 8	NA	NA	XXX	XXX	XXX	XXX	XXX
staff 9	Y	XXX	Y	N	Relatives	Y	Information was well explained
staff 10	NA	NA	XXX	XXX	XXX	XXX	XXX
staff 11	NA	NA	ER: N	XXX	ER: no one	ER: Y	ER: I understand what the doctor
staff 12	XXX	XXX	Sometimes	N	XXX	XXX	XXX
staff 13	Y	Understanding what was	Sometimes	N	Relatives	Y	Patients trust and are comfortable
staff 14	NA	NA	Sometimes	N	Relatives	Y	XXX
staff 15	NA	NA	Sometimes	N	Relatives	Y	They understand the patient, and
staff 16	NA	NA	Sometimes	N	Friends/Relative	Y	Patients understand better when
staff 17	Y	XXX	Sometimes	N	Attendant	Y	XXX
staff 18	Sometimes	XXX	Sometimes	N	Friends/Relative	Sometimes	Not a daily situation
staff 19	NA	NA	Y	Y	NA	Y	XXX

Appendix S - Answers of staff members to questionnaire

	Were you satisfied with the consultation?	Please state why	Do patients bring their interpreters?	Are they professional interpreters?	If the answer is "No" or "Sometimes" Who are these interpreters to patients?	Were you satisfied with the consultation?	Please state why
staff 20	NA	NA	Sometimes	N	Friends/Neigbou	Y	XXX
staff 21	Y	Interpreters are helpful	Sometimes	N	Relatives	Y	Patient's relatives understand
staff 22	XXX	XXX	Sometimes	Sometimes	Attendants/Relati	Y	XXX
staff 23	NA	NA	Sometimes	Sometimes	Attendants/Relati	Sometimes	XXX
staff 25	NA	NA	Sometimes	Sometimes	Attendants/Relati	Sometimes	XXX
staff 26	XXX	XXX	N	N	Colleagues	XXX	XXX
staff 27	XXX	XXX	XXX	XXX	XXX	XXX	XXX
staff 28	Sometimes	Difficulty for patient to	Sometimes	Not sure	Friends/Relative	Sometimes	XXX
staff 29	XXX	XXX	XXX	N	Relatives	Y	Well conveyed message
staff 30	XXX	XXX	Y	N	Relatives	N	Some issues are uninterpretable
staff 31	NA	NA	Sometimes	N	Friends/Relative	Y	The relative knew English well.
staff 32	NA	NA	Sometimes	N	Friends/Relative	Y	XXX
staff 33	NA	NA	Sometimes	ER Y	Relatives	Y	XXX
staff 34	Y	XXX	Sometimes	N	Relatives	Y	XXX
staff 35	Y	XXX	Sometimes	N	Friends/Relative	Y	XXX
staff 36	NA	NA	Sometimes	N	Friends/Relative	Y	Enabled to do my work
staff 37	Y	XXX	Sometimes	N	Relatives/Fellow	Sometimes	Terminology is not understood,
staff 38	Sometimes	They sometimes do not	Y	Sometimes	Relatives	Y	XXX
staff 39	Sometimes	Unsure that patients	Sometimes	N	Friends/Relative	Sometimes	XXX

Appendix S - Answers of staff members to questionnaire

	Were you satisfied with the consultation?	Please state why	Do patients bring their interpreters?	Are they professional interpreters?	If the answer is "No" or "Sometimes" Who are these interpreters to patients?	Were you satisfied with the consultation?	Please state why
staff 40	NA	NA	Sometimes	N	Relatives	Y	XXX
staff 41	NA	NA	Y	N	Relatives	Y	XXX
staff 42	Y	Good interpreting	Y	N	Nurses/Relatives	Y	Good interpreting
staff 43	NA	NA	Sometimes	N	Relatives	Y	XXX
staff 44	Sometimes	XXX	ER N	N	XXX	N	XXX
staff 45	NA	NA	Sometimes	N	Relatives	Sometimes	Message not always delivered
staff 46		Good interpreting	N	NA	NA	NA	NA
staff 47	NA	NA	Sometimes	N	Friends/Relative	Sometimes	XXX
staff 48	NA	NA	Sometimes	N	Friends/Relative	Sometimes	Message not always delivered
staff 49	Y	Improved communication	Sometimes	N	Friends/Relative	Y	Improved communication
staff 50	Y	Enabled to convey	Y	N	Relatives	Sometimes	Message difficult to convey for the
staff 51	Sometimes	Ill-informed ad hoc	Sometimes	N	Relatives	Sometimes	Relatives are not always
staff 52	Y	XXX	ER N	N	Escort nurses	Y	It is not the role of Escort nurses
staff 53	NA	NA	Y	N	Relatives	Y	XXX
staff 54	Y	Enabled to do my work	Sometimes	N	Relatives	Y	Enabled to do my work
staff 55	NA	NA	Sometimes	IDN	Relatives	Y	Patients understand better when
staff 56	Sometimes	At times, an intervention is	Sometimes	N	Relatives	Sometimes	Intervention is needed as patients
staff 57	Y	Understanding with the	Sometimes	N	Friends/Relative	Y	The patient understands
staff 58	NA	NA	Sometimes	Sometimes	Relatives	XXX	XXX

Appendix S - Answers of staff members to questionnaire

	Were you satisfied with the consultation?	Please state why	Do patients bring their interpreters?	Are they professional interpreters?	If the answer is "No" or "Sometimes" Who are these interpreters to patients?	Were you satisfied with the consultation?	Please state why
staff 59	XXX	XXX	XXX	XXX	XXX	XXX	XXX
staff 60	NA	NA	N	ER:	Nurses	XXX	XXX
staff 61	Y	XXX	Sometimes	N	Friends	Y	XXX
staff 62	NA	NA	Sometimes	N	Nurses/Relatives	XXX	XXX
staff 63	Y	XXX	Sometimes	N	Relatives	XXX	XXX
staff 64	NA	NA	Sometimes	N	Relatives	Sometimes	XXX
staff 65	Y	Enabled to communicate	Sometimes	N	Department staff	Y	Enabled communication
staff 66	NA	NA	Sometimes	N	XXX	Sometimes	XXX
staff 67	Y	XXX	N	XXX	XXX	XXX	XXX
staff 68	NA	NA	Sometimes	N	Relatives	Y	XXX
staff 69	Y	Interpreters are fluent in	Y	N	Relatives	Y	Patients' relatives understand both
staff 70	Y	Patient understood	Sometimes	N	Friends/Relative	Sometimes	XXX
staff 71	Y	XXX	Always	N	Relatives	Y	The patient understands the
staff 72	Y	XXX	Sometimes	N	Relatives	Y	XXX
staff 73	XXX	XXX	Sometimes	N	Relatives	Y	The patients understand
staff 74	NA	NA	N	ER N	NA	NA	NA
staff 75	Y	I understand what is being	Sometimes	N	Relatives	Y	Mutual understanding
staff 76	Y	XXX	Sometimes	Sometimes	XXX	Y	XXX
staff 77	NA	NA	Sometimes	N	Relatives	Y	It's helpful

Appendix S - Answers of staff members to questionnaire

	Were you satisfied with the consultation?	Please state why	Do patients bring their interpreters?	Are they professional interpreters?	If the answer is "No" or "Sometimes" Who are these interpreters to patients?	Were you satisfied with the consultation?	Please state why
staff 78	XXX	XXX	Sometimes	Sometimes	Relatives	Y	XXX
staff 79	Y	XXX	Sometimes	N	Escort	Y	Enabled communication

Appendix S - Answers of staff members to questionnaire

	Have you ever been trained to work with an interpreter?	Does the hospital have a database of interpreters it works with?	How long does it take you to consult, record or attend a patient?	Are you satisfied with that timing?	Please state why	What are the languages that hinder the dynamism of your work?
staff 1	XXX	IDN	30mn maximum	Y	Enough time to cater for the patient and	Afrikaans
staff 2	N	N	10mn	N	Because of language barrier, it	French,
staff 3	N	IDN	Depends on case	XXX	XXX	French
staff 4	N	IDN	Time varies	XXX	XXX	Any language
staff 5	N	IDN	10mn	Y	The message goes across between	isiXhosa
staff 6	N	N/IDN	Depends on case	XXX	XXX	Other African
staff 7	N	IDN	Around 5mn	Y	Enough time to cater for the patient and	Other African
staff 8	XXX	IDN	15 - 30mn	Y	XXX	Afrikaans,
staff 9	N	IDN	Less than 30mn	N	It is too long	French, Swahili
staff 10	N	IDN	Around 20mn	Y	Enough time for the patient to express	French,
staff 11	N	N	Depends on case	Y	No one compained	Afrikaans,
staff 12	N	XXX	Around 30mn	Y	XXX	Foreign
staff 13	N	IDN	5 - 10mn	Y	Enough time for consultation	African and
staff 14	N	N	Around 30mn	Y	Enough time for consultation	French, SiSwati
staff 15	N	IDN	20 mn	Y	Depends on case	Afrikaans,
staff 16	N	IDN	Depends on case	Y	Enough time for consultation	Any language we
staff 17	N	N	15 - 20mn	Y	XXX	Local languages
staff 18	N	N	Depends on	Y	XXX	Foreign
staff 19	Y	Y	5mn	Y	Depending on whether I understand what	Afrikaans,

Appendix S - Answers of staff members to questionnaire

	Have you ever been trained to work with an interpreter?	Does the hospital have a database of interpreters it works with?	How long does it take you to consult, record or attend a patient?	Are you satisfied with that timing?	Please state why	What are the languages that hinder the dynamism of your work?
staff 20	N	IDN	Unsure	XXX	XXX	African
staff 21	N	IDN	30mn	N	Sometimes staff members take their time	ER: English
staff 22	N	IDN	XXX	Y	XXX	French
staff 23	N	IDN	XXX	XXX	XXX	French
staff 25	N	IDN	XXX	XXX	XXX	French
staff 26	N	IDN	NA	XXX	XXX	Afrikaans,
staff 27	XXX	XXX	XXX	XXX	XXX	XXX
staff 28	N	IDN	Around 35mn	XXX	Depends on case	Foreign
staff 29	N	IDN	20mn	Y	XXX	Foreign
staff 30	N	N	ASAP	Y	Because of the Batho Pele principle	Afrikaans,
staff 31	N	Y	5 -10 mn	Y	XXX	Foreign
staff 32	N	IDN	5mn	Y	XXX	Foreign
staff 33	Y (ER)	IDN	5mn	Y	XXX	French,
staff 34	N	IDN	Depends on case	Y	XXX	Foreign
staff 35	N	IDN	15 - 30mn	Y	XXX	Portuguese,
staff 36	N	IDN	Depends on case	Y	XXX	Any language I
staff 37	N	IDN	15mn	N	The patient's load is heavy. Some	African
staff 38	N	IDN	15 - 30mn	Y	XXX	French,Sepedi,
staff 39	N	N	15 - 20mn	Y	XXX	isiZulu, isiXhosa,

Appendix S - Answers of staff members to questionnaire

	Have you ever been trained to work with an interpreter?	Does the hospital have a database of interpreters it works with?	How long does it take you to consult, record or attend a patient?	Are you satisfied with that timing?	Please state why	What are the languages that hinder the dynamism of your work?
staff 40	N	IDN	Depends on case	Y	Enough time for consultation	Any language I
staff 41	N	IDN	It takes too long	N	It takes too long and sometimes you do	XXX
staff 42	N	IDN	20mn	Y	Enough time for consultation	African
staff 43	N	IDN	Around 30mn	N	The interpreting process takes too long	Local languages
staff 44	N	IDN	Around 20mn	N	Though it depends on the case, it could	Any language I
staff 45	N	IDN	30 -50 mn	Y	Enough time for consultation	Local languages
staff 46	N	N	20 - 30mn	N	The language barrier makes it	Local languages
staff 47	N	IDN	Depends on case	XXX	XXX	Any language I
staff 48	N	IDN	10 - 30mn	Y	Enough time for consultation	Any language I
staff 49	N	IDN	30mn	Y	Enough time for consultation	French,
staff 50	N	IDN	Around 30mn	Y	Enough time for consultation	Local languages,
staff 51	N	IDN	Around 20mn	N	When interpreter is not found,	Foreign
staff 52	N	IDN	Depends on case	Y	Enough time for consultation	Xitsonga,
staff 53	N	N	Around 15mn	N	Irrelevant	Xitsonga, Swahili
staff 54	N	IDN	Depends on case	Y	Enough time for consultation	African
staff 55	N	IDN	30mn minimum	Y	XXX	Foreign
staff 56	N	IDN	30mn maximum	N	Depends on case	Foreign
staff 57	N	Y	Depends on case	Y	Enough time for consultation	French,
staff 58	Y	IDN	15 - 30mn	XXX	XXX	French,

Appendix S - Answers of staff members to questionnaire

	Have you ever been trained to work with an interpreter?	Does the hospital have a database of interpreters it works with?	How long does it take you to consult, record or attend a patient?	Are you satisfied with that timing?	Please state why	What are the languages that hinder the dynamism of your work?
staff 59	XXX	IDN	XXX	Y	XXX	XXX
staff 60	N	IDN	XXX	XXX	XXX	XXX
staff 61	N	N	Depends on case	Y	XXX	XXX
staff 62	N	IDN	Less than 5mn	N		French
staff 63	N	IDN	XXX	XXX	XXX	XXX
staff 64	N	IDN	NA	NA	NA	Foreign
staff 65	N	IDN	15 - 60mn	Y	Enough time for consultation	African
staff 66	N	IDN	5mn	N	It should be more	isiZulu, Sesotho
staff 67	XXX	IDN	XXX	Y	XXX	French
staff 68	N	Y	XXX	XXX	Time consuming: You have to first listen	French,
staff 69	N	IDN	It depends	Y	There is always a multilingual person	Afrikaans,
staff 70	N	IDN	10mn	Y	XXX	isiXhosa,
staff 71	N	IDN	20mn	Y	XXX	isiXhosa,
staff 72	N	IDN	10mn	Y	XXX	XXX
staff 73	N	IDN	Around 20mn	Y	XXX	Foreign
staff 74	N	IDN	No consultation	NA	NA	Afrikaans, isiZulu,
staff 75	N	IDN	Around 10mn	Y	When there are 40 patients on the daily	African
staff 76	N	IDN	A few minutes	Y	Most speak English	isiZulu, isiXhosa
staff 77	N	IDN	2mn	N	Not enough time	Afrikaans,

Appendix S - Answers of staff members to questionnaire

	Have you ever been trained to work with an interpreter?	Does the hospital have a database of interpreters it works with?	How long does it take you to consult, record or attend a patient?	Are you satisfied with that timing?	Please state why	What are the languages that hinder the dynamism of your work?
staff 78	N	IDN	10-15mn	Y	RE: Accurate time	XXX
staff 79	N	IDN	A few minutes. It	Y	XXX	Foreign

Appendix S - Answers of staff members to questionnaire

	Studies have shown that working with professional interpreters is financially rewarding to institutions. What do you think?	Will it be useful for hospitals to work with interpreters?	Why?	Is the hospital applying any language policy?	If yes, please could you indicate which one(s)?
staff 1	True: Patients will feel	Y	Life and the	Y	Use of decent
staff 2	XXX	Y	Patients will be	N	NA
staff 3	I have never worked with	Y	Trained	N	NA
staff 4	I cannot comment; I have	Y	There will be	N	NA
staff 5	Professional interpreters	Y	It will make life	XXX	XXX
staff 6	I have never worked with	Y	Patients will	N	NA
staff 7	TRUE	Y	XXX	N	NA
staff 8	I am not sure, but I am	Y	Patients will be	N	NA
staff 9	It can improve service	Y	It can improve	N	NA
staff 10	Since interpreters are not	Y	Different culture,	N	NA
staff 11	I cannot comment; I have	N	No patient	N	NA
staff 12	Good: it is time saving for	Y	Patients will	N	NA
staff 13	It will be helpful both for	Y	There will be	N	NA
staff 14	Probably yes	Y	Time saving in	N	NA
staff 15	I cannot comment; I have	Y	XXX	IDN	IDN
staff 16	Plausible	Y	It'll improve	IDN	NA
staff 17	Probably, more patients	Y	XXX	IDN	NA
staff 18	If do my job and the	N	XXX	N	NA
staff 19	They should go out and	Y	Patients come to	IDN	NA

Appendix S - Answers of staff members to questionnaire

	Studies have shown that working with professional interpreters is financially rewarding to institutions. What do you think?	Will it be useful for hospitals to work with interpreters?	Why?	Is the hospital applying any language policy?	If yes, please could you indicate which one(s)?
staff 20	Good: it is time saving for	Y	Good: it is time	Y	English (As the
staff 21	People should help with	Y	It will be helpful	N	NA
staff 22	XXX	Y	Time saving	Y	English
staff 23	True: the hosptital will	Y	Time saving	Y	English
staff 25	True: the hosptital will	Y	Time saving	Y	English
staff 26	I disagree: Financially	Y	It will improve	N	NA
staff 27	XXX	XXX	XXX	XXX	
staff 28	True: it will save a lot of	Y	Confidentiality	N	NA
staff 29	XXX	Y	Time and money	Y	XXX
staff 30	Statistically speaking and	Y	To avoid that	N	NA
staff 31	It could be financially	Y	Interpreting for a	IDN	NA
staff 32	TRUE	Y	So that	N	NA
staff 33	XXX	Y	XXX	N	NA
staff 34	Time saving and improve	Y	Time saving	XXX	XXX
staff 35	Yes, provided that the	Y	???	IDN	NA
staff 36	Possibly, though we	Y	Time saving in	IDN	NA
staff 37	Possibly	Y	Improve	IDN	NA
staff 38	I have never worked with	Y	Useful for	IDN	NA
staff 39	TRUE	Y	Improve	N	NA

Appendix S - Answers of staff members to questionnaire

	Studies have shown that working with professional interpreters is financially rewarding to institutions. What do you think?	Will it be useful for hospitals to work with interpreters?	Why?	Is the hospital applying any language policy?	If yes, please could you indicate which one(s)?
staff 40	TRUE	Y	Improve	IDN	NA
staff 41	I have never worked with	Y	XXX	IDN	NA
staff 42	TRUE	Y	Benefits patients	IDN	NA
staff 43	I do not know	Y	Improve	IDN	NA
staff 44	TRUE	Y	Time saving and	IDN	NA
staff 45	I do not know	Y	XXX	IDN	NA
staff 46	XXX	Y	Improve	IDN	NA
staff 47	I cannot comment and I	Y	Improve service	IDN	NA
staff 48	I cannot comment and I	Y	Improve	Y	Patients have the
staff 49	TRUE	Y	Improve	IDN	NA
staff 50	TRUE	Y	Improve service	IDN	NA
staff 51	Time saving	Y	XXX	IDN	NA
staff 52	TRUE	Y	Time saving	IDN	NA
staff 53	I am not sure	XXX	XXX	IDN	NA
staff 54	A professional interpreter	Y	XXX	IDN	NA
staff 55	I do not know	N	What about	IDN	NA
staff 56	I disagree: In a hospital	Y	It wil be useful	IDN	NA
staff 57	Though it is helpful, it will	Y	Patients will	Y	XXX
staff 58	I do not know	XXX	XXX	XXX	XXX

Appendix S - Answers of staff members to questionnaire

	Studies have shown that working with professional interpreters is financially rewarding to institutions. What do you think?	Will it be useful for hospitals to work with interpreters?	Why?	Is the hospital applying any language policy?	If yes, please could you indicate which one(s)?
staff 59	XXX	Y	Because we	Y	XXX
staff 60	XXX	Y	XXX	IDN	NA
staff 61	XXX	Y	Patients will	N	NA
staff 62	True: it will save time for	Y	It will make life	IDN	NA
staff 63	XXX	Y	XXX	IDN	NA
staff 64	TRUE	Y	XXX	IDN	NA
staff 65	Possibly	Y	Improves	IDN	NA
staff 66	TRUE	Y	XXX	Y	XXX
staff 67	Complexity of numbers of	XXX	XXX	XXX	XXX
staff 68	Having professional	Y	Enables	XXX	XXX
staff 69	XXX	XXX	XXX	N	NA
staff 70	True: doctors don't leave	Y	Time saving	IDN	NA
staff 71	I AGREE	Y	XXX	IDN	NA
staff 72	XXX	Y	XXX	IDN	NA
staff 73	Time saving:patients	Y	Difficulty to	IDN	NA
staff 74	I AGREE: Time saving	Y	Time saving	IDN	NA
staff 75	The Department is too	N	We don't have	IDN	NA
staff 76	I AGREE	Y	Help patients	N	NA
staff 77	XXX	Y	Time saving	IDN	NA

Appendix S - Answers of staff members to questionnaire

	Studies have shown that working with professional interpreters is financially rewarding to institutions. What do you think?	Will it be useful for hospitals to work with interpreters?	Why?	Is the hospital applying any language policy?	If yes, please could you indicate which one(s)?
staff 78	XXX	Y	Time saving	IDN	NA
staff 79	I AGREE: Language	Y	XXX	IDN	NA

APPENDIX T

TRANSCRIPTIONS

TRANSCRIPTION CONSULTATION 1

#00:00:00-0# Doctor: ok Mama the last time we saw you [small cough] was that in May were you here in May

#00:00:06-2# Trained interpreter: *Zulu* isikhathi esaqala ngaso / esagcina ukukubona ngoMay (*the time we started / we last saw you was in May*)

#00:00:10-2# Patient: yes

#00:00:11-2# Trained interpreter: yes

#00:00:11-7# Doctor: ok hmmm do you remember if you had an operation right at the beginning

#00:00:17-6# Trained interpreter: *Zulu* mhh usakhumbula ukuthi uke waba ne-operation ekuqaleni (hmm *do you remember that you had an operation at the beginning)*

#00:00:22-5# Patient: [no

Doctor: [no operation

#00:00:23-9# [long silence: the doctor is busy reviewing the patient's file]

#00:01:27-9# Doctor: ok Mama are you having any problems now since we saw you in May

#00:01:33-6# Patient: [no

#00:01:34-3# Trained interpreter: [*Zulu* kukhona izinkinga onazo manje

njengoba sagcina ukukubona ngoMeyi *(end of the Zulu sentence* #00:01:38-3#) (*do you have problems right now since we last saw you in May)*

#00:01:38-1# Patient: no
#00:01:40-6# Trained interpreter: no I don't have a problem
#00:01:42-1# Doctor: hmm any bleeding from the bottom or discharge
#00:01:45-9# Patient: [he
#00:01:45-9# Trained interpreter: [*Zulu* kukhona okuphumayo ngaphansi (*is there something coming out underneath)*

#00:01:47-8# Patient: no
#00:01:48-4# Doctor: nothing [short pause] hmmm when you're going to pee / is there any burning or pain

#00:01:56-4# Patient: [yes
#00:01:56-4# Trained interpreter: [*Zulu* uma ngabe uchama kukhona okuphumayo noma okushisayo uma ngabe u…(inaudible) uchama (*when you pee is there anything coming out or does it burn when you…*(inaudible) *pee*)

#00:02:00-5# Patient: *Zulu* yebo kukhona (*yes there is*)
#00:02:01-8# Trained interpreter: yes there is a bur[ning
#00:02:03-2# Doctor: [what is it burning Mum

#00:02:04-7# Patient: yes #00:02:05-1#

[short silence]

#00:02:06-5# Doctor: How long has the burning been for
#00:02:08-4# Trained interpreter: *Zulu* sekuyisikhathi esingakanani manje ma kushisa (*for how long has it been now burning ma)*

#00:02:11-3# Patient: *Zulu* ukuthi angi- angithi ngesikhathi ngise- ngingena emshinini ngaba nesilonda ngapha ngasha / sahlala unyaka wonke e- base bengithumela e-*gastro* / besihleli sisekhona bafika (inaudible) bangifaka futhi bangiklina bangifaka umuthi / nalapha ngaphambili uma bengifake umuthi / liyaphuma kancane igazi kuba buhlungu kushise (it is I don't isn't that so w*hen I got into the machine I had a sore this side I got burnt / it stayed for the whole year and then they sent me to gastro / this sore was there (inaudible) they again cleaned me and put some medicine / also here in front when they put the medicine / the blood does come out a little and it becomes painful and it burns*)

#00:02:46-5# Trained interpreter: {Ok} hmm last time hmm they took me to- to- on the machine and I have a- a- a- sore at the back so each time when I- when I pee / the pain is there and I hmm I went there and after- after- that I have just been experiencing the burning sensation

#00:03:06-1# Doctor: so is the burning in front when she pees or in the back when she goes number two
#00:03:11-6# Trained interpreter: *Zulu* ukushisa lokhu kuphuma ngaphambili (*does this burning come from the front)*

#00:03:13-6# Patient: *Zulu* ngaphambili (*from the front*)
#00:03:14-8# Trained interpreter: In the front

#00:03:15-4# Doctor: in the front [pause] so the back everything is fine no bleeding

#00:03:19-5# Patient: hmm bleeding is stop hmmmm *Zulu* kumile manje ngase ngiblida bengiye ngomhlaka 3 October base beyangiklina (inaudible) (bleeding has now stopped when bleeding I went on the 3 October and they cleaned me (inaudible))

#00:03:36-1# Trained interpreter: the bleeding has stopped #00:03:37-2#

[Short silence]

#00:03:39-4# Doctor: ok hmmmm so she- she mentions that she went to the people up

at the- the GI clinic

#00:03:46-8# Trained interpreter: *Zulu* uke wakhuluma ngokuthi uke waya e-*GI clinic* (*you said you had been to the GI clinic*)

#00:03:49-8# Patient: e-*gastro*

#00:03:51-9# Trained interpreter: [yes

#00:03:52-0# Doctor: [true it's true

#00:03:52-3# Patient: [yes

#00:03:53-3# Doctor: ok // so is she still seeing them

#00:03:56-1# Patient: [yes

#00:03:56-1# Trained interpreter: [usaya khona (*do you still go there)*

#00:03:57-3# Trained interpreter: yes

#00:03:57-4# Doctor: ok alright so basically hmm- just to explain to her they are treating her for that- that problem is because of the side effect of the radiation so they are treating her for that so she needs to continue following up with them

#00:04:11-2# Trained interpreter: Ok *Zulu* kusabalulekile ukuthi uqhubeke uye *e-gastro* / inkinga leyo bayayilungisa / izogcina isilungile wena kufanele ulokhu uqhubeke ulokhu uhamba khona bazoyilungisa inkinga leyo (*it is still important that you continue to go to gastro / that problem they are sorting it / it will end up solved you need to keep on to continue to keep on going there they will solve that problem*)

#00:04:23-3# [Long silence]

#00:04:39-9# Doctor: ok Mama I need you to lie on the bed for me ok

#00:04:43-0# Patient: ok

#00:04:43-1# Trained interpreter: *Zulu* uthi ulale embhedeni (she says lie on the bed)

#00:04:45-3# Patient: ok

[The consultation now takes place behind the curtains, far from the desk where the recording equipment is set as the doctor examines the patient and the interpreter is not permitted to go with them]

#00:04:57-9# Doctor: (inaudible) here (inaudible) no I ok that is fine

#00:05:02-8# [long silence]

#00:05:32-0# Doctor: (inaudible) in your back ok [silence] (inaudible) [silence] ok bend the legs straight straight good [silence] no pain here

#00:05:52-1# Patient: (inaudible)

#00:05:56-8# Doctor: [oh

[the patient keeps speaking but she is inaudible to the researcher]

#00:05:59-9# Doctor: (inaudible)

#00:06:00-9# Patient: yes (inaudible)

#00:06:03-3# Doctor: yes true

#00:06:03-8# Patient: yes yes true #00:06:04-2#

[short silence]

#00:06:07-9# Doctor: alright Mama I'm gonna put my fingers inside to check ok [short silence] yeah do that bend the knees for me #00:06:15-0#

[long silence]

#00:06:49-5# Doctor: ok Mama I am coming back now ok [doctor walks away from the curtain and walking back to the desk area]

#00:06:51-3# Patient: thank you

#00:06:52-1# Doctor (addressing the trained interpreter): you look so sad

#00:06:52-7# Trained interpreter: [laughs says something inaudible]

#00:06:54-5# [doctor walks out of the consultation room]

[long silence]

#00:07:39-8# [the doctor walks back in the consultation room and walks to the patient behind the curtains]

#00:07:45-6# Doctor: ok dear [short pause] just relax ok [short pause] it's good [short pause] alright [short pause] we are done

#00:08:00-9# Patient: [inaudible]

#00:08:02-5# Doctor: ok when you finish come sit there right

#00:08:04-3# Patient: dankie

[Doctor walks back to her desk, sits down and works on the patient's file]

[Long silence]

#00:08:58-7# [Patient reaches the desk, takes back her sit and sighs]

[long silence]

#00:09:05-4# Doctor: Hmmm mama do you what tablets you're taking now

#00:09:08-3# Trained interpreter: *Zulu* uyawazi amaphilisi owathathayo njengamanje (*Do you know the tablets you are taking at the moment)*

#00:09:11-7# Patient: (shakes her head) Zulu [cha angiwazi (*no I don't know them*)

#00:09:11-9# Trained interpreter: No doc[tor

#00:09:13-3# Doctor: You don't know ok hmmm how old are you

#00:09:16-7# Trained interpreter: *Zulu* uneminyaka emingaki (*how old are you?)*

#00:09:18-1# Patient: thirty-eight

#00:09:18-8# Trained interpreter: [thirty-eight

#00:09:18-8# Doctor: [thirty-eight

#00:09:19-9# Doctor: are you still using the cream

#00:09:21-6# Patient: [yes

#00:09:22-2# Trained interpreter: [yes she is using the cream

#00:09:24-3# Doctor: Hmm are you taking anything for pain

#00:09:26-7# Trained interpreter: *Zulu* kukhona into oyithathayo uma uzwa ubuhlungu (is there anything you taking when you feel the pain)

#00:09:27-4# Patient: no

#00:09:29-3# Trained interpreter: no

[silence]

#00:09:36-0# Doctor: ok so Mama I am gonna give you the hum the cream again you carry on with the cream

#00:09:43-3# Patient: I don't like cream I need gel

#00:09:45-9# Doctor: oh you've got the cream have you got the cream

#00:09:48-0# Patient: no I didn't but I

#00:09:48-9# Doctor: but why don't you want the cream

#00:09:50-5# Trained interpreter: *Zulu* yini indaba ungafuni ukusebenzisa u-cream (why don't you want to use the cream)

#00:09:52-3# Doctor: (inaudible) the cream is like the gel why

#00:09:54-5# Trained interpreter: *Zulu* u-cream unjenge-gel / yini indaba ungafuni ukuwusebenzisa (the cream is like the gel / why don't you want to use it)

#00:09:58-4# Patient: *Zulu* bathi usiza uma ngabe une-boyfriend anginayo i-boyfriend (they say it helps when you have a boyfriend I don't have a boyfriend)

#00:10:02-2# Trained interpreter: they said it helps when you have a boyfriend and I don't have a boyfriend #00:10:06-3#

[short silence]

#00:10:07-8# Doctor: so you are happy not to use it

#00:10:10-0# Trained interpreter: *Zulu* awuthandi ukuwusebenzisa (you don't like to use it)

#00:10:11-7# Patient: no

#00:10:12-1# Doctor: (smiling) ok [pause] alright [pause] ok so I am gonna give you the a the gel

#00:10:17-6# Patient: yes

#00:10:17-9# Doctor: [and then I am going to give you something for -the- burning

Interpreter:

#00:10:21-1# Patient: yes

#00:10:21-4# Doctor: ok]

#00:10:21-5# Trained interpreter: [*Zulu* ngizokunikeza i-gel nento ezosiza ukuthi iqede ukushisa (I will give you the gel and something that will help to stop the burning)

#00:10:22-5# Patient: yes]

#00:10:24-3# Patient: ok

#00:10:24-9# Doctor: but you need to carry on going to gastral

#00:10:27-4# Trained interpreter: Zulu [kodwa kuzofanele uqhubeke uye e-gastro (but you still need to continue going to gastro)

#00:10:27-4# Patient: [yeah

#00:10:28-0# Doctor: ok

#00:10:29-4# [Trained interpreter ends her rendition]

[short silence]

#00:10:33-7# Doctor: and then we will see you again in six months' time [the interpreter starts talking but as the doctor continues, she stops] and then when you come back in six months we are going to do another pap smear for you ok

#00:10:42-7# Trained interpreter: *Zulu* sizokubona emva kwenyanga eziyisithupha / uma ubuya futhi kuzofanele ukuthi senze -ipap smear (we will see you after six months / when you come back we should do a pap smear)

#00:10:48-2# Patient: ok

#00:10:48-9# Trained interpreter: yes doctor

#00:10:49-6# [long silence]

#00:10:59-5# [A woman (woman 1) comes inside the consultation room and starts addressing the doctor]

#00:11:03-8# Woman 1: [She greets the doctor by her name]

#00:11:04-7# Doctor responds

#00:11:05-2# Woman 1: how are you darling

#00:11:06-0# Doctor: good how are you

#00:11:06-7# Woman 1: ok [short pause] be ok *né*

#00:11:09-9# Doctor: thank you my dear

#00:11:10-5# Woman 1: things- things will go

#00:11:12-4# Doctor: [thank you [pause]

#00:11:12-4# Woman 1: [ok yeah just [just be strong

#00:11:14-5# Doctor: [I appreciate it thank you

#00:11:15-8# [long silence]

#00:11:26-0# Patient: (addresses woman 1 in Zulu): Kunjani sisi [she says the woman's name]

#00:11:26-7# Woman 1 (addresses patient back in Zulu) ngiyaphila unjani [she says the patient's name]

[silence]

#00:11:28-6# Woman 1: [eeee #00:11:29-1# iphi i-make up angisakuboni

#00:11:28-2# Patient: oh-[oh [laughing] bengivele ngazi ukuthi uzo (inaudible)???

#00:11:32-6# Woman 1: (addresses the patient in Zulu) wena uyazi unge ngacabanga ukuthi unyangidelela wena

#00:11:34-2# Patient [bursts in laughter and replies in Zulu] [laughter]

#00:11:36-2# Woman 1: Wena

[Patient and woman 1 laugh very hard]

#00:11:38-3# Woman 1: wena

[Patient laughs very hard]

#00:11:39-2# Patient: [addresses woman 1, laughing]

#00:11:41-3# Patient [still laughing]

#00:11:44-7# Woman 1: (Possibly says something as the patient is still laughing. The door creaks. Apparently, Woman 1 goes out and someone else comes in, Woman 2) #00:11:54-1#

#00:11:49-5# Woman 2: what the fuck? (speaking simultaneously with the door closing) Hawu konje yini yonke le eniyenzayo

#00:11:49-8# Doctor: oh shame we- they told you they are making a movie [laughter]

#00:11:53-0# Woman 2: what kind of movie

#00:11:54-1# Doctor: we are making a movie [laughter]

#00:11:55-3# Woman 2: really

#00:11:56-0# Doctor: no it's the people from the language school

#00:11:58-9# Woman 2: [yeah

#00:11:59-0# Doctor: [hmm she is an interpreter

#00:12:00-8# Woman 2: yes

#00:12:01-3# Doctor: so she's interpreting for me to see if we can improve the communication and we can help the patients better

#00:12:07-7# Woman 2: ok

#00:12:08-3# Doctor: so that's why they are film[ing so have to [sign...

#00:12:09-7# Woman 2: [ok #00:12:10-7# [ok

#00:12:11-1# Doctor: ...to say that it is ok

#00:12:11-8# Woman 2: ok [Everybody laughs as the door closing]

#00:12:14-6# Doctor: that's what we are doing we are making a movie [laughter]

#00:12:18-7# [short pause]

#00:12:19-8# Doctor: ok Mama so you don't need any other tablets

#00:12:22-8# Trained interpreter: Zulu kukhona amanye amaphilisi owadingayo (are there any tablets you need)

Patient: [hun hun [says something in Zulu?] #00:12:25-3# just the pain tablet

#00:12:26-7# Doctor: just [the pain tablet

#00:12:27-1# Trained interpreter: [just pain tablet

#00:12:27-8# Patient: yes

#00:12:29-4# Doctor: ok is the pain very bad mum

#00:12:32-3# Trained interpreter: [*Zulu* ibuhlungu kakhulu (inaudible) uzwa izinhlungu (is the pain too much (inaudible) you feeling the pain)

#00:12:33-6# Doctor: [ok

#00:12:34-9# Trained interpreter: yes [short pause, the doctor nodds?] its very painful
#00:12:36-6#

[silence]

#00:12:44-5# Doctor: ok and then we'll see you in six months time ok

#00:12:47-5# Patient: ngiyabonga (thank you)

#00:12:48-0# Trained interpreter: [Zulu

#00:12:49-1# Patient: yes [laughter]

#00:12:50-1# Doctor: thank you Mum

#00:12:50-8# Patient: thank you doctor

#00:12:51-9# Doctor: ok bye bye

#00:12:53-5# Patient: bye bye

#00:12:54-5# Trained interpreter: bye ma siyabonga (bye ma thank you)

#00:12:55-3# Patient: siyabonga (thank you)

#00:12:56-6# [Patient leaves the consultation room]

TRANSCRIPTION CONSULTATION 2

#00:00:00-0# Patient: Zulu (why are we doing this) [Transcription not provided]
#00:00:06-3# Trained interpreter: Ok Zulu ma sizama ukuthi siseshe ukuthi kubalulZeke kangakanani ukuthi kube khona umuntu otolikayo ipatient uma ngabe izobona udokotela ngoba kwesinye isikhathi uthole ukuthi kukhona into ofuna ukuyitshela udokotela but then uyehluleka ukuthi uyichaze wena nge-English / so sifisa ukuthi umuntu nomuntu abe no / uma kungukuthi ukhuluma isiPedi or ukhuluma isiTsonga ukhulume isiTsonga and then ke thina ke sesizoba sesikhuluma nodokotela i-English

(Ok Ma we are trying to research the importance of having someone to interpret when a patient comes to the see the doctor because sometimes there will be something you want to tell the doctor but you are not able to explain it in English / we wish that each person should / for instance if you speak Pedi or Tsonga you speak Tsonga and then we will talk to the doctor in English)

#00:00:09-6# [Door closing: researcher leaving the consultation room]

#00:00:32-3# [laughter]

#00:00:34-0# Trained interpreter: ok alright hum before we start doctor...

#00:00:36-8# Doctor: [hm

#00:00:36-8# Trained interpreter:...I just want to say my name is (the trained interpreter introduces herself by name) I'm an interpreter everything that is said in this room will be (breath) will remain in this room

#00:00:43-2# Doctor: ok (girl?)

#00:00:43-9# Trained interpreter: hum Zulu njengoba ngiqeda ukusho kudokotela ukuthi konke okushiwo la kule room kuzosala khona kule room (as I have finished telling the doctor that everything that is said in this room will remain in this room)

#00:00:49-3# Trained interpreter: we can start

#00:00:50-3# Doctor: can we start

#00:00:51-2# Trained interpreter: yes please

#00:00:51-9# Doctor: good morning dear how are you doing

#00:00:53-9# Trained interpreter: Zulu unjani (how are you)

#00:00:54-4# [Phone rings while the trained interpreter interprets]

#00:00:55-8# [doctor moved her chair to the table where the telephone lies]

#00:00:56-1# Doctor: [not clearly understood because the phone is ringing]

#00:00:58-3# Trained interpreter: yes ngikhona (*I am fine*)
#00:00:59-0# Doctor: Excellent #00:00:59-7# (end of doctor's turn)

[No one speaks. The phone still rings]

#00:01:02-4# Doctor: ok you're currently on radiation how is your treatment going
#00:01:06-4# Trained interpreter: Zulu okwamanje uku-radiation/ kuhamba kanjani (*at the moment you are on radiation, how is it going)*
#00:01:10-1# Patient: Zulu (inaudible)

#00:01:12-4# Trained interpreter: so so doctor

#00:01:13-5# Patient: hm

#00:01:13-7# Doctor: what's wrong is it (inaudible) are you having any problems any pain

#00:01:17-2# Trained interpreter [Zulu [Transcription and back translation not provided]

#00:01:17-9# Patient: [yeah ya uma ngigwinya la yabona la (inaudible– because of the telephone) kunezilonda kuba dry and so kube ngathi kukhona izilonda phakathi la / that is why ngize la kudoktha (yes when I swallow you see here (inaudible– because of the telephone) there are sores it gets dry and as though there are sores right inside here / that is why I have come to see the doctor)

#00:01:34-4# Trained interpreter: currently doctor when I'm swallowing hmm it's very painful and I have mouth sores as well when I swallow it's very painful the whole side...

#00:01:42-4# Doctor: hm

#00:01:42-5# Trained interpreter: ... is very very painful that is why I am here today

#00:01:45-2# Doctor: ok (inaudible) I just wanna check what pain medication are you currently taking

#00:01:50-5# Trained interpreter: Zulu yimiphi izinto ozithathayo zenhlungu (what are

you taking for pain)

#00:01:54-0# Patient: Panado
#00:01:55-3# Trained interpreter: Panado doctor
#00:01:56-3# Doctor: Only Panado
#00:01:57-2# Patient: Only panado
#00:01:57-8# Trained interpreter: Panado doctor

#00:01:58-6# Doctor: are you allergic to any medication

#00:02:00-2# [the door opens as the interpreter starts interpreting. In the meantime, the telephone is still ringing]

#00:02:00-5# Trained interpreter: Zulu kukhona into ongazwani nayo (*is there anything you are allergic to*)

[Impossible to determine when the patient speaks because of the noise from the door] Patient: cha (*no*)

#00:02:02-1# Trained interpreter: no doctor
#00:02:02-1# Doctor: ok (to the person at the door) sorry (to the trained interpreter) I am going to give you something much stronger after examining...

#00:02:07-2# [the door is opening again as the telephone is still ringing for the last time]

#00:02:07-6# Doctor: (inaudible) of severe {cardiatric} (inaudible) #00:02:11-4# (end of doctor's turn)

#00:02:11-4# [the door closes]

#00:02:11-5# Doctor: and we will decide on what medication but I will give you something stronger ok [pause] the second thing ah ok

#00:02:18-3# Trained interpreter: [smiling] hmm hmm Zulu ngizokunikeza into ezokwenza ukuthi inhlungu zakho zibe ngconywana kunepanado estronger kakhulu kunePanado / ngizokwazi ukuthi ngikutsheke manje ngibone ukuthi yini ewrong ukuze sikunikeze itreatment ezoba ngconywana (*I will give you something that will ease your pain something better than panado something stronger than panado / I will be able to check you now and see what is wrong so that we can give you better treatment*)

#00:02:26-3# [door opens with a noise while the interpreter interprets]

#00:02:31-6# [door closes]

#00:02:35-0# Patient: hm

#00:02:35-3# Trained interpreter: (inaudible "the period"?) stopped

#00:02:36-4# Doctor: ok can I ask what you're eating right now

#00:02:39-7# Trained interpreter: Zulu yini oyidlayo okwamanje (what do you eat at the moment)

#00:02:42-5# Patient: I eat is sometime.....

#00:02:48-6# Trained interpreter: Zulu udla ini nje (what do you eat)

#00:02:49-3# Patient: no kwesinye isikhathi ngidla amahewu ngidle nepapa nenkomazi or i-*pasta* e-*dry* / Eyi ngiyakhetha nje izinto engizidlayo (*sometimes I eat mahewu I eat pap and maas (nkomazi) or dry pasta / am very choosy with what I eat*)

#00:03:01-4# Trained interpreter: i don't really eat hmmm a lot of of things I eat pap

[hmm

#00:03:05-1# Doctor:

[hm hm (nodding)

#00:03:05-4# Trained interpreter: hm nkomasi I eat hm (indistinct) mahewu? [as well

#00:03:07-8# Patient: [angina appetite (I don't have appetite)

#00:03:09-1# Trained interpreter: I- I don't have appetite

#00:03:10-6# Doctor: oh ok can I ask as well are you eating (things?) like pumpkin spinach mash potato

#00:03:18-4# Trained interpreter: Zulu uyazidla izinto ezinjengo spinashi / potato / e / ispinashi (do you eat things like spinash / potato / spinach)

#00:03:24-6# Patient: Zulu (inaudible)… heartburn

#00:03:27-8# Trained interpreter: I also have heart burn doctor

#00:03:29-4# Doctor: ok but hm just to come back to first answer that are you able to tolerate what the foods that I mentioned

#00:03:36-2# Trained interpreter: Zulu uyakwazi kodwa ukudla okunjenge isipinashi namazambane uyakwazi ukukudla ukuthi ukudle ukugwinye kuhlale esiswini (are you able to eat food like spinach and potatoes are you able to eat and swallow it and it stays in the stomach)

#00:03:41-0# Patient: yebo

#00:03:41-8# Trained interpreter: yes doctor

#00:03:42-4# Doctor: ok tell me (indistinct)

#00:03:43-9# ?: hm

#00:03:45-1# Trained interpreter: Zulu yenza njani iheartburn (what does the heartburn do)

#00:03:47-8# Patient: Zulu kuba sawa emlonyeni kuzwakale sengathi kuyashisa (it becomes sour in my mouth and feels like it is burning)

#00:03:52-4# Trained interpreter: Zulu kusuke kwenzenjani uma… (what has happened when you…)

#00:03:53-4# Patient: Zulu uma ngithi ngiyabhodla ngibhodle sawa (when I burp I burp something sour)

#00:03:57-8# Trained interpreter: hm (nodding?)

#00:03:58-4# Patient: hm (nodding)

#00:03:58-6# Trained interpreter: hmm I just burp soarness

#00:04:01-2# Doctor: hm hm (nodding?)

#00:04:01-4# Trained interpreter: it just comes and then I just burp soarness

#00:04:04-3# Doctor: ok and sorry and just to clarify meat you are not able to eat meat

#00:04:10-1# Trained interpreter: Zulu uyadla inyama (do you eat meat)

#00:04:11-9# Patient: Zulu ngiyayidla but angiyithandi (I eat it but I don't like it)

#00:04:14-4# Trained interpreter: I do I eat it but I don't like it

#00:04:16-7# Doctor: ok you're able to chew it and swallow it without any problems

#00:04:20-6# Trained interpreter: Zulu yakwazi ukuthi uyihlafune uyigwinye ngaphandle kokuthi ube nenkinga (are you able to chew it and swallow it without any problem)

#00:04:24-7# Patient: Zulu uma ngenza amaphisi amancane (when I make it small pieces)

#00:04:27-4# Trained interpreter: only when I've to cut it up in very small pieces

#00:04:30-5# Doctor: ok the difficulty again is it ch- chewing it or / swallowing it

#00:04:35-4# Trained interpreter: Zulu kahle kahle inkinga iba kuphi / iba sekuthenini uyayihlafuna noma uyayigwinya (exactly where is the problem / is it in chewing it or swallowing it)

#00:04:40-1# Patient: Zulu ukuyigwinya (swallowing it)

#00:04:40-1# [telephone starts ringing as the patient is answering the question]

#00:04:41-1# Trained interpreter: swallowing it

#00:04:42-7# Doctor: ok / anything else you want to tell me

#00:04:45-4# Trained interpreter: Zulu kukhona futhi okunye ongafisa ukungitshela khona (is there anything else you wish to tell me)

#00:04:49-2# Patient: Zulu cha (no)

#00:04:49-9# Trained interpreter: no

#00:04:50-3# Doctor: have they explain to you about the radiation how to take care of your body how to take care of your skin during radiation

#00:04:57-5# Trained interpreter: Zulu bakuchazelile ku-radiation ukuthi yini ongayenza ukuthi uzinakekele unakekele nesikhumba sakho (did they explain to you at radiation how to take care of yourself and how to take care of your skin)

Patient: (checking her head)

#00:05:03-6# Trained interpreter [no

#00:05:03-7# Doctor: [no

#00:05:04-4# Doctor: ok has hmm do you have any questions for me at this stage

#00:05:08-2# Trained interpreter: Zulu kukhona imibuzo ongafisa ukuthi ungibuze yona

(are there any questions you would like to ask me)

#00:05:11-7# Patient: Zulu ya (yes)

#00:05:12-8# Trained interpreter: yes doctor

#00:05:13-7# Doctor: please (indistinct)

#00:05:14-5# Patient: [(indistinct)

#00:05:14-5# Trained interpreter: [Zulu ungabuza (you can ask)

#00:05:15-4# Patient: Zulu njengoba ngilaphaya ku-radiation kusekhona okunye engisazokuzwa okudiferent (as I am at radiation, am I going to feel anything (more) different)

#00:05:17-7# [the telephone rings for the last time as the patient is speaking]

#00:05:21-0# [the door opens while the patient is speaking]

#00:05:23-4# [door make some noise]

#00:05:24-2# Trained interpreter: I would like to know / since I am in radiation is there still more that I'm supposed to do

#00:05:31-1# [the door makes noise as it is closing

#00:05:32-3# Doctor (starts speaking as the door is making noise to close): so (indisctint)...

#00:05:34-9# ?:hm

#00:05:35-1# Doctor: ... and then at the end of it I'm going to explain everything to you about the number of treatment you need to get...

#00:05:40-1# ?:hm

Doctor: ...and the side effects to expect and what you can do to to not hmm not have any side effects but to minimise the chances of side effects I'd also explain...

#00:05:51-1# (noise from the chair as the doctor is moving?)

#00:05:51-1# ...to you bout what the plan is in terms of pre-chemotherapy

#00:05:54-9# Trained interpreter: hm alright hmm Zulu ngizothanda ukuthi manje

ngikuhlole uma sengikuhlolile yilapho ngizokwazi khona ukuthi ngithathe khona isinqumo sokuthi iyiphi indlela esingenza ngayo / ngizokuchazela nakhona ukuthi i-radiation yakho izoba yisikhathi ezingakanani njengoba uzaku-radiation / ngiphinde ngikuchazele futhi ukuthi uma uzwa inhlungu ezinjengama side effects singakwazi ukuthi sizehlise kanjani hayi ukuthi sizimise but sizame ukuthi sizehlise siphinde futhi senze sho ukuthi uyazinakekela wena

(I would like to examine you / after examining you it is only then that I will be able to take a decision of what we will be able to do / I will explain also explain how long your radiation is going to be as you are coming to radiation / I will again explain to you about how we can reduce side effects pain not stop them but will try to reduce them and also make sure that you look after yourself)

(Patient nodding)

#00:06:24-0# Doctor: ok

#00:06:24-3# Trained interpreter: yes

#00:06:24-5# Doctor ok and you are welcome to ask me any more questions after we're finished may I ask for you to please come around for me you are hmm if you can take off you jacket your shirt and your pas hmm skirt for me (indistinct) #00:06:40-0# (end of doctor's turn)

#00:06:38-2# [noise from the recording device as the interpreter switches off the second recording device?]

#00:06:38-7# Trained interpreter: Zulu ngicela ungikhumulela nje / ukhiphe ijakhethi neshethi nesiketi (please take off your clothes / take off your jacket / shirt and skirt)

#00:06:41-7# Doctor: don't worry we're not going to film you on that side right

#00:06:44-5# Trained interpreter: [laughter] and I am not coming that side

#00:06:45-7# Doctor: ok

#00:06:46-0# Trained interpreter: yes

#00:06:46-6# Patient: Zulu [Transcription and back translation not provided]

#00:06:48-0# Trained interpreter: hmmmm

#00:06:48-1# Doctor: yes [come around....

#00:06:48-6# Trained interpreter: [{yes}

#00:06:49-0# Doctor:...come and just do the undress on that side somebody may come in through that door ok / you may remove your you can keep the shoes on it's ok / I have a cover on the bed #00:06:56-9#

[silence]

#00:07:08-2# Doctor: shout for me when you're ready ok

#00:07:10-1# Patient: ok #00:07:10-4#

[silence]

#00:07:11-5# (doctor leaves her chair?)

#00:07:13-6# (noise from the doctor wearing gloves?)

(doctor joins the patient behind the curtain?)

#00:07:36-1# Doctor: oh your shirt broke down

#00:07:38-2# Patient: (indistinct)

#00:07:41-7# Doctor: your hmmm (indistinct) I don't want to use something (indistinct)

#00:07:46-1# Patient (indistinct) #00:07:46-4#

[silence]

#00:07:48-5# Doctor: (indistinct) focus stay on

#00:07:50-2# (doctor and patients laugh)

#00:07:51-2# Doctor: (laughing) that's it now please sit for me

#00:07:53-2# Patient: yes yes doctor #00:07:54-1#

[silence]

#00:07:57-1# Doctor: (indistinct) you ok

#00:07:58-5# Patient: ok

#00:07:59-9# Doctor: (indistinct)

#00:08:00-6# Patient: {ok}

#00:08:01-4# Doctor: (indistinct)

#00:08:06-5# Doctor: stick your tongue right out for me / ok we're gonna take care of (indistinct as the doctor puts an instrument on the table) alright it's something good to (indistinct) is it painful (indistinct) is it very (indistinct) hmmmmm I see that #00:08:19-4#

[silence]

#00:08:23-1# Doctor: (indistinct)

#00:08:27-5# Doctor: good lips up for me (indistinct) sit down thank you please (indistinct) / hm hm cary on// (indistinct) #00:08:42-4#

[silence

#00:08:55-0# Doctor: (indistinct) thank you / (indistinct)

#00:09:02-6# Patient: (indistinct)

#00:09:04-3# Doctor: it's fine (indistinct) (the doctor removes her gloves)

#00:09:11-9# Doctor: change before you come this side ok

#00:09:14-0# Patient: ok #00:09:14-4#

[silence]

#00:10:14-7# [the patient joins the doctor and the trained interpreter at the desk]

#00:10:17-0# Doctor: ok so let's start at the beginning you plan for radiation we are going to take you out to about thirty-one fractions alright thirty one treatment and treatment is Monday to Fridays that's about/ six weeks of treatment #00:10:33-5#

#00:10:33-4# Trained interpreter: ok *so* sizoqala ekuqaleni // i-treatment yakho izoba, izothatha isikhathi esingango-*30 days*// *so* kuzofanele ukuthi uze *Monday to Friday* uhambe i-treatment yakho ye-radiation (*we will start from the beginning // your treatment will be- will take about 30 days // you will have to come Monday to Friday to take your radiation treatment*)

#00:10:48-0# Patient: (indistinct)

#00:10:48-5# Doctor: right (indistinct) that's the first thing now the second thing is during treatment we're also going to give you chemo but it's not the chemo where the hair falls out and you get very sick that chemo is where you get it everyday for many months for many weeks 'right your chemo is going to be just a trip/ for p maybe two three hours most 'right once and then three weeks later again and maybe one more time at most you shoud get three but possible two right in order to access if you're ok for chemo we do blood test every week to make sure that you are fine and just before you get your chemo we do blood test again and if your blood is strong and it's healthy we give you chemo/ the chemo is to make the radiation work better #00:11:37-0#

#00:11:39-4# Trained interpreter: ok/ so Zulu so / into ezokwenzeka lokhu kwesibili ukuthi sifuna ukuthi sikufake ku-chemo / i-chemotherapy le ozongena kuyona akuyona le eyenza ukuthi inwele zakho zize ziphume le ukuthi ithusa kakhulu cha / le eyokuthi ikusize ukuthi i-radiation yakho isebenze kangcono / so yona ke uzoyithola kabili noma kathathu but before uyithole kuzofanele ukuthi sikuhlole igazi sitsheke ukuthi igazi lakho lilungile yini ukuthi ungayithola i-chemotherapy / again siphinde futhi sikuhlole ukuthi ungakwazi yini ukuthi uyithole
(secondly what will happen is that we want to put you on chemo / the chemotherapy that we will put you on is not the one that makes your hair to fall off it is not the one that is scary no / this one is to help that your radiation must work better / you will have it twice or three times / but before you have it we will have to test your blood to check if your blood is right for you to have chemotherapy / again we will check whether you supposed to have it)

#00:12:17-4# Doctor: ok you understand about that you're comfortable with that / no questions so far on the chemo or the radiation

#00:12:23-6# Patient: [no

#00:12:23-7# Trained interpreter: [Zulu unemibuzo (do you have questions)

#00:12:25-3# Patient: Zulu nginemibuzo / i-Chemo leyo ngizoyenza uma sengiqedile i-radiation / or ngizayenza in between (I have questions /will I do the chemotherapy after finishing the radiation / or will I do it in between)

#00:12:32-7# Trained interpreter: I'd like to know if the chemo am I going to do the

chemo while on radia[tion...

#00:12:37-2# Doctor: [yes

#00:12:37-3# Trained interpreter: ...or afterwards

#00:12:38-3# Doctor: so it's what we call concurrent chemo it's at the same time/ so as an example right today Im gonna take your bloods...

#00:12:46-8# ? {hm hm}

#00:12:47-4# Doctor: ... tomorrow you'll come to me to check your blood results....

#00:12:50-7# ?: {hm}

#00:12:51-0# Doctor: ... if your blood results are ok/ (indistinct) do your chemo for Thursday

#00:12:55-2# ?:{hm}

#00:12:55-3# Doctor: ... so Thursday you start up with the machine you get your radiation then you go to chemo you get the treatment for about two hours and you go home

#00:13:03-4# ?: {hm hm}

(short silence)

#00:13:04-5# Trained interpreter: Zulu so indlela ezokwenzakala ngayo ukuthi i-chemotherapy ne-radiation izosebenza kanye kanye / ukuze ngikwenzele umzekelo namhlanje uzofika kimina ngifike ngikutsheke igazi lakho and then kusasa ubuye uma ngabe sesibonile ukuthi igazi lakho lithini sikufake ku-radiation / uma usuka ku-radiation ube sewuyahamba sewuyokwenza i-chemotherapy / uzofaka nje i-drip for two to three hours / uma kuphela loyo two to three hours bese uyagoduka

(how this will happen is that the chemotherapy and radiation will work at the same time / to make an example today you will come to me for blood test and then tomorrow you will come back when we have seen what your blood says and then we put you on radiation / when you come out of radiation you will then go to chemotherapy / you will only have a drip for two to three hours / when the two to three ours is over you will go home)

#00:13:31-3# Doctor: ok

#00:13:32-0# Patient and trained interpreter?: yes

#00:13:32-3# Doctor: very very important for the radiation to work you can't miss any treatment/ right so if there's a problem with transport in such you let us know we write a letter to your local hospital to try and get a bed bear or we look at other options there are certain (indistinct) for you can go just for the you know the duration of treatment...

#00:13:53-2# [door opens making a lot of noise while the doctor speaks]

#00:13:52-8# Doctor:...but it is very important that once you start our treatment that you don't miss out treatment...

#00:13:58-4# (door closes as the doctor speaks, making a lot of noise)

#00:13:58-8# Doctor: ok so you can't come Monday Tuesday /and not come Wednesday Thursday then come Friday/ because you'll go through the whole thing and it won't be of much benefit to you (end of dortor's turn: #00:14:07-9#)

#00:14:08-6# Trained interpreter: Zulu okubalulekile kakhulu ukuthi kufanele ukuthi lungadluli usuku lwakho lokuthi uthole i-treatment / uma kungukuthi mhlawumbe unenkinga nge-transport siyakwazi ukuthi thina sikubhalele incwadi / leyo ncwadi leyo siyakwazi ukuthi siyise emaklinikhi aseduze nawe / kwezinye izikhathi siyakwazi ukuthi uthole i-treatment khona endlini / but kubalulekile kakhulu ukuthi ungaphuthwa yi-treatment ngoba uma ngabe usuyiphuthile ngeke ize isebenze / so kufanele ukuthi izinsuku esizozisho ukuthi ufike ngazo / ufike ngazo ngempela (*what is important is that you must not skip a day of your treatment / if perhaps you have a transport problem we are able to write you a letter / that letter we can take it to clinics near you / at other times we can make you get treatment in a house / but it is very important that you must not miss your treatment because if you miss it it will not work / when we tell you the days that you must come on those days*)

#00:14:39-6# (door opens making a lot of noise while the interpreter is at work)
#00:14:43-6# (door makes a lot of noise as it is being closed, while the interpreter is still at work)

#00:14:43-6# Doctor: [ok
#00:14:43-6# Trained interpreter: [ok doctor

#00:14:44-4# Doctor: you understand up to now ehh in terms of what we discussed

#00:14:47-6# Trained interpreter: [Zulu uyazwisisa konke? (uzwa kahle konke? (patient nodds?)

#00:14:48-0# Doctor: [ok

#00:14:49-2# Doctor: the next issue that I want to discuss with you is that like any treatment the chemo and the radiation have side effects / has anyone told...

#00:14:56-4# [doors opens making a lot of noise while doctor speaks]

#00:14:57-3# Doctor: ... you anything about the side effects of our treatment...

#00:15:00-1# [door closes making a lot of noise while the doctor is speaking]

#00:15:00-5# Doctor: ...yet (end of doctor's turn: #00:15:00-9#)

#00:15:01-6# Trained interpreter: Zulu njengazozonke ama-treatments akhona zonke lezo zinto kuba nama-side effects / so wena ngokwakho kukhona oke wakuchazela about izinto ezinjengama-side effects ayo i-chemotherapy (like all treatments there are those things which are side effects / has someone explained to you about things like chemotherapy side effects)

#00:15:05-6# [door opens making a lot of noise while the interpreter is at work]

#00:15:09-2# [door closes making a lot of noise while the interpreter is at work]

#00:15:09-6# Trained interpreter: Zulu cha doktha (no doctor)

#00:15:14-8# Patient: (indistinct)

#00:15:15-3# Trained interpreter: no doctor

#00:15:15-8# Doctor: ok so firstly in term of the chemo it's not a / very big chemo where you...

#00:15:22-2# (door opens making noise as the doctor is speaking)

#00:15:22-8# Doctor: ... (indistinct) there is (indistinct due to the door noise)...

#00:15:25-2# (door closes making a noise)

#00:15:25-3# Doctor: ....all the hair is got to fall out everybody is always worried that all

their hair is going to fall out and you know after you get so sick / I'm not going to lie to you the chemo does make your liver a bit sick but just for about three or four days / you can feel very nauseous / you may even vomit you can feel a little bit high and a little bit weak but what we do is we give you some medication to try and prevent that / ok it may not / work hundred per cent but it'll help with the side effects and within the week you should be back fine ok and the chemo again is only gonna be three weeks / if your blood results are ok #00:16:01-0#

#00:16:01-8# Trained interpreter: {ok} ok *Zulu* indlela esebenza ngayo ama-*side effects* akhona kuyatholakala ukuthi kwesinye isikhathi sengathi ungaba ne... kube sengathi uyahlanza / kwezinye isikhathi kube sengathi umzimba wakho ukhathele // *but* thina siyakwazi ukuthi sikunikeze amaphilisi akwazi ukuthi azivimbe lezozinto / kodwa awazivimbi *hundred per cent //* indlela azivimba ngayo ukuthi uzothola *but* angeke kuze kube kubi kakhulu kubi kangako / *but again* kuzo *diphenda* ngama-*results* egazi lakho ukuthi azobuya enjani *and* nakhona i-*treatment* yakho uzoyithola emva kwamasonto amathathu *everyday* (*the way it works with these side effects it is found that at times you feel as though you want to vomit / at times it is as though your body is tired // but we are able to give you tablets that can stop that / but they don't stop them hundred per cent // the way they stop them is that you will find but they will not be that bad / but again it depends on the blood test results and you will get your treatment after three weeks every day*)

#00:16:39-7# Doctor: ok
#00:16:40-4# Trained interpreter: {yes doctor}

#00:16:40-6# Doctor: now that was the chemo / so radiation has its side effects as well
#00:16:44-9# ?: {oh}

#00:16:45-2# Doctor: ok / the commonest side effects all our patients have some degree of it is tiredness/ you fell very tired you know you feel like at one o'clock two

o'clock you wanna go to bed you want to sleep/ and when that happens feel free to do so you mustn't try to be strong you know at home all the washing and all the house work you need some somebody to help you at home you know for that added support alright you gonna get very tired tiredness can last after the radiation finishes it may even be after ten to six months later you're still feeling tired ok so expect that by about two three weeks a lot of patients start to be tired some patients a bit sooner some of them go to treatment then say not much side effects but there are you know it is a common side effect that many patients complain about/ ok #00:17:36-1#
#00:17:36-1# (short silence)

#00:17:37-9# Trained interpreter: Zulu *i-radiation* ke yona ama-*side effect* akhona ukuthi uzozwa kakhulu ukukhathala, ukukhathala umzimba wakho uzothola ukuthi ngezikhathi zabo 2 emini sewukhathele awusafuni lutho // ungazami ngalesosikhathi ukuthi uzame uziqinise ufune ukuzenzela izinto ezinjengamawashingi nokuklina endlini noku-ayina // kuzofanela ukuthi nje kube khona umuntu ozokusiza but nakhona kuyenzeka ukuthi ilaste *until three to six months after* isikutholile ukuthi *i-radiation* (inaudible) so kufanele nje wazi ukuthi uzoba nokukhathala // amanye ama-*patient* kodwa ayasho ukuthi awezwa lutho kuya ngomuntu ukuthi yena i-*side effect* izoba kanjani (*the radiation itself its side effects is that you will feel very tired you will find that your body is very tired around 2 during the day you are so tired that you don't want anything // at that time don't try to make yourself strong and do things like washing your clothes, cleaning the house and ironing // you will need to have someone to help you but even then it happens that it will last for three to six months after getting radiation (inaudible) so you need to know that you will get tired // but other patients say they don't feel anything // it depends on a person how the side effect would be*)

#00:18:24-3# Doctor: ok am I going at an appropriate pace for you I am not giving too much information to translate

#00:18:30-1# Trained interpreter: {(indistinct)} no it's fine

#00:18:30-9# Doctor: ok the next thing is a common side effect is in the mouth you can get a *mucositis* alright you can get like hmm- the mouth becomes raw and eating may become a huh problem swallowing may become a problem hh- chewing may be difficult and the taste starts to go as well/ right a lot of patients get some degree of it some may be mild some may be much more serious #00:18:59-3#

#00:19:00-7# Trained interpreter: Zulu enye futhi ongakwazi ukuthi uyithole i-*side effect* ejwayelekile ukuthi abantu bayithole yile yokuthi ulimi lwakho njengama- konke uvesane ungakwazi ukuthi uphuze *something* noma udle *something* noma uze ukwazi ukuthola *i-taste* yento olimini ngoba kuvele nje kubi kakhulu // *so* amanye ama-*patients* ayaba nawo akubi *that bad* amanye ama-*patients* kuba yinto enkulu kakhulu (*another side effect you can have that is normal is that people find their tongue like everything you are not able to drink or eat anything or taste it just becomes bad // for other patients it does not get that bad*)

#00:19:29-3# Doctor: ok so what can you do to prevent it or to decrease your chances/...

#00:19:34-1# ?: {hm hm}

#00:19:34-4# Doctor: ...so...

#00:19:34-9# ? : {hm hm}

#00:19:35-3# Doctor: you need to have a very good mouth hygene right / in terms of that what I'm gonna say is your toothbrush you need a very soft toothbrush nothing hard nothing which you're gonna be scrubing inside the mouth alright *plus that* where we giving the *fute* of the radiation /...

#00:19:50-5# ?: hm hm

#00:19:50-9# Doctor: ... that's the first thing the second thing is try *pram* today I'm gonn to give you a special mouth wash and you gonna used it everytime you eat and at least about three or four more times during the day as many times as you want / and you gargle and you gonna spit / right I also see for you that you have some *crash* in the mouth and that's going to increase you chances of getting a mucositis which is why we're gonna treat it today/ already we're gonna start treatment/ ok hmmm the taste will

go some patients have a problem with the taste / and / even when it may be weeks before the taste does return / so just be aware that...

#00:20:28-8# ?: hm hm

#00:20:29-5# Doctor: ...your food you're not gonna d d you're not gonna / get taste as good as before it's because of where we're going to give the radiation #00:20:36-2# (end of doctor's turn)

#00:20:36-3# ?: {hm hm}

#00:20:37-6# Trained interpreter: Zulu into ezokwenzakala ke manje ukuthi njengoba sisho ukuthi i-radiation yakho uzoyithola izobe ifakelwa la kule phathi yobuso bakho yingakho yiyona into eyenza ukuthi ama taste buds akho angeke aze asebenze / so into ongakwazi ukuthi uyivikele ngayo ukuthi ugcine ukuthi ama taste buds akho asebenze ukwazi nanokuthi udle / ukuthi uthole isixubho sokuwasha / isixubho sakho ozoxubha ngaso singabi yisixubho esiqinile ukwazi ukuthi singakulimazi ngaphakathi ngoba uma sikulimaza nakhona kuyenza ukuthi uzwe ubuhlungu / nakhona futhi okunye namhlanje engizokunikeza kona ngoba ngiyabona ukuthi olimini lwakho ngathi une-trash / ngizokunikeza imouth wash / leyo mouth wash leyo ungayisebenzisa noma ikangaki ngelanga iyakusiza ukuthi at least ukwazi ukuthi ukwazi ukuthi kube khona into ozoyigwinya uphinde futhi uyikhiphe / yona indlela futhi esebenza ngayo uzoyiphuza nje ugaglishe ngayo bese uyayifela futhi

(what will happen now is that as we say that you will get your radiation on this part of your face this is the thing that makes your taste buds not function / what you can do to prevent that your taste buds and keep them working and be able to eat is to get a soft tooth brush that you will brush your teeth with because a hard toothbrush will injure / hurt you inside and you will feel the pain / again today what I will give you / as I can see trash on our toungue / is the mouth wash / you can use the mouth wash many times during the day it will help you to be able to swallow and you can again take it out / how it works you drink it / guggle and spit it out)

#00:20:46-1# Patient: {hmm}

#00:20:46-3# Trained interpreter: ...Zulu... [Transcription and back translation not provided]

#00:20:48-5# Patient: {sure}

#00:20:48-7# Trained interpreter: ...Zulu.. [Transcription and back translation not provided]

#00:21:34-6# Patient: [{hm hm}

#00:21:34-7# Trained interpreter: ...[Zulu #00:21:35-0# (end of trained interpreter's turn)

#00:21:35-6# Doctor: ok / and when the taste goes the appetite goes...

#00:21:39-1# Patient: {hm hm}

#00:21:39-3# Doctor: but it's important for me that we meet to keep you as strong as possible/ everytime when you come to us we gonna be taking your weight...

#00:21:46-4# ?: {hm hm}

#00:21:46-6# Doctor: I see your weight was sixty-nine/ on the second of september/ and today it's sixty-eight it's ok you have lost a kilo but you've lost a kilo for like almost two months

#00:21:56-8# ?: {hmm}

#00:21:56-9# Doctor: right so it's still ok but we gonna closely watch by by two three weeks time when the appetite starts to go you mustn't fast yourself you must eat ok/ it's very important for us that you keep up the nutrition...

#00:22:10-3# ?: {hmm}

#00:22:10-9# Doctor: …ok

#00:22:12-0# Trained interpreter: Zulu kubalulekile ke ukuthi njengoba i-appetite yakho izohamba ngoba ama-taste buds azobe engasebenzi kahle kubalulekile ukuthi nawe uzame ukuthi udle noma ngabe kunzima but uzame ukuthi ufake something ngoba lokho kuzokusiza kakhulu / ngiyabona ngokuthi i-weight yakho nayo the last time ufikile on the 2nd of September ibiwu-69 manje uma sikutshekha u-68 / awehlile kakhulu kodwa kubalulekile ukuthi siyimonithe ukuthi wehla kangakanani

(it is important that as you loose appetite because your taste buds will not be working well, it is important that you must also try and eat no matter how difficult but you must try and put something that will help you a lot / I can see your weight also the last time you came on the 2nd of September was 69 now it is 68 / you have not lost it too much but it is important for us to monitor how much you loose) #00:22:40-2# (end of trained interpreter's turn)

#00:22:41-5# Doctor: ok you're ok with that any questions so far

#00:22:44-8# Trained interpreter: Zulu kukhona imibuzo onayo (do you have question)

#00:22:46-8# Doctor: {no ok} now there is another common side effect I just need to let you know about...

#00:22:51-1# [noise: a door next door closes]

#00:22:51-8# Doctor: the skin / has anyone told you what to do how to help about and the scalp of your skin

#00:22:58-9# Trained interpreter: Zulu kukhona umuntu oke wakuchazela ngale side effect eba semzimbeni wakho ukuthi ugeza kanjani ngokuthi usebenzise kanjani umzimba wakho (is there anyone who explained to you about this side effect that is on your body how you bath and how you use your body)

#00:23:01-7# [Patient coughs once while the interpreter is at work]

#00:23:01-8# Trained interpreter: ...Zulu [Transcription and back translation not provided]

#00:23:07-3# (Patient shakes her head)

#00:23:08-1# Trained interpreter: no [doctor

#00:23:08-5# Doctor: [no ok so this is very important right our machines are very good / it's very good to burn the cancer / but it's not a clever machine / it can't say that this is the good [skin

#00:23:19-9# ?: [{hmmm}

#00:23:20-3# Doctor: I must spare this I must only burn the cancer so in the field where we're giving the radiation you can get burn to the machine ok it happens and we find patients maybe by / two weeks three weeks four weeks the skin scalp to start gets red and it starts to get darker and in some patients it starts to get dry and it's peeling off it can even get very bad where you know big pieces fall off and it come / dry desquamation it can become what we call moist desquamation it's everything you know the skin is peeling quite a bit / some patients very few patients go the way to you know to these severe reactions / most patients' skin just get a bit darker maybe a few areas of dryness #00:24:02-4# (end of doctor's turn)

#00:24:03-6# Trained interpreter: Zulu indlela esebenza ngayo i-radiation imishini yethu esiyisebenzisayo njengoba wazi ukuthi siyifaka la ebusweni bakho / kuyenzeka ukuthi ngoba imishini awuhlakaniphile kakhulu awazi ukuthi iyiphi indawo okufanele iyishise njengoba ishisa icancer / so kuhamba kuhambe emuva kuka two to three weeks ubone sengathi isikhumba sakho siyashintsha uma ngabe sishintsha kube sengathi siba mnyama siphinde futhi kwesinye isikhathi kube sengathi siba bomvu bese sivesane

siyaxebuka straight / amanye ama-patients kuba sengathi kuba kubi kakhulu uthole ukuthi sesiyaqhuphuka nje ingathi siyavithika isikhumba sakho but hayi ukuthi wonke umuntu uzoba nalokho
(how radiation works the machines we use as you know they we put them here on your face / it happens that the machines are not clever they do not know which place to burn as we burn the cancer / after a while as we proceed after two to three weeks you see your skin changing / when it changes it becomes darker at times as though it becomes red and it starts peeling off / with other patients it becomes so bad that it peels off severely but this does not happen to everyone)

#00:24:14-0# Patient: [{hm}

#00:24:14-1# Trained interpreter: ...Zulu #00:24:40-0# (end of trained interpreter's turn)

#00:24:40-3# Patient?: {hm}

#00:24:41-1# Doctor: ok hmm what can you do to- to decrease your chances of a severe reaction...

#00:24:46-6# ?: {hm hm}

#00:24:47-7# Doctor: ... firstly/ up here up / you can't use any soap / any shampoo no lotion / no powder / and no perfume anywhere alright / if you can do this already your chances of getting a bad reaction are much less than most patients / but there're some patients that try to use homeopathic creams bio-oil and all these funny make-up they get burned / alright / the second thing is oh sorry I shouldn't try to (indistinct)

#00:25:19-2# Trained interpreter: Zulu indlela esingakwazi ukuthi senze ngayo ukuthi isikhumba sakho sixebuke kakhulu / kusukela la phezu kwamabele akho kuya phezulu akusafanele ukuthi usebenzise insipho akufanele ukuthi usebenzise into enjenge shampoo, amaloshini ama-make up ungafaki lutho ngoba lezo zinto zenza ukuthi isikhumba sakho sixebuke / abanye baye bakusebenzise bazitshele ukuthi basebenzisa o-bio oil nezinto ezingo-aroma therapeutic lotions lezo zinto akufanele bazisebenzise ngoba uma sewuya emshinini sizoxebuka isikhumba
(the only way we cannot be able to make your skin not to peel heavily / from your chest up you must not use soap you must not use something like shampo lotion, make-up / you must not put anything on because things like that make your skin peel off / other people do use it telling themselves that they use bio-oil and things like aroma therapeutic lotions / things like those are not supposed to be used because when you go to the machine your skin will peel off)

#00:25:51-2# Doctor: ok and this you gonna do / the whole duration of treatment plus say another ten days after we're finished/ don't think that on the weekends you know you're not getting radiation you can give a good scrub you've to be very careful and also

when you come out of the bath you gonna use luke warm water not very hot water ok you're not gonna scrub with the towel you gonna hurt yourself if you [try

#00:26:11-9# ?: [{hmmm}

#00:26:12-2# Doctor: gentle gentle cause if you start being very aggressive the skin is going to get damaged / ...

#00:26:17-2# ?: {hm hm}

#00:26:17-5# Doctor: ...quicker and easier / and it will take good care of it

#00:26:21-4# ?: {hm}

#00:26:21-6# Doctor: Ok

#00:26:22-2#Trained interpreter: Zulu kubalulekile ke ukuthi noma ugeza amanzi ozowasebenzisa kungabi amanzi ashisayo kube ngamanzi nje antukuntuku ngoba uma ungase usebenzise amanzi ashisayo azokuxebula isikhumba / noma ubugeza ungasebenzisi ithawula uzithobe nje ngamanzi uthathe amanzi uzithobe uzithobe ngoba uma uxebula isikhumba sizoxe (inaudible) uma usebenzise into eqinile sizoxebuka isikhumba sakho / so kubalulekile futhi ukuthi indlela ozosebenzisa ngayo uzogeza kanje uphinde wenze kanje / noma seyiphelile i-radiation uqhubeke futhi mhlawumbe na after 10 days uqhubeke ungasebenzisi lutho ngoba uma usebenzisa into ethize sizoxebuka isikhumba
(it is important that you use luke water when you bath and water must not be hot because when you use hot water the skin will peel off / when you bath dont use the towel (inaudible) with water / take water and (inaudible) because when it peels off the skin will peel off when you use something hard / so it is important how you bath you will do it like this again like this / even when the radiation is over you must continue even after ten day without using anything because when you use something the skin will peel off) #00:27:02-9# (end of trained interpreter's turn)

#00:27:03-3# Doctor: ok the last thing I'm gon to tell you about your skin / is that your skin is gonna get more sensitive to the sunlight because of the radiation that can go up even six months after you finish radiation/ what's very good from now is to buy one of those big hats/ not the cap (you'll be a bit?) the one that's goes all around the head alright and to protect yourself whenever you are (in) the sun because it's summer time now you gonna feel when you go out in the sun / it's gonna feel extra hot you gonna feel very you know like (indistinct) and/ your skin will get/ burned easier than it'd get to before #00:27:37-5# (end of doctor's turn)

#00:27:38-4# Trained interpreter: Zulu njengoba ke uzohamba i-radiation isikhumba sakho sizozwela kakhul / so kubalulekile ukuthi njengoba sekushisa manje

sekuyisikhathi selanga uthenge isigqoko isigqoko lesi esikhulu hhayi ikepisi but uthenge isigqoko esikhulu esizozama ukuthi sikukhave yonke indawo ukuze isikhumba sakho singathintwa yilanga ngoba uma sibonwa yilanga sizoxebuka isikhumba sakho / so wenze sho ukuthi uthola nje isigqoko esizovala yonke indawo
(as you are on radiation treatment your skin will be very sensitive / it is important as it is so hot and is the time of sun you must buy a hat a very big hat not a cap but buy a big had that will try to cover everywhere so that the sun does not touch the skin because if it was seen by the sun the skin will peel off / make sure that you get the hat that will cover everywhere) #00:28:01-5# (end of trained interpreter's turn)

#00:28:02-5# Doctor: ok and the last thing as well is that / {it's} very important to come everyday for the radiation treatment right/ try not to miss treatment where possible / if however there are some patients but if the reaction gets very bad in their mouth in their neck or something we're very worried about but we can't stop treatment completely or we can split treatment / (indistinct: Where we leave a little break in between proof) and then we carry on with treatment #00:28:28-1#(end of doctor's turn)

#00:28:28-1# ?: {hm hm}

#00:28:28-4# Doctor: ok

#00:28:29-7# Trained interpreter: Zulu kubaluleke kakhulu ke ukuthi ungaphuthi ilanga lakho lokuthi uzothola i-treatment ngoba uma ngabe uyinqamula i-treatment angeke ize isebenze / kubalulekile ukuthi ufike njalo / amanye ama-patient ke kuyaye kwenzeke ukuthi umlomo seku serious kakhulu nangaphakathi olimini akasakwazi ukwenza lutho or isikhumba sakhe sesixebuka kakhulu / esiye sikwenze ngaleso sikhathi ukuthi siyayimisa i-treatment sibone ukuthi singayisiza kanjani i-patient / uma kungukuthi seyisizakele siphinde siqhubeke but kubalulekile ukuthi wena ufike ngelanga okufanele ufike ngalo uzothola i-treatment

(it is very important that you do not miss your treatment because if you break the treatment it will not work / it is important that you come all the time / it happens that other patients' mouths get very severe and inside in the tongue one cannot do anything or the skin has peeled off too much / what we do at that time we do stop the treatment to see what we can do to help the patient / when there is improvement we continue but what is important is that you must come every day for your treatment) #00:29:04-9# (end of trained interpreter's turn)

#00:29:05-5# Doctor: ok to check that you're not getting very bad hm reactions / every Tuesday / we see you in the clinic ok hmmm so every Tuesday you come you let us know any problems you have been we make sure you have enough medication we examine you to make sure there's no bad reactions / and you tell us you know {if you've} any problems at all / (indistinct: I've to say?) though that it's a Tuesday but we are here everyday Monday to Friday so even if there is a Thursday and maybe you're feeling very bad or you're not feeling (indistinct) you can come in at any time / but the

really few date you know just to make sure that you don't forget is on a Tuesday / alright hmmm we also see patients on the Thursdays as well but at any time you can come if you get sick over the weekend you come by casualty and one of our doctors will come there / ok #00:29:53-6# (end of doctor's turn)

#00:29:54-4# Trained interpreter: Zulu kubalulekile ke ukuthi wazi ukuthi ngoLwesibili njalo ngoLwesibili la si… khona ama-patient sizowatshekha ukuthi ihamba kanjani i-treatment / sizohlola yonke into sibone ukuthi i-treatment iyakusebenzela na noma cha / kodwa ke lokho akusho ukuthi ungafiki ngelinye ilanga uma kuwukuthi kukhona la uzwa khona ubuhlungu ufike noma yinini asiwavimbi ama-patients ukuthi afike azobona udokotela / nangoLwezine futhi siyakwazi ukuthi ama-patient afike sizowahlola ukuthi i-treatment iyasebenza yini / uma kuwukuthi uba ne-emergency uyakwazi ukuthi uzongena ngasesibhedlela e-casualty then odokotela bethu bakhona khona lapha bayakwazi ukuthi baye khona e-casualty bayokuhlolela khona and then bakwazi ukuthi bakusize / so kubalulekile ukuthi wazi ukuthi ngoLwezibili yilapho senza khona ama-reviews ukuthi sikubone ukuthi itreatment isebenza kanjani ngokuthi iyahambisana yini nawe
(it is important that on all Tuesdays every Tuesday here we check patients how the treatment is going / we check everything to see if the treatment is working for you or not. But it does not mean that you cannot come on other day if you feel the pain you can come we do not stop patients from coming to see the doctor / on Thursdays as well we do allow patients to come for check-up to see if the treatment is working / if you have an emergency you can go to hospital in the casualty ward / our doctor will come and examine you from there and then help you it is important that you understand that Tuesdays are set days for your check-up)#00:30:50-1# (end of trained interpreter's turn)

#00:30:51-2# Patient: {hm}

#00:30:51-2# Doctor: thank you now I spoke a lot today (soft laughters) it's a lot of information the first appointment like this you know with that's when we started treatment / we go through everything cause we don't want you to get unnecessary side effects because you know if you don't understand properly hmm but don't worry if you don't understand it all every Tuesday when you come / you can discuss if you need anything write it down so you don't forget...

#00:31:13-5# Patient: {hm hm}

#00:31:14-0# Doctor: ...we can discuss anything you want / ok #00:31:16-3# (end of doctor's turn)

#00:31:16-6# Trained interpreter: Zulu osukwini lwanamhlanje hayi impela ngikhulume kakhulu kodwa ukuthi nje sikuchazele ukuthi itreatment isebenza kanjani / kubalulekile ukuthi nawe noma usesekhaya uma kuwukuthi kukhona imibuzo onayo uyibhale phansi ukuze mawufika ngoLwesibili usukwazi ukuthi ukhumbule nawe ukuthi hayi unenkinga ngokuthi nokuthi / thina siyakwazi ukuthi sikuchazele

(today I have spoken a lot but I had to explain how the treatment works / it is important that you also at home if it happens that you have questions you must write them down so that when you come on Tuesday you are able to remember that I have a problem about this and that / we will then be able to help you) #00:31:35-1# (end of trained interpreter's turn)

#00:31:35-8# Doctor: ok hm do you have any questions after all that

#00:31:39-2# Trained interpreter: (soft laugh) Zulu kukhona eminye imibuzo onayo (are there any other questions)

#00:31:41-1# Patient: Zulu Hayi namhlanje .....

#00:31:43-4# Trained interpreter: we are good today thank you very much

#00:31:44-8# Doctor: ok (indistinct) thanks (indistinct) you you're welcome to come first next week Tuesday now going ahead from today/ you're going to do some blood test for me today / (indistinct) to a test for chemo

#00:31:57-2# Patient: {hm}

#00:31:57-4# Doctor: tomorrow you'll come back to me have your treatment tomorrow and then come back to me we'll check the blood results if it's ok I'm going to order your first chemo for Thursday

#00:32:06-8# ?: {hm}

#00:32:07-2# Doctor: alright that's the first thing the second thing / I would like you to please get me a pink file you know where the clerk sit when you're coming to this department

#00:32:15-1# Patient: hm

#00:32:15-7# Doctor: they sit by the windows I want you to please bring me a pink file I need to write your medication / I'm not happy with the the trash in the mouth...

#00:32:23-2# ? hm

#00:32:23-4# Doctor: the second thing is that I'm not happy about is the the level of the pain medication / which I'm going to optimise now ok and we'll just give you some e mouth wash that's about it #00:32:34-7# (end of doctor's turn)

#00:32:36-8# Doctor: ok

#00:32:37-6# Trained interpreter: {alright} Zulu okwamanje ke njengoba sikade

sikhulumile ngizocela ukuthi uhambe uyongithathela amagazi, amagazi lawa azokuhlola ukuthi iyiphi i-chemo uzofanela ukuthi uyithole / uzobe sewuyabuya ke kusasa ubuyele kimina mina ngizobe sengiyakwazi ukuthi ngiku-odele i-chemo okufanele uyithole / engicela futhi ukuthi ungenzele khona ukuthi ungitholele ikhadi eliphinki lelokhadi ulithola la uma ungena uza ngapha kukhona nje onesi abahlala ababhalisayo bazokunikeza ikhadi eliphinki ukuze ngizokubhalela i-treatment okuzofanele uyisebenzise for itrash yakho ngoba ngiyabona ukuthi hayi iba yimbi kakhulu ngizokutholela ne-mouth wash nokuthi umzimba wakho nawo ngikutholele ukuthi umzimba wakho nawo ngikutholele ukuthi uwusebenzise
(right now as we have spoken I will ask you to go and take the blood out for me, this blood test will determine which chemo will be good for you to take / you will come back to me tomorrow and I will be able to order you the chemo that you can take / please do me a favour and get me a pink card / you get that card as you come in you get from nurses who write your names they will give you the card so that I can write treatment for your trash because I can see it is getting bad I will also get you a mouth wash / also for your body I will find you something to use????) #00:33:22-8# (end of trained interpreter's turn)

#00:33:22-8# Doctor: ok

#00:33:24-1# Patient: Zulu i-blood test yona ngizoyithatha kuphi (where do I take the blood test)

#00:33:26-5# Trained interpreter: so where do I get the blood test

#00:33:28-1# Doctor: ok I'll show you where in the chemo room / every time you need to take any blood for chemo / it's the chemo room just two doors down but I'll show it to you now [ok

#00:33:36-3# Patient: [ok

#00:33:37-0# Trained interpreter: Zulu [ngizokutshengisa ukuthi kumele uye kuphi / uma kungukuthi uthatha amagazi ekhimo uya iminyango emibili ukusuka lapha / but ngizokutshengisa (*i will show you where to go / when you take chemo blood tests you go two doors from here / but I will show you*)

#00:33:37-4# Patient: Zulu [so ngizoqala ngothatha ifayile… (*must I start by taking the file…*)

#00:33:38-2# Trained interpreter: ....Zulu...

#00:33:44-8# Doctor: [ok

#00:33:44-9# Trained interpreter: ...Zulu...

#00:33:46-0# Patient: Zulu

#00:33:49-6# Trained interpreter: do I start by getting the pink file or [do I

#00:33:51-6# Doctor: [(indistinct) you'll start by getting the pink file for me / and there's something that I'd just like to chat to chat to you off camera / about the blood test as well alright and then the next the last thing is hmm hmmm don't look so worried alright...

#00:34:05-7# Patient: [(indisinct)

#00:34:05-7# Doctor: [We're here to help you to every step of the way / it sounds like a lot you're right at the beginning/ we be three fractions done so far / but with four fractions before you know it / then you're at twenty then you'll be at thirty and then you'll be finished

#00:34:20-0# ? hmmm

#00:34:20-6# Doctor: alright

#00:34:21-1# Patient: [yeah

#00:34:21-1# Doctor: [with the time goes so quickly (indistinct)

#00:34:23-8# Patient: hmmm

#00:34:24-9# Trained interpreter: Zulu engithanda nje ukukutshela kona ukuthi Ungakhathazeki kakhulu ngiyakubona ukuthi ubukeka sengathi ukhathazekile khululeka thina sizoba sinawe kuyona lendlela esizoyihamba nawe futhi okwamanje okwamanje ukuthi (inaudible) yesi 4 uzoqhubeka uqhubeke nini nini uzobe usuqedile uzobe usu-right. So ke uzame ukuthi uyiqinise ube-right (what I would like to tell you is that you must not worry / I can see you are worried, relax we will be with you in this journey. We will go through it together for now you are in 4th treatment as you continue before you know it will be finished and you will be ok / try and be strong you will be alright)

#00:34:48-8# Doctor: ok/ darling if you can get me the pink file/ and then we'll wrap up these machines so that you and I can chat a little bit more once you bring me the pink file

#00:34:57-7# ? :ok

#00:34:58-0# Trained interpreter: so Zulu ke ungahamba uyongithathela i-pink file (you can now go and get the pink file for me)

#00:34:58-2# Doctor: [please

#00:34:59-3# Patient: [Zulu ngiyothatha lelikhadi eli-blue (must I go and get the blue card)

#00:35:02-1# Trained interpreter: hmmm do I give the pink file with the blue card

#00:35:05-3# Doctor: yes

#00:35:05-9# Trained interpreter: yes

#00:35:06-4# Doctor: please take your bag with you as well alright/

#00:35:08-8# [the patient is getting on her feet takes a bag to head towards the door] thank you

#00:35:11-0# [the patient leaves the consultation room]

TRANSCRIPTION CONSULTATION 3

#00:00:00-0# Doctor: so they will- will they brief her about/ this / or the've the have they already

#00:00:06-7# Nurse: I don't know / I don't know

#00:00:08-5# Doctor: or they'll do it after

#00:00:09-8# Nurse: Zulu uthi udokotela *nenimbrifile* na / (the doctor says did you brief/)

#00:00:12-0#

#00:00:12-5# Researcher's assistant (standing outside by the door): yes

#00:00:13-5# Nurse: i-patient (the patient)

#00:00:14-2# Researcher's assistant (standing outside, by the door): {yes}

#00:00:14-3# Nurse: yes she has been briefed

#00:00:16-4# Doctor: ok

#00:00:17-5# Nurse: so what's happening #00:00:18-2#

#00:00:20-3# Doctor: alright / no I was just reading my / my part #00:00:23-9#

(long silence)

#00:00:53-9# Doctor: ask her if she's been told about this hand-out if she's been told about this and she agreed #00:00:57-2# (end of doctor's turn)

#00:00:58-2# Nurse: [Zulu uthi udokotela ngikubuze ukuthi bakhulumile na ngalento ezokwenziwa njengoba uzovela ingathi / njengoba kuthathwa izithombe (the doctor says I must ask you if they spoke to you about what is going to happen as you will appear / as they are taking pictures)

#00:01:07-8# Patient: [Zulu yebo ba (inaudible) yes they...(inaudible)

#00:01:10-6# Nurse: Zulu bakhulumile nawe / bakuchazelile uyazi (did they speak to you / they explained it to you)

#00:01:12-8# Patient: Zulu yebo. (yes)

#00:01:13-9# Nurse: ok / yeah she has [(indisctinct)

#00:01:15-1# Doctor: [she's been told

#00:01:15-9# Nurse: yeah she has been told

#00:01:17-3# Doctor: hmm #00:01:17-7# (end of doctor's message)

#00:01:20-5# Doctor: I see you're on treatment almost for sevenden- seventeen days now huh

#00:01:25-9# Patient: hmm- hmm

#00:01:27-3# Doctor: how is our treatment hmmm going

#00:01:30-4# Patient: *eish* I don't know about / it […

#00:01:32-4# Nurse: [Zulu he- e- he- e- umshini // uthi udokotela njengoba usemshinini sekuphele u-*17 days*, uzizwa unjani khona manje / uyawubona umehluko noma awuwuboni umehluko (*mmm-mmm the machine // the doctor says as you are in the machine for 17 days how do you feel right now / do you see the difference or you don't see the difference*)

#00:01:33-6# Patient: o- ngiyawubona wona (*oh I can see it*)

#00:01:34-0# Nurse: Zulu kwenzakalani / ubona ini (what is happening / what do you see) #00:01:42-0# (end of nurse's turn)

#00:01:42-8# Patient: Zulu angisho manje bekubuhlungu ngapha bekuphuma i-something so so uma ngiyifila so ngivele ngizwe seyi- (it was painful. Something was coming out when I feel now I feel its-)

#00:01:44-3# Nurse: hm hmmmmm

#00:01:45-0# Patient: Zulu ngiyizwa seyincane. Ngiyayizwa ukuthi seyiyancipha. (I feel it is small. I can feel it is decreasing) [starting a sentence but interrupted by the nurse]

#00:01:45-3# Nurse: Zulu iyancipha / seyincane (It is decreasing / it is now small)
#00:01:46-6# (end of nurse's turn)

#00:01:47-4# Patient: Zulu ya ayis... (yes it's not...)

#00:01:54-0# Nurse: hm hmmm

#00:01:54-2# Patient: ... Zulu... ayis... (It's not...)

#00:01:55-5# Nurse: Zulu [Transcription and back translation not provided]

#00:01:56-3# Patient: ... Zulu... ya (yes)

#00:01:58-1# Nurse: ok

#00:01:58-5# Patient: ... Zulu... [Transcription and back translation not provided]

#00:02:00-0# Nurse: ok

#00:02:00-4# Patient: ...Zulu .....[Transcription and back translation not provided]

#00:02:01-0# Doctor hmmm

#00:02:01-8# Nurse: alright there was a deep I mean there is a difference because when she was putting a finger she would feel the tumour / now it is decreasing

#00:02:05-5# Doctor: [hmmm
#00:02:05-8# Nurse: [eeee because when he was putting in the finger she could feel the tumor there

#00:02:10-8# Doctor: hmm[m
#00:02:10-9# Nurse: [but now it's decreasing [so there is a difference
#00:02:13-2# Doctor: [decreasing in size

#00:02:14-5# Nurse: [yeah

#00:02:14-5# Doctor: [hmmm / ok any- any problem
#00:02:18-4# Patient, (nurse speaks at the same time) Nurse: inkinga enye ekhona

njengoba uqalile ukuya emshinini (any other problem since you started going to the machine)

#00:02:18-8# (voice of the nurse takes over the patient's) Zulu kuphuma izinsila so / kuphuma izinsila / angazi ukuthi kusho kusengathi zihlangene negazi nokungathi amafinyila so (there is dirt coming out / dirt is coming out / I don't know it is like it is mixed with blood and also something like mucous)

#00:02:18-7# Doctor: [during this period

#00:02:19-9# Nurse: (patient and nurse are still speaking at the same time) [Zulu ziphuma kuphi / ngaphambili noma ngemuva (where do these come out in front or at the back)

#00:02:20-4# Patient: [Zulu ngapha emuva (here at the back)

#00:02:20-4# Nurse: [Zulu (voice of the nurse takes over the patient's) ngapha ngemuva (at the back)

#00:02:22-4# Nurse: aaaaahhhh

#00:02:22-9# Patient: Zulu (No lines)

#00:02:24-0# Nurse: Zulu #00:02:24-8# (end of nurse's turn) (No lines)

#00:02:26-5# Patient: Zulu (No lines)

#00:02:29-7# Nurse: ya [Zulu

#00:02:31-7# Patient: [Zulu #00:02:32-8# (end of patient's turn)

#00:02:33-2# Nurse: ok alright / there's some something that is coming [out #00:02:37-7#

#00:02:37-7# Doctor: [hmm [m

#00:02:38-0# Nurse: [and which is mucous like / and it's lit dirty and then it's like is little slack[ly

#00:02:46-2# Doctor: [hmmm

#00:02:46-9# Nurse: (indistinct)

#00:02:48-6# Doctor: (glat?) ah since when that hmm [she has started seeing that

#00:02:51-2# Nurse: Zulu kuqale nini (when did this start)

#00:02:53-6# Patient: Zulu vele manje mangicala ilokhanji ngoba ekucaleni bekuphuma kuyigazi (now when I started this because before only blood was coming out)

#00:02:57-8# Nurse: Before the Zulu before uzoqala umshini (before you started the machine)

#00:02:58-9# Patient: eeee Zulu #00:02:59-9# Nurse: Zulu manje seku-

#00:03:01-4# Patient: Zulu eeee soloko uqalile umshini kwenzeka lento (since you started with the machine now this is happening)

#00:03:06-5# Nurse: [hm hm / [ok njengoba uzoqala umshini (as you started the machine)

#00:03:08-2# Patient: ...[Zulu..... [uyazi izinto zakhona ziyaphuma okunye sengathi yinyama nje mara hayi ukuthi yinyama lejelly iphuma ivele ithi- ma uyibhekile ayi ngathi- (inaudible) (you know these things come out some things are like meat but not real meat its jelly it just comes out this- when you look at it it's not like-)

#00:03:09-1# Nurse: [alright

#00:03:09-4# Patient: ...Zulu... #00:03:11-4# (end of patient's message) Ayi-

#00:03:11-9# Nurse: alright/

#00:03:13-1# Nurse?: Zulu seloku uqale umshini kwenzeka lento (since you started this machine this happens)

#00:03:15-6# Nurse: before she started treatment

#00:03:17-3# Doctor: hmmm

#00:03:17-7# Nurse: [yeah] there was blood coming out

#00:03:17-7# Doctor: [so that's what I was thinking]

#00:03:19-5# Nurse: and since she's started the treatment / so it's [this (indistinct)] (the nurse stops her sentence and listens to the doctor)

#00:03:22-4# Doctor: [the blood] dried out but hmm there is [still...
#00:03:24-6# Nurse: [yeah...

#00:03:25-0# Doctor: ...the mucous
#00:03:25-2# Nurse: there is this mucous thing

#00:03:27-1# Doctor: [ok
#00:03:27-2# Nurse: [that is co[ming out

#00:03:28-3# Doctor: [hmmm / just tell her that eee // the mucous is because the rectum is still working
#00:03:35-8# Nurse: ok

#00:03:36-7# Doctor: she has a e bag outside here
#00:03:39-5# Nurse: hm h[m

#00:03:40-1# Doctor: [everything is coming through here
#00:03:42-0# Nurse: hm hm

#00:03:42-5# Doctor: But the the *kaka* /
#00:03:44-4# Doctor: i[s not coming that side because is the (inaudible) / ...
#00:03:44-6# Nurse: [hmm

#00:03:46-8# Nurse: hmm[mm
#00:03:47-2# Doctor: [coming outside [here
#00:03:48-1# Nurse: [hm hm

#00:03:48-8# Doctor: but the rectum is still working / so it produces the mucous / to lubricate your caca
#00:03:55-1# Nurse: hm hmmm

#00:03:55-8# Doctor: So when it / there is nothing to come out then that mucous will come out #00:03:59-7# (end of doctor's message)

#00:04:00-8# Nurse: Zulu uthi udokotela ngikuchazele ukuthi njengoba kuye kwavulwa

ukuthi ukake ngapha ufakwe isikhwama ngapha kwavalwa (the doctor says I must explain to you that since it was opened for you to excrete on this side the bag was put in and the other side was closed)

#00:04:07-4# Patient: hm hm

#00:04:08-1# Nurse: So Zulu angithi umuntu uma ezoya ethoyilethi enza unamba thu kuba ukuthi amakaka vele aphuma egcobisekile so ke njengoba kuvaliwe kungaphumi amkaka akusho ukuthi lendawo ayisasebenzi (*when a person goes to the toilet to do number two the faeces come out smeared / Now as this part is closed it does not mean it is not working*)

#00:04:27-8# Patient eeee

#00:04:28-1# Nurse: so Zulu lawo mafinyila layo aphumayo enziwa yingoba vele abevele ephuma ngesikhathi noma ukaka so azolibele ephuma vele ngoba lendawo isasebenza kodwa ayisebenzi ukuthi iphume amakaka isebenza ukuthi sekuphuma leyonto nje engamafinyila (*the mucous that is coming out is caused by the fact that it was going to come out when you excreted / the mucous will still come out because this part is still working although it does not work as the faeces now it only excretes this mucous thing*) #00:04:44-9# (end of nurse's message)

#00:04:46-1# Nurse and patient: {hmmm}

#00:04:47-3# Doctor: e any change of the skin colour

#00:04:50-3# Nurse: Zulu la uthola khona ukwelashwa umshini la ushisa khona isikhumba sakho sinjani (where you are getting the treatment, where the machine is used, how is your skin like)

#00:04:51-7# Doctor: [where we are to treat

#00:04:52-6# Nurse: ... Zulu umshini la ushisa khona isikhumba sinjani (where the machine is used, how is your skin)

#00:04:56-8# (end of nurse's turn)

#00:04:57-6# Patient: hash zulu angisiboni (I don't see it)

#00:04:59-5# Nurse: Zulu awusibheki (you don't look at it)

#00:05:00-5# Patient: hin hin

#00:05:01-6# Nurse: Zulu yini indaba ungasibheki (why don't you look at it)
#00:05:02-4# (end of nurse's turn)

#00:05:03-5# Patient: Zulu angikhoni ukusibheka (I am not able to look at it)

#00:05:05-2# Nurse: Zulu hawu noma ume esibukweni awukwazi ukuthi ungazibheka (even when you stand at the mirror you are not able to see it)
#00:05:07-6# (end of nurse's turn)

#00:05:09-8# Patient: hm Zulu sengizozibheka (I will now look at it)

#00:05:11-1# [Nurse bursts in laughter]

#00:05:12-0# Doctor: hm hm

#00:05:12-3# Nurse: Zulu [kodwa ke akulumi awuzwa buhlungu (but now is it not itchy, you are not feeling any pain)

#00:05:14-3# Patient: [Zulu manje inkinga yami ukuthi ngapha kuyaluma ene nakhona ngapha embobeni kuyaluma kodwa akulumi njengangapha (now my problem is that it is itchy this side and also this side in the hole it is itchy but it is not as itchy as this side)
#00:05:16-8# (end of patient's turn)

#00:05:16-4# Nurse: ya ngaphambili ekukwni (in front in the vagina)

#00:05:17-1# Patient: Zulu ngaphambili / ngapha kuluma kakhulu sista noma ngingathi ngizama ukuthi nginanwayi kuyangifosta ukuthi ngenze so / angithi last ngizile ngatshela udoktha ukuthi ngathi ngizinwayile wangipha amaphilisi so lawo maphilisi akazange angincede (infront / this side it is very itchy sister even when I try not to scratch I am forced to do like this / last time I came to tell the doctor that as if I scratched myself he gave me tables / those tablets did not work) #00:05:18-3# (end of patient's turn)

#00:05:17-9# Nurse: hm hmmm

#00:05:18-6# Patient: Zulu kuluma kuze kulume phakathi embobeni (it is so itchy it itches right in the hole)

#00:05:21-0# Nurse: hm hmmm

#00:05:22-0# Patient: Zulu No lines

#00:05:24-1# Nurse: Zulu phakathi ya / ya (inside yes / yes) #00:05:24-9# (end of nurse's turn)

#00:05:24-8# Patient: [Zulu No lines right through here.

#00:05:24-8# Nurse: [Zulu [Transcription and back translation not provided]

#00:05:26-2# Patient: Zulu [Transcription and back translation not provided]

#00:05:30-2# Nurse: anh anh[hh

#00:05:31-1# Patient: [hmm Zulu [....[Transcription and back translation not provided]

#00:05:33-7# Nurse: [ai hm hmmm #00:05:34-4# (end of nurse's turn)

#00:05:33-8# Patient: ...[Zulu .... [Transcription and back translation not provided]

#00:05:34-7# Nurse: [hm hmmm

#00:05:34-8# Patient: ...Zulu [Transcription and back translation not provided]

#00:05:37-4# Nurse: yeah

#00:05:37-8# Patient: Zulu [Transcription and back translation not provided]

#00:05:40-8# Nurse: hm hmmmm #00:05:41-3# (end of nurse's turn)

#00:05:42-2# Patient: Zulu. [...[Transcription and back translation not provided]

#00:05:43-8# Nurse: [Zulu yeah yeah #00:05:45-3#(end of nurse's turn)

#00:05:46-7# Nurse: ok

#00:05:47-5# Doctor: hmm

#00:05:47-8# Nurse: the only problem that she's go t/

#00:05:50-6# Doctor: hmm

#00:05:51-0# Nurse: it's the itching /

#00:05:52-4# Doctor: hm[mm

#00:05:52-5# Nurse: [the vagina/ she [says it's unbearable /

#00:05:54-3# Doctor: [hmmm

#00:05:56-3# Nurse: it's even inside /

#00:05:58-5# Doctor: [hmm

#00:05:58-5# Nurse: [so like she keep on scratching it because she can't resist it the way it's itching #00:06:03-7#

#00:06:04-5# Doctor: doc[tor/ hmm

#00:06:04-9# Nurse: [so she she was given [the I think] it's antibiotics

#00:06:07-0# Doctor: [yes]

#00:06:08-6# Doctor: yes [that has been it's not working it's not it's not helping]

#00:06:09-5# Nurse: [but she says that there is a difference there hmm hmm] #00:06:12-6#

#00:06:12-5# Nurse: it's not [helping]

#00:06:13-0# Doctor: [helping] alright {ok} can I see you in the back

#00:06:16-0# Nurse: Zulu ucela ke ukuthi udokotela ugibele ngale embhedeni azokubona (*doctor is asking that you get there on to the bed for him to see*) #00:06:19-0#

#00:06:25-7# Doctor: eiy (as he realises that the door was opened)

#00:06:28-0# the doctor closes the door

#00:06:39-6# Nurse: so khona akukho into ephumayo yiloku kuluma nje kuphela (*there there is nothing coming out is it only the itchiness*) #00:06:42-5# (end of nurse's turn)

#00:06:43-2# Patient: Zulu mhh nokulimala / angisho ngiya ngiyazithinta bese lenyama seyi ilimele (mhh I am injured / I touch myself and (this tissue) gets hurt

#00:06:46-6# Nurse: hm hmm

#00:06:47-1# Patient: Zulu..[Ilimele (injured)

#00:06:49-0# Nurse: [hmmmm

#00:06:50-6# Nurse: Zulu [yini na awugezi ngamanzi wensipho nakhona lapha ngaphambili (what's wrong are you not using soapy water in front)

#00:06:53-7# Patient: [he e ngigeza ngamanzi kuphela (no I wash with water only)

#00:06:55-0# Nurse: Zulu ugeza ngamanzi kuphela (you wash with water only)

#00:06:55-5# Patient: Zulu [ngigeza ngamanzi kuphela (I wash with water only)

#00:06:56-8# Nurse: ok #00:06:57-4# (end of nurse's)

#00:07:00-4# Patient: {zulu}

#00:07:01-4# (end of patient's turn)

#00:07:09-4# Doctor: {ya there is a fungus (indistinct) }

#00:07:10-5# Patient {eish eish}

#00:07:12-4# Doctor: (indistinct)

#00:07:14-0# Nurse: Zulu phenduka ufuna ukubheka (turn around he wants to see)

#00:07:14-7# Nurse: Zulu ufuna ukubheka ngemuva (he wants to see at the back)

#00:07:16-1# yoh (shout of pain)

#00:07:16-3# Doctor: Sorry {there you go (indistinct)}

#00:07:19-8# Doctor: (indistinct)

#00:07:25-0# Nurse: Zulu ungagqoka ke wehle embhedeni (you can now dress up and get off the bed)

#00:07:26-0# Doctor: ok

#00:07:26-5# Nurse: [(indistinct) #00:07:27-0# (end of nurse's)

#00:07:26-5# Patient: [hmmm (pain)]

#00:07:54-0# Patient: Zulu #00:07:55-0# (end patient's)

#00:07:55-2# Nurse: hmm ngicela uhlale la phansi esitulweni (please sit on the chair) #00:07:55-6# (end nurse's)

#00:08:27-4# Doctor: eh- just tell her that you have a vaginal candida e you have a fungus in the in your vagina #00:08:34-0# (end of doctor's message)

#00:08:34-3# Nurse: hmm

#00:08:35-0# Doctor: and I'm going to give her some a hmmm antifungal for it

#00:08:40-1# Nurse: hm hm

#00:08:40-3# Doctor: as well as disinfectant as well so I'm gonna give you antifungal and antibiotic

#00:08:45-7# Nurse: ok

#00:08:46-3# Doctor: and- and a pain medicine

#00:08:48-6# Nurse: ok/ Zulu uthi ke udokotela kunokugcola okukhona laphana ngaphambili / uzokubhalela amaphilisi ukuthi azokunceda ozowasebenzisa (doctor says there is dirt here infront / he will write you tablets that you will use to help you) #00:09:01-0# (end of nurse's turn)

#00:09:02-2# Patient: Zulu angeke ngisabuya (will I not come back)

#00:09:03-9# Nurse: Zulu kuzobonakala / sizozwa ngawe emuva kwamaphilisi ukuthi umehluko uyawubona noma awuwuboni / ngoba uyabona vele nokuthi akhona amanye beka odiwe awakuncedanga / but uzokwenzela futhi ile- / le eyishubhu bowuyifaka futhi nayo / bekakubhalele ini okuphuzwayo kuphela bekungena ma- ok alright uzokubhalela ke futhi amanye amaphilisi ahlukile kunalawa owatholile sibone ukuthi azokwenza njani

(it will depend / we will hear from you after the tablets if you see or not any difference / you see that other tablets were ordered for you they did not help / but he will also do the- that tube that you were also putting in / what did he write for you to drink there was no- t's alright he will write again other different tablets for you and we will see what they will do)

#00:09:20-9# Patient: [Zulu namaphilisi (and tablets)

#00:09:22-1# Nurse: ok Zulu #00:09:29-3# (end of nurse's turn)

#00:09:34-4# Doctor: and you'll just continue with the our ra radiation till two months [ok

#00:09:38-5# Nurse: [ok uthi uzoqhubeka ke nomshini / into esizoyicela sizocela ukuthi uye ngale efasteleni uyocela ikhadi leli eli-blue (this is correct, no hesitation) I mean i-pink file khona ezokwazi ukuthi akubhalele amaphilisi (he says you will carry on with the machine / can you please go that side to the window and ask for the card a blue card I mean pink file so that he can write the tablets for you) #00:09:51-1# (end of nurse's turn)

#00:09:52-2# Patient: {hm hmm} #00:09:53-7# (end of patient's turn)

#00:09:53-8# Nurse: we done

#00:09:54-9# Doctor: ya hmm pink file so that I can write the medicine

#00:09:59-1# Nurse: alright

#00:10:00-5# Nurse leaves the consultation room later followed by the patient.