"ABASIVA ASIBEVA"

"We don't understand them, they don't understand us"

AN EVALUATION OF A COMMUNITY HEALTH INTERPRETER PILOT SCHEME IN TWO PUBLIC HOSPITALS IN CAPE TOWN SA:

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Declaration:

I, George Petros hereby declare that the work on which this dissertation is based is my own research and that all the sources I have quoted have been indicated and acknowledged by means of references. All the work or part thereof will not be used or submitted in any other tertiary institution for the purpose of obtaining a degree or diploma.

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Abstract

This mini thesis describes the evaluation of the work of Community Health Interpreters (CHIs) in two Cape Town public hospitals, Its aim is to ascertain whether the introduction of interpreters in public hospitals led to an improvement in communication between health providers and their non-English and non-Afrikaans speaking Xhosa patients and whether this led to improved patient satisfaction, efficiency, improved quality of treatment and improved hospital accessibility. A number of test cases internationally has shown that the introduction of trained health interpreters within the hospital context improves communication between health providers and their patients leading to patient contentment. This qualitative study with a limited quantitative aspect was carried out to assess the perceptions of patients, health professionals and the health interpreters themselves about the work of the interpreters. One hundred (100) Xhosa speaking patients and guardians were interviewed using an interview schedule, fifty (50) from Hospital A and fifty (50) from Hospital B. Fifty (50) health professionals were given self-administered questionnaires, twenty-five (25) were delivered in each hospital. Three (3) interpreters were interviewed at hospital A and two (2) interpreters were interviewed at hospital B using an interview schedule.

The study measured: perceptions of knowledge of service, availability of interpreter service, faith in interpreters by patients, caring within the hospitals, participation by patients in management meetings of the health interpreters, proportion of clients using the service, frequency of service use , education status, language and place of origin (Province) of patients who use the service, duration (in hours) of interpreting, number of days of work per week, education status, gender, age and language competency of the interpreters. Perceptions of doctors, nurses, social workers, managers have also been elicited about the work of the interpreters.

The study found that 75% of clients, mainly Xhosa speaking from the Eastern Cape Province, required the interpreter service on a daily basis at the two hospitals. Seventy four per cent (74%) of the clients from both hospitals found the service very helpful and think it must be continued, 81% of Xhosa speaking clients are making use of the interpreter service every time they visit the hospitals, 69.9% of the clients have faith in the interpreters' work, and 89.7% believe that caring has improved significantly since the arrival of the health interpreters at the two hospitals. The intervention has improved communication between patients and health providers, has improved the quality, efficiency and effectiveness of patient care.

Seventy three per cent (73%) of the clients learned about the existence of the interpreter service via health providers at the hospitals and only 23% learned about it through community organisations or members of the community. Interpreter assistance was promptly available for 84% of the respondents. In 72% of the clients the education status is below standard five (5). None of the clients is involved in any capacity in the interpreter management meetings.

This study concludes that the existence and work of Community Health Interpreters within the hospital environment is long overdue, it improves communication between health providers and patients, improves quality of patient care, improves efficiency and effective patient care. It has further established that health providers need to be trained in how to work with interpreters. This study should assist hospital management in understanding and appreciating the important role the interpreters play as part of a multidiciplinary team in general patient care in the hospital and not only in the clinical encounter.

Section 1.

Introduction and rationale for the study:

1.1 Author's initial awareness of the problem of poor communication at public hospitals and the importance of good communication:

In the years I spent working in the African Shanty Towns of Cape Town in community-based health clinics, it became abundantly clear to me that when Xhosa speaking people visit public hospitals and general practitioners they face a number of problems. The majority of health personnel speak a different language from Xhosa, in most cases English or Afrikaans, which most Xhosa speakers cannot read, write, speak or understand. An added problem is that they suffer the humiliation of having to reveal their health status to a third non-medical party in the doctor's consulting room. These people may be complete strangers such as other patients, a porter, a child etc. This badly affects the client's dignity and right to privacy. Over and above this the doctor patient confidentiality principle was constantly violated.

Accessibility to health care services does not only mean accessibility in terms of physical distance, time or financial accessibility, but language and cultural accessibility are equally important. The following anecdote captures the problem clearly. A Xhosa speaking old lady "fresh" from the rural areas was close to tears after a visit to one of Cape Town's hospitals:

Mntanam ndincede ndisuka esibhedlele kodwa andinelisekanga, akukho mntu undicaciseleyo ukuba yintoni le indihluphayo. Ndisukenje ndakhululiswa, nalogqirha wasuka wandiphatha-phatha endicofa-cofa, wandipopola amehlo neendlebe suka apho bandithi mba ngezinkobe zeepilisi. Nalomntu ebendinika zona uthethe isiwiliwili endingasivanga. Khawutsho zezani zonke ezipilisi, khona kufuneka ndizisele nini ?

My child I am from one of the hospitals around here. I am not happy at all, those people there just do not care. On my arrival I was shown the doctor's consulting room, ordered to undress. The doctor just probed me here and there, looked in my eyes, ears, and mouth. After this I was given this cocktail of tablets; even the person who gave them to me I could not understand a thing he was saying. Will you please explain to me what are all these tablets for and how must I take them?"

People arrive from hospital with a big provision of tablets not knowing how to use them, simply because there was no-one able or willing to explain things to them or willing to listen and understand them. The above scene is very similar to that in a veterinary surgeon's consulting room with no-one speaking apart from giving orders to the affected party, just examining and giving treatment (Swart:1991). The health interpreter is someone who will seek to change or at least improve this doctor-patient unequal relationship and communication divide and therefore improve accessibility, patient compliance and help non-English speaking patients give informed consent when they are to undergo invasive procedures.

In response to this situation the National Language Project (NLP), a non-governmental organisation involved in language training and democratisation in the Western Cape Province, has introduced Community Health Interpreters in some public hospitals. There is a need to evaluate the impact this intervention has had on the health provider-patient communication divide and to see whether this intervention can be extended and be used in other parts of the country where the same problem exists.

2. Aim:

The aim of this study was to explore whether the introduction of Community Health Interpreters at public hospitals leads to an improvement in communication between health providers and their Xhosa speaking patients/guardians and therefore to improved quality, efficiency and effectiveness of treatment.

3. Objectives:

1) To assess the perceptions and views of patient/guardians, health interpreters and health providers in a pilot project in South Africa.

2) To compare the results of this study with the baseline study performed by the NLP.

3) To recommend the future role and functions of Community Health Interpreters within the South African context.

4. Literature Review

4.1 The magnitude of the problem of poor communication at Public Hospital(s):

Table 1 captures the skewed distribution by ethnicity of the health providers within hospital A compared to the majority of patients that seek health care or get admitted to this hospital for furhter treatment and care, the majority of whom are Xhosa speaking from rural areas and speaking little or no English or Afrikaans.

Table 1: Health Personnel Distribution by Ethnicity (Red Cross Hospital)

Category	Black	Coloured	Asian	White	Total
Clinical Technician	0	1	0	1	2
Medical Officers	1	6	3	42	52
Dieticians	0	0	0	2	2
Specialists	4	10	1	69	84
Radiographer -s	1	12	1	6	20
Optometrists	0	0	0	1	1
Chief Prof. Nurses	0	5	0	11	16
Sen.Prof. Nurses	28	71	0	49	148
Nursing Assis	10	281	0	0	291
Staff Nurses	22	83	0	0	105
Pharmacists	0	3	0	3	6
Physiotherapi-st	0	4	0	6	10
Occupational therapists	1	0	0	7	8
Social Workers	3	1	1	7	12
Radiologists	0	0	0	3	3

(Sources: Red Cross Hospital records 1997)

In her study of this problem of poor commuication between Xhosa speaking patients and health providers, Crawford found that half of all patients seen daily at Red Cross Childrens Hospital needed interpreting services (Crawford:1994). Ngqakayi (1994) also found that at Groote Schuur Hospital's emergency psychiatry unit less than 20% of staff, where no

interpreter service existed, spoke no African language at all. This is coupled with the difficult task of finding suitable referral agencies for continued intervention, for example Rape Crisis, as there is a major shortage of properly trained therapists to refer Xhosa speaking clients to. In a survey at Valkenberg Hospital, Drennan (1994) established that 20-30 % of admissions required interpreting services. This was provided in 67% of the cases by nurses and 10% by cleaners. Personnel with psychiatric insight and education were clearly preferred, he argued. Immediate interpreting services were available in 69% of the cases, while 9% had a delay of more than one day. The greatest impact of unavailability of interpretrers was felt when 14 interviews could not take place at all in the female admission ward which had no Xhosa speaking staff members for one entire month of the study. The resultant delays in commencement of treatment, management and ultimately in discharge of the patients, sometimes for weeks, caused significant financial and clinical burden on the hospital services. Patient management began under conditions of poor clinician-client communication and diagnostic uncertainty also led to poor compliance and the increased likelihood of relapse and readmission, placing additional burden on the health services and the community as a whole.

The above scenario is symptomatic of a much deeper problem within the health sector, that of a lack of popular participation by the broader public in health providing institutions. Mckaye and Romm suggest that endeavours towards democratisation, transformation and generation of a social system which is truly popular must of necessity stimulate popular participation in the broadest and most horizontal way (Mckaye & Romm:1992). What Mckaye and Romm say is that, without the active involvement of other stakeholders (students; workers; parents) in the institutions' policy development, the problem cited above will continue to bedevil the public health institutions.

4.2 Who is the ideal health interpreter?

In the literature reviewed for this paper, authors differ substantially in their definition, labelling and requirements of this person. These labels and definitions vary from patient mediator, health advocate, community interpreter, health partner, cultural broker and so on.

For the purpose of this paper an interpreter is viewed as a health advocate, which van Esterik (1985:60) define as: "one who performs the act of interceding or speaking on behalf of another person or group of persons." Paine (1985) embraces this view and explains advocacy as: "explicit intervention of a mediator on behalf of others." By definition therefore, health interpreters must occupy a positions in the socio-political structure of an institution (or society; organisation) that enables them to challenge authority. The use of translators within the public sector for African patients is as old as the 'mountains' albeit never recognised officially as an important part of health delivery. Friends, children of patients, other patients, nurses and relatives too have been used to fulfil this role.

4.3 The Power relationships within the clinical encounter:

Anthropologists such as O'Neil and Lazarus have investigated the wider contextual variables that produce the asymmetric power relationship within the clinical encounter between doctor and patient, such as ideological barriers inherent in the organisation of health care in public health institutions, and have come to the conclusion that it is difficult to overlook issues such as racism, political economy and sexism in the medical encounter when doctors are overwhelmingly drawn from the dominant class and patients from the dominated class (O'Neil,1989 , Lazarus,1988). Turner(1967:299-391) argues that the ambiguity of the concept of health advocacy or interpretation (used interchangeably) with its symbolic dimension, suggests power and danger at the same time. The health advocates\interpreters are in a state of transition, they are neither lay public nor health professionals but lie 'betwixt' in a liminal state. Douglas(1966:96) concurs with this view and further warns that "this spells danger in transitional status, since transition is neither one state or the next, it is indefinable."

Crawford (1994) observed that the powerlessness of interpreters can be seen in the following example: the health professionals have a legitimised degree or professional qualification reflecting their academic and clinical training which gains them recognised status within the hierachy and a respectable salary. The health interpreters' knowledge of the language and culture of their clients only brings them status and recognition within the clinical encounter. The interpreters ensure that they are never late for appointments with both practitioner and patient. It is not uncommon, however, for health interpreters to be kept waiting. It is the doctor's time and emergencies that determines the nature and length of the conversation. O'Neil (1989:331) argues that, in order to be able to advocate for their clients and improve their own power position within the clinical encounter, advocates or interpreters must occupy a position in the socio-political structure of the institution that enables them to challenge authority especially that of the health professionals.

He further adds that most professionals usually dismiss the powerlessness of their clients in their discourse as a cultural problem and miss the underlying fact that the cultural difference they talk about operates within particular relations of power. Swartz(1991) suggests that culture is the space where people construct identity, and in cultural difference that doctors talk about there is a silence about the culture of domination or the disempowered culture that is marginalised. Foucault(1977) concurs with Swartz and further adds that power engenders bodies of knowledge: there is no knowledge without power and conversely no power without knowledge. Swartz further suggests that "Patients .... who in South Africa are chiefly but not exclusively black and powerless can be managed in a veterinary way". On the other hand Tellefson(1991) reminds us that: "The foundation for rights is power and that constant struggle is necessary to sustain language rights". Shackman(1985:13) supports this line of reasoning and argues that "The provision of a monolingual service in a multilingual and culturally diverse society is necessarily discriminatory"

As Navarro (1986:15-36) have observed in other diverse and unequal societies, the biomedical model in its particularity reproduces the relations of dominance and subordination prevalent in broader society. It is logical to suggest that to be a Xhosa speaking patient in relation to an English or Afrikaans speaking patient one is doubly disadvantaged by the language system operating in public health institutions. They further argue that "This problem is not of a completely different nature or order, but rather a further point on the same continuum of power imbalances between the health providers and the patients". Kleinman(1980) is also critical of the biomedical model in its reinforcement of the power imbalance between the health providers and patients and claims that it does not facilitate healing. He further adds that patients want to be accepted, reassured and helped to place their illness in a context where they can grasp it, understand it and take steps to recover their health, but somewhere in this discourse of power, knowledge and control, healing sadly gets lost. Foucault(1977:243) has made an interesting observation about the technology doctors use to diagnose patients' health status. He argues that "Diagnostic instruments represents a formalisation which he terms - clinical gaze". This he suggests, is a mode of looking at patients, of interpreting their signs and symptoms as signifying and most fundamentally of establishing a power relationship between the person watching and those being watched.

Bluen and Udesnki (1988:50-57) and Swartz (1989) have observed that in South Africa, for example, Xhosa is the mother tongue of some Black people and a foreign language to most psychiatrists and psychologists most of whom are white. The power relationship between the (white) clinician using a translated instrument and the (black) Xhosa speaking patient being observed through the medium of this instrument takes an added force - that of living in a country that was divided by apartheid and exploitation and in a current state of enormous social transformation. Seedat,Nell and Butchart take this argument further and argue that "Explanations offered by the health professionals using these instruments are frequently inadequate from the patient's point of view and the resultant sense of disempowerment stimulates increasing levels of

patient dissatisfaction. It is therefore within this context that disempowered people come to perceive health care as an extension of the state's disempowering process. Therefore, the interpreter's or advocate's role is to re-empower the patient within this context", argue Seedat, Nell and Butchary (1990:143-163). Erasmus and Mathibela(1996) concur with this view and further add that the interpreters should not only interpret for the patient but represent their interests, assess their needs and help them obtain whatever they are entitled to within the health service. This is of fundamental importance within the South African context, because the South African politics of health can be characterised as 'exclusive and foreign' in which local traditional health practices and political ideas struggle for expression and recognition within the dominant and powerful Euro-centric biomedical model which uses legal and political means gained over many years of political and economic dominance.

Having established from the literature reviewed that language difference alone does not constitute a barrier to communication, it is also necessary to determine the combination of language and culture as one of the main constraints to providing a satisfactory standard of care for marginalised groups such as the Xhosa speaking patient. McNaught(1988:57) concedes that: "quite clearly these differences (language and culture) pose enormous problems in the delivery of health care . . . lack of communication can both offend and cause damage." This however, deflects from the fundamental issue identified by Swartz and other authors that of power imbalances and the lack of involvement of the marginalised cultures in the delivery of health care. Cammaroff(1982:58) points out that "There can be no solution unless the socio-cultural basis of the existence of this problem is addressed and the interconnection of physical, social and moral being, both in health and illness are restored". Bylav(1991) proposes that to solve the problem of communication, health advocates or interpreters need to be properly bilingual to be able to facilitate linguistic and cultural communication between health providers and patients who do not share the same language and cultural practices. Jewkes and Fulop (1992) take this line of reasoning further and argue that the question of being communicated to in one's language should not only start with and end with health

interpreters - there must be means created for patients to communicate with staff, signposts should be in the relevant community language and health promotion posters should be written in simple, realistic and easy to understand language and in a **culturally sensitive manner** [my emphasis].

Spearman(1991) supports this view and makes the comparison that: "The relationship of language to culture communication can be compared to 'appropriate' services. Easy access is important in order to obtain a service but, it is the appropriateness of the service that needs to be examined and if necessary, be changed. Services alone do not cure illness he reasons". Therefore, it begs the question: What does one do when one is faced by a mother fresh from the rural areas who cannot speak, write or understand English or Afrikaans and is carrying a very sick baby? Even if one provides the latest technology in treating the baby one will still end up with a sick baby within no time after treatment. Therefore, talking to the mother in her language, in a culturally sensitive manner, making her understand the baby's condition and how it can be remedied is of great importance.

Burgess(1984) has observed and claims that "more often than not, however, during interpreting it is the health professional who benefits most from the process of interpreting. Interpreting of biomedical terms, diagnosis and treatment take priority over the patient's explanation of his\her illness and misfortune". Butchart and Seedat (1991), Kleinman(1980) all point out that: "patient participation is subtly discouraged as the health professional conveys recommendations and prescriptions which often take on the tone of directives".

Crawford(1994) found in her study that doctors who acquired a working knowledge of Xhosa felt better and more in control once they could hear whether an interpreter was omitting, adding or changing information. However, this working knowledge can be a recipe for conflict between the doctor and the interpreter. The interpreter may have a much more comprehensive understanding of the patient, knows not only the language but the culture and certain gestures and expressions of the patient, while the health professional only has a working knowledge of the language.

4.4 The role of the Interpreter:

Some authors have observed that some health care providers often express the wish that interpreters assume a stricly "neutral" role in the interpreting process. O'Neil (1989:331), in his study of health interpreters' activities among the Inuit Indians in Canada, showed that "neutrality" can result somewhat parodixically in the circumscription of the patient's presentation of their problems due to the asymmetric power relationship between the health provider and the patient.

Given the perceived tension between "neutrality" and open bias in favour of the patient's voice within the clinical encounter by the interpreter, Anderson(1976:209) proposes that the interpreter's role must be worked out in detail and not be an ad hoc arrangement since this may result in role overload and further disadvantage or disempower the patient. Sluzki(1984) adds that there is a potential danger with poor definition of the role of the interpreter because it might lead to confusion and frustration on the part of the interpreter's clients (health provider and patient) and further argues that a pattern of freely shifting between roles by a health interpreter can lead to 'chaos' within the clinical encounter. The specific exchanges between translator and health provider must be clearly framed as such and differentiated from regular patient-provider flow.

Hasselkus(1992) supports these authors and writes that poor or loose definition of the role of the interpreter does not help in affirming the voice of the powerless patient\guardian, and further argues that the role of the interpreter is a powerful one as it is inherent with all positions that control scarce resources and as a result their role plays considerable influence on the outcome of the consultation. Kaufert and Koolage(1984:283-286) offer a compromise position and focus strongly on the interpreter's need to protect the interest of both parties. They argue that s\he needs to correct and elaborate on the patient's information in order to protect the doctor or may make sure the doctor understands the patient in order to protect the patient. In other words their argument is that, first and foremost the duty of the interpreter is his\her commitment to the integrity of the encounter or consultation and the asymmetr y of the power relationship between the two parties is of secondary importance.

4.5 Interpreting within the health sector:

Use of family members, friends, other patients as interpreters:

Historically and commonly in many South African public hospitals the use of untrained translators, be it for outpatient or inpatient communication purposes with non English speaking patients, is fairly common and taken for granted. Diaz-Doque(1982:1380) is of the opinion that this practice should be relegated to the category of last resort, since all these people lack health -care background training, interpreting skills and therefore lack either language, knowledge of medical terminology, nor are they familiar with hospital policies, procedures, routines and patients' rights within the hospital setting. Saldov and Chow (1994) further add that untrained interpreters must be avoided since sensitive information relevant to the treatment may not be communicated by the patient or by the untrained person. Parson's and Day's (1992) study of obstetric outcomes in ethnic minorities in Hackney, captures succinctly the problem associated with this practice. They found that a quarter of patients who attended a mothers' clinic did not speak English, friends and relatives were used to translate, but this

practice caused considerable embarrassment and answers of dubious reliability. Hasselkus(1992) also came to the same conclusion in his observational study of using care-givers of elderly patients to interpret and found that they negotiate and verify facts with each other. But often the care-givers become a second patient and perhaps an advocate for themselves. Shackman (1992:20) takes this argument further and points out the inherent danger of using informal interpreters, particularly children. He claims that "Interpreting may place an unacceptable strain on a child and can seriously affect parent child relationships."

A lone contending voice in favour of using family members as interpreters is that of Whitefield(1990). She argues that family members normally bring to the interview a constellation of activities including those of the interpreter. The family member's and patient's shared personal history contributes to the resources, power and loyalties of the care-giver and interpreter in this environment. In effect what she says is that, the patient's illness must be contextualised in the sense that his\her home environment [family; physical structure of his\her house; day to day activities etc] must be brought into the picture to fully understand the patient's illness and therefore no one is better equipped or suitable to know this than a relative.

4.6 Nurses as health interpreters:

van Willigen(1986) is of the opinion that "as a nursing strategy interpreting requires a nurse to mediate between patients and the biomedical health care procedure because nursing is concerned with man's socio-cultural orientation as well as his or her physiological make-up". He further lists several reasons to justify why he thinks the nurse should be the perfect candidate for this role:

1. Nurses normally share the same language and socio-cultural orientation as the patient
2. Nurses are accustomed to the hospital environment and to the clinical encounter as representative of biomedicine.
3. Nurse have the means to be sensitve to the socio-cultural difference between patients and biomedical personnel, therefore are able to be objective.

4. Nurses have an important educational function in the hospital.

5. Their role in the hospital also includes consultation and co-operation.
6. Their role could be seen as that of brokerage.

The National Language Project (NLP:1996) is at variance with this position and argues that nurses and nurse assistants, even if they were trained for their interpreting duties, tend to identify or are loyal to the institution within which they work and feel accountable to them rather than to the patient. Wood(1993:347-353) concurs with this view and adds that interpreting is not formally a nurse's job description, there is always tension between their formal duties and interpreting and the doctor-patient confidentiality is violated. In the judicial system for example, interpreting is performed by court interpreters who have been trained to do this duty and are remunerated accordingly; police are not expected nor do they interpret in court cases. So then, it begs the question, why must it be different with the public health care sector?

4.7 Qualities of a health interpreter:

Interpreting, tradition, religion age and gender:

According to Soga(1931) in the African tradition knowledge and certain social practices are closely associated with gender and age of a person. Old men are expected to know about matters affecting men, the history, traditions and culture of the tribe while old women are expected to know about matters concerning women, such as promoting of girls to womanhood, child birth, nurturing, nutrion and health. This knowledge and ability to perform these tasks are gained purely through experience and information passed on orally by elders (wise men and women) in initiation and passage schools through the different developmental stages of the individual child, for example in the Ntonjana custom for girls and during the Circumcision school for boys. Therefore, because of this traditonal separatist practice in terms of duties between the genders and age groups, the principle of non-discrimination in recruiting, training and placing of interpreters may impose immense cultural problems under certain

circumstances if it is not implemented carefully and selectively. For example, a female Xhosa patient with gynaecological problem might feel compromised to talk freely to a male interpreter about her condition. On the other hand male patients will not open up to a female interpreter when suffering from sexually transmitted disease. Gilligan(1982) argues that the practice and meaning of interpreting touches upon larger patterns of socialisation and status differences in men and women. He claims that interpreting entails behaviours and skills often culturally ascribed to women such as helping, connecting, mediating, bridging and caretaking. Nurturing roles have been socially defined and internalised as women's work, reinforced by lifelong patterns of socialisation and structural constraints. Graham(1984) adds that, like other forms of caring, interpreting becomes inseparable from feelings of love and ties of obligation, and this concern for others rather than self represents a defining aspect of femininity.

The authors of the literature I have gathered do not say much about how the culture and gender of the interpreter might impinge on his or her duties. Possibly most of these authors take it as a given that the appropriate gender will be utilised under appropriate circumstances. Therefore, what is of significance here is appropriate training, conscientisation and sensitisation of the person and educating of end users (communities and health providers) about the role and purpose of community health interpreters. This is an area that needs extensive exploration.

4.8 Problems of untrained interpreters:

As good and necessary as it may appear on the surface, the health interpreting arena is not without its share of problems and disadvantages. Some authors have identified common weaknesses that constantly bedevils health interpreters especially untrained interpreters. (Anderson1976; Koolag & Kaufert 1984; Hasselkus 1992; O'Neil 1989). These been have identified as being the following:

Omission, Condensation, Addition, Substitution, Role exchange, Divided loyality (role ambiguity), Mistranslation, Lengthening of consultation time, Minimisation and exaggeration, Distortion, Non-equivalence of concepts, and terminology in communicating biomedical information.

All these problems lead or may result in misdiagnosis and therefore wrong treatment or management of the patient. Richardson(1953:247) and Nida (1964) suggest that the tendency of interpreters to omit, substitute, alter, or skip a word or sentence(s) for a more easy or similar one during interpreting is due to the belief that its message seems to mean what already has been said or is similar to previous information in intention. Therefore, all the rest is largely non-purposeful.

4.9 Training and recruiting of health interpreters:

If community health interpreters are to be viewed and accepted as professionals in their own right among other professionals, it appears to be sound logic for them to have a training and qualification that is accredited and recognised within the relevant field of their work. This position is recognised and accepted in other fields of public service such as the legal profession, translators in international bodies such as the United Nations (UN) and lately the Truth and Reconciliation Commission (TRC) of South Africa.

Sanders (1990) is of the opinion that health interpreters are performing a very critical task within the health profession and as such need to be trained and knowledgeable in the areas of: interpreting techniques, agency knowledge, process skills, code of practice and ethics. Protor(1996:12) on the other hand argues that "It does not matter what qualification, what educational status, marital status or how old one is, when one is interpreting one is just the voice of the client". Richie(1964:27) supports this position and submits that "What is necessary is that the person must have great qualities such as not be intrusive or biased and must have complete respect for the confidential nature of the interview and a thorough knowledge of the patient's culture".

5. Methods

Method(s) mainly applied are qualitative in nature with limited quantitative aspects triangulated with hospital records.

5.1 Setting

The setting for the study was the Mowbray and Red Cross Children's Hospitals. Three (3) of the interpreters are placed at Red Cross Children's Hospital and two (2) are placed at the Mowbray Maternity Hospital after having completed a training period of eight months.

The two hospitals have been coded A and B respectively in the text to protect informants identity.

5.2 Study population:

All the people (patients; guardians; health providers and health interpreters) who were 'potentially' available to be sampled (i.e. all out patients and or guardians).

5.3 Sampling:

- Health Interpreters:- All the interpreters were interviewed.
- Patients/Guardians:- A random sample (clients were arbitrarily picked and interviewed as they came out of the consulting room and while sitting in the waiting room and corridor benches) of clients/guardians who make use of the service were interviewed.
- Fifty (50) in-depth interviews were carried out in each hospital with clients/guardians using an interview schedule. Two different interview schedules, one for patient and one for health providers.
- Health providers:- A cross-section of 50 health providers , 25 in each hospital (doctors, nurses, social workers, hospital managers) were issued with self-administered, semi-structured questionnaires by matrons.

5.4 Data collection:

The perceptions and comments of all the informants (health providers, interpreters, patients) were captured using interview schedules and semi-structured questionnaires.

An audio-tape was used to record the interviews of the interpreters and patients. Interactions between the health providers, interpreters, patients\guardians were taped (where possible) and documented.

The researcher carried out all the data gathering (literature review; observations; audio-taping).

5.5 Analysis:

1) In total one hundred and forty four (144) response sheets were analysed.
2) All the in-depth (qualitative) interviews were categorised, broad themes developed and recategorised into specific categories.
3) The quantitative data was pre-coded, scored and then analysed using the Epi-Info data analysis package.
4) The results of the study were used to ascertain the perception of all the informants of the effectiveness, efficiency, and quality of care in the above hospitals since the introduction of the pilot scheme. These factors were compared to those observed in a baseline study carried out by the National Language Project (NLP) prior to the implementation of the pilot scheme in 1996, to assess whether there had been a shift in perceptions about communication between health providers and patients\guardians and significance of the presence of health interpreters at the two hospitals.

5.6 Ethical considerations:

1) Permission to conduct the study was applied for from the NLP, the hospitals Ethics Committtee (UCT) and the hospital management (hospital superintendents and matrons). They all appproved the application to conduct the study.

2) Permission to be interviewed was sought from each informant (patient\guardian). Each was fully informed of the purpose of this study and that their anonimity was ensured or protected.

6. Pilot study and field work:

A pilot study a week prior to the study proper was carried out so as to test and refine the measuring instruments (patients and interpreter interview schedule; self administered questionnaires). The field work was preceded by an extensive literature review (local and international) of the implications both practical and theoretical around the issue of introducing health interpreters within the hospital context. Literature on research methodology was studied with the purpose of developing a research design for this study. Baseline data gathered by the National Language Project (NLP) prior to the implementation of the interpreter project was consulted so as to use it as a benchmark at the data analysis and

comparison stage. Current staff provision (health professionals) data were gathered from hospital managers at the hospitals.

Final permission to conduct the study was granted by the hospitals Ethics Committee (UCT), superintendents and matrons in charge at the different hospitals gave their approval for the study; all patients\guardians were also asked for their permission to be interviewed. Hospitals A and B were selected because the pilot project has been running at these two hospitals for more than twelve months and much longer than at other hospitals and therefore it was felt that in-depth and significant information could be gained from all three categories of informants or respondents. All the informants interviewed had made use of the community health interpreters' services. To ensure reliability of information elicited the same questions were asked differently in different sections of the interview schedule and probing was constantly applied where ambiguity in answering was detected. To limit as much as possible the response bias, patient were informed clearly that the researcher was not part of nor in any way or capacity employed by the hospital and that their responses would be treated with utmost confidentiality. Without any exceptions responses to same questions phrased differently and placed in different secton of interview schedule were the same.

All unclear or ambiguous questions were corrected, and duplicate and irrelevant questions were done away with for all three instruments.

7. The Survey and the Results from the two hospitals:

7.1 The survey experience(s):

The interviews were quite an eye opener for the researcher, never boring and always full of suprises. I have learned that no two interviews are the same and all interviews have one common characteristic- their ever present unpredictability.

Although patients and guardians are a 'captive audience' within the hospital environment, it seemed however, that most informants were quite assertive and not threatened by the whole excercise; for example one patient asked "why are you asking me this?", "I do not want to answer that", "can you come to that question later?". I am not sure whether these utterances were made because the researcher was not viewed as a medical professional or because of the fact that he is a black person relatively younger than most of the informants.

The relatively unstructured nature and flexibility of qualitative research proved its methodological strength under these circumstances, which allowed the researcher to rephrase questions, change approach (by not following the logical sequence of the questions in the interview schedule) and to meet unexpected difficulties as they arose in the field.

8. Survey results:

8.1 Community health interpreter profile:

Table 2

Comparison of interpreters' profile from the two hospitals:

	Hospital	
Profile of interpreters	A	B
Mean age (in yrs)	33	30
Education status (std)	10	10
Average No of patients assist per day	49	45
No of hours worked per day	8	8
Interpreting experience	2	1
Gender (f=female; m=male)	3 f	2 f
Bilingual (Xhosa & English)	3	3

In general the interpreters in this project are relatively young, are fully bilingual (can speak Xhosa and English perfectly) and all have twelve years of schooling. Sixty per cent of them

had done some interpreting before (formally and informally) although not in a hospital context. Each interpreter assists in clinical encounters over a period of five days per week and on average for 8 hours per day. Each interpreter assists in approximately 40 to 50 encounters per day.

8.2 Interpreters' knowledge of their duties, rights and responsibilities within the hospital:

On asking an interpreter about knowledge of their duties, responsibilities and rights, one response was:

> "Well you know, even before I was a trained interpreter, I was working as a lawyer's interpreter, I read and used to attend sessions where we used to be informed about our rights and the client's rights within the work place. Althogh I did not have extensive or broad training as it is in this interpreter course, I knew my rights very well and that of the clients. I encourage patients to speak up or express themselves and things like that you know."

Another general response was that:

> "We see ourselves as advocates for the patients, it is important part of our duty to guard against anyone violating our rights and that of the patient. For example we know that we are not supposed to involve ourselves in activities that are not in our job description or might endanger ourselves' such as handling needles, soiled bandages and things like that."

On prompting the interpreter further on why they must defend the patients' rights; the response was that:

> "Most of the patients who visit this hospital are from the rural areas, have little or no knowledge of English or Afrikaans, are scared and know nothing about the thing of rights, so it is my duty to make them aware and feel assured so that they can explain their problems and worries easily."

Enquiring further on what skills they have acquired that will make them different from any other person who can do translation at the hospital(s) the responses were by and large the same, namely:

> "We have been trained to be assertive, diplomatic, a bit of counselling and be advocates for the patients. For example, now I am from the maternity ward there

is a mother there who is from the rural areas, who has come to give birth here, but unfortunately the doctor has found out that the foetus is not alive. I had to tell this mother these bad news, you see I had to be very careful when breaking these news and show sympathy to this mother. She was obviously aware that something was wrong. I had to tell her exactly what was wrong. She began to cry and I had to counsel her you know."

8.3 Roles of the Community Health Interpreters (CHIs):

From the foregoing example(s) it is apparent that the interpreters are not only translating information from one language to another, they are also expected to be counselors, cultural brokers, empathise with their patients, advocate for the patients; all this rolled into one. Interpreters adopt implicit advocacy, by which their translation of patients' statements or narratives are sometimes altered to enhance the broader socio-economic complaint of a patient. For example at Hospital A, a guardian had brought a severely malnourished child with other systemic problems. The example\encounter below captures implicit advocacy in action. In the transcript, the English translation of both patient's and interpreter's Xhosa statements are indicated in italics.

hlth.P=health provider Int=Interpreter G=Guardian

Encounter 1.

hlth P : Tell this lady the child is very ill, we will have to admit her, is it okay with her?

Int : *Mama the child is very ill, the hlth P is going to admit her, is it okay with you?*

G : *Yes, its okay as long as it is going to help.*

Int : *She says, it's okay if this is going to help* them

hlth P : Okay, I will try my best to help them.

Int : *Mama, she says she is going to try her best to you.*

G : *Thank you very much my child.*

In this encounter the interpreter did not only focus on the sick and malnourished child, she noticed that the guardian was just as malnourished and very shabbily dressed. Because of

this, in her translation of the information between the guardian and the health provider she included the plight of the guardian as well by implicitly sensitising the health provider that the guardian needs help as well by saying: Yes it is okay as long as it is going to help them and not just only the child.

On engaging the interpreter later about this encounter, it transpired that the interpreter's style of interpreting is part of her general understanding of the health providers who seem to just concentrate on the medical problem at hand and seemingly show less interest in the broader socio-economic problems that lead to such medical problems. She therefore, saw fit that the guardian's situation needs to be taken into account and addressed as well.

This example also illustrates initiative and perceptiveness on the part of the interpreter and the ability to control the encounter, clarify the guardian's description of the situation, rather than translating questions and responses in a mechanical manner. All the interpreters when asked whether they do explicit advocacy, (i.e. stopping an interview if there seems to be insensitivity on the part of the health provider) all believed that they did. But observation revealed that they were more implicit in their advocacy as encounter 1 illustrates.

In the following encounter the interpreter was mainly called to mediate in cultural misunderstanding between the health provider (Hlth P) and the guardian (G).

Encounter 2:

A middle aged Xhosa speaking lady (G) came to the hospital with a referral letter from one of the Community Health Centres in the Townships for a child who had diarrhoea. Although the health provider (hlth P) had a letter with her describing when and how often the child had diarrhoea and stool colour, she proceeded to take a new new history: (Interpreter =Int).

Hlth.P : Will you ask the mother when did the diarrhoea start

Int : *When did the diarrhoea start Mama?*

G : *Sometime this week, maybe on Monday* **(utsho entla nangezantsi)** —

Int : *Sometime this week doc.....*

: The health provider interjects (visibly irritated) before the interpreter finishes the sentence. Hlth P; was it two, three days back, at night or during the day or all the time; at least she can remember that ?

Int : *Mama the doctor wants to know the day and how many times a day the child gets diarrhoea?*

G : (visibly shaken and looking down) *I cannot remember the day or how often , but he had diarrhoea all the time.*

Int : *She cannot remember the day when it started nor how many times a day exactly he gets diarrhoea but he passes loose stools frequently.*

Hlth P : Mh-h-h -h-h(sighs) all right. The health provider starts writing something.

In this instance it was more a question of cultural insensitivity on the part of the health provider.

First of all she did not introduce the interpreter to the mother, the interpreter introduced herself. This in itself shows little or no respect for the guardian's age. Secondly many people of this guardian's age from the rural areas do not understand the concept of (calendar time) dividing the day into time and space and into discrete numerical units as it is with the Western cultural set-up. Thirdly the interpreter did not get enough time to communicate fully what the guardian said. For example, the expression (**utsho entla nangezantsi**). Although there is no direct English translation of this expression, it means that the child is vomiting and has diarrhoea at the same time. The interpreter here was faced by the daunting task of interpreting a euphimistic concept into English.

What was of significance in the above encounter was that the interpreter kept her composure, was not distracted by the health provider's irritable behaviour and dealt with the central issue, which was to keep the communication channel between the health provider and the guardian open.

8.4 Behaviour and attitude of some health providers during the clinical encounter:

The interpreting procedure normally took a sequential process with each interlocutor getting his or chance to speak. However, in many of the encounters the health provider will interject sometimes visibly irritated or impatient with the interpreter rarely doing this and the patient never doing this at all. The following example\encounter 3 depicts this:

In encounter 3 a mother carrying a referral letter from a Community Health Centre brought a child who had a cough and tight chest for further attention at the hospital.

A health provider (medical doctor) walks into the interpreters' room.

Encounter 3

Dr : Excuse me can someone come and help a mother here, she just says yes, yes to everything; we are not getting anywhere.

Interpreter follows the doctor to the consulting room and is briefed by the doctor on the way to the consulting room.

Dr : Ask her when did the child start having the problems (no eye contact with the guardian)?

Int : Mama when did the child start coughing and having a tight chest (looking at the guardian)?

G : It's a couple of weeks, it's on and off

Int : It's a couple of weeks now doctor

Dr : No man! , is it two, three or four weeks or did the two begin at the same time or not?

Int : Doctor wants to know exactly how many weeks and whether the problems started at the same time or not?

G : I'm not sure anymore, maybe the letter from the health centre might have that information, this is not my child:

Int : She cannot remember exactly and this is not her child

Dr : (visibly irritated) Was it last week, this week, ask her (with a tone)?

Int : The doctor wants to know whether it was last week or this week?

G : The guardian sits quietly does not respond (aparently shaken)

Dr : Okay, we shall see and asked the child to be undressed

What this encounter illustrates is that first of all the health provider does not see or view the interpreter as someone who is there to help her as much as to help the guardian. The impatience and irritation of the health provider with the interview is characteristic of some of the problems the interpreter had to put up with and try to play down, for example, some of the non-central factors such as the tone of the voice and gestures of the health provider, so as to keep the communication 'lines' open between the guardian and the health provider.

8.5 Ethical matters and interpreting:

The concepts of **confidentiality** and **informed consent** have become very topical lately within the health service sector and legal sector and society at large. A number of litigations published by the print media have been instituted by patients against their doctors for performing procedures they claim they did not consent to or did not fully understand the long-term effects of. Incidentally, most of these litigations were launched by patients who spoke the same language as the health provider. Therefore, it is reasonable for interpreters to have a clear understanding of what these terms mean so that they can explain to their non-English and non-Afrikaans speaking patients.

Confidentiality: generally all the responses were the same, in that all the interpreters understood confidentiality as a secret between the health provider and the patient and that no one else should know about it unless the patient gives permission for the secret to be disclosed to a third party.

Informed consent: This concept seemed to be more problematic to define or they had varied interpretation of it, but after probing their answers it became clear that they understood what this concept means: defining the concept was the problem. For example:

Q = question, Ax = answer

Q : What do you understand about the concept - informed consent?

A1: When a patient agrees to a procedure (s)he cannot hold the health provider responsible if things go wrong.

A2: It's full understanding of the reasons for accepting any procedure suggested by a health provider, for example performing an operation.

A3: It is agreeing to what health professional or a hospital says is going to be performed on you or your relative. Such as sterilisation, testing for HIV, child immunisation and so on.

On asking the interpreters whether it is necessary to obtain consent every time from the patient if (s)he visits the hospital for the same procedure (such as reconstructive surgery), the responses were as follows:

Interpreter	Responses of the interpreters
1	Yes, because no one has the right whether its a doctor or not to interfere with another person 's body whether he has good intentions he must first get permission all the time from the person concerned.
2	Yes, every time because things might have changed now either for better or worse after the first procedure or the patient might feel different now, for example (s)he might be more sick after the procedure and so on.
3	Yes, so that whatever happens the patient does not blame anyone if anything bad happens you know.
4	Yes, you see, maybe a new way might have been developed that performs the same procedure faster and cheaper than the previous one, but carries more risks.
5	Yes, it's the patient's body so every time they touch it especially if surgery is involved the patient's consent is necessary all the time.

8.6 Patient's Perceptions:

Table 3 displays the distribution of patients served by place of origin, language and the hospital that serves them:

Table 3

8.7) Origin (Province), hospital, language of patient distribution served by interpreters at hospitals (A) and (B) :

Origin (Province)	Language	Hospital(No)	Total(%)	Total
Western Cape	Xhosa	A(16) B(6)	22 %	22
Eastern Cape	Xhosa	A(31) B(44)	75 %	75
Free State	Sotho\Xhosa	A(2) B(0)	2 %	2
KwaZulu Natal	Zulu\Xhosa	A(1) B(0)	1 %	1
Total		A(50) B(50)	100 %	100

Key: A - is hospital A
B - is hospital B
(N) - is the number of patients who speak a particular language(s) seen in that particular hospital (i.e. Hospital A or B).

This table displays the diversity of the catchment areas of all the patient\guardian-clientele that the interpreters served. The clientele is not only diverse in terms of place of origin but also in terms of language. Although there were Zulu and Sotho first language speakers they were all competent in Xhosa and were duly interviewed in Xhosa. The highest education level reached by the informants was standard six in both hospitals (35%) and the lowest standard was subA (65%). These statistics show that a relatively high number of the patients served by the interpreters can be considered ill-equipped to hold a meaningful conversation in English or Afrikaans and therefore functionally illiterate with concomitant access problems other than language hence will always need someone to assist and interpret for them at these hospitals.

8.8 Patients' likes and dislikes about the interpreter service:

On asking the informants what it is that they like or dislike about the work of the interpreters, some responses were general about all the interpreters and others were specific about certain interpreters; some patients even called them by their first name which is something very uncommon in a hospital environment between health providers and patients. Responses to the question were as follows:

Patient	Response by the patient
1	"They are very caring and understanding, I like that too much."
2	"So and So (referring to an interpreter) should have been a nurse, she is very kind, patient and empathetic."
3	"They understand our problems and you can explain to them your difficulties; they advise you, it's really nice, you come out from the doctor feeling good that you have said everything that worries you."
4	"They tell you everything that the doctor says and also they guide you to the different places that you get referred to in this big hospital."
5	"They are very helpful to people like me who are from the rural areas who don't understand a thing here."
6	"They make you speak your mind, I can tell you that is nice, believe me."
7	"You know what, things used to be very impersonal and cold in this hospital. People would scream at you, nothing gets explained properly as if you are sick in your head, but now with these interpreters, they have a way of talking to you."

The only problem or dislike that permeated all responses was the unavailability of the service for twenty four hours a day and over weekends. One repondent had this to say:

> "Yes they are nice and know their work, but on weekends when one needs them they are nowhere to be found; I do not know whether they think people stop getting sick or get accidents over weekends, I don't understand how is this."

What comes out strongly, albeit implicitly expressed, is the socio-cultural and power relationship aspects involved in interpreting. For example, the general trend of the responses above is that these people (interpreters) are not only dealing with us as patients but also understand our backgrounds, our difficulties, our fears and not just the physical problems we present to the doctor. They (patients) feel empowered in that they can for the first time speak their language to someone who is prepared to listen: as the one said: "You can speak your mind to the doctor."

8.9 Patients' attitudes about the gender, age and cultural background of the interpreter:

In establishing what the informants' feelings or perceptions about who interprets for them in terms of their age, gender, religious and cultural background, the responses were generally the same, except for gender, at hospital (B). General responses were as follows:

Informant	General responses
1	"I don't mind the age or religion of the interpreter, they are all educated to help us speak our minds to the doctor."
2	"Ag, you do get health providers who are male, young and some not religious. We get help from them as well, so what is the difference with the interpreters? "
3	"Sometimes it is difficult to say everything to a male person especially when it comes to pregnancy problems."

It is of significance to point out that the third (3) respondent was more traditional in outlook and expression than the rest and, incidentally, was 'fresh' from the rural areas where relationships between male and female, young and old, rich and peasants are still governed by strict traditional rules or customary practices.

In trying to detect consistency and sincerity in the patients' responses about how they really perceive the work of the interpreters, the following questions were asked under different sections of the interview schedule, and it turned out that they were all consistent. The questions were- (1) Do you have faith in the interpreters? (2) How often do you use the services of the interpreters when you visit this hospital? The answers were as follows:

Questions	Answers from the informants
(1)	"Yes, I have a lot of faith in these interpreters because they are very helpful to people like me."
(1)	"Of course, because they are very useful not only to patients but to doctors as well."
(2)	"Every time I visit this hospital I request for their assistance, I trust them."
(2)	"When I come here I no longer have worries about how am I going to answer all the questions the doctor asks and I don't have to get a stranger to talk for me."

8.10 What patients used to do (or cope) before the arrival of the interpreters:

Continuing with this line of questioning, the researcher asked, now that they have so much faith in the interpreters, what did they do before the interpreters arrived and how did they feel about those previous encounters? The responses were as follows:

Respondent	Answers by respondents to the above question:
1	"Well, the doctors used to call the nurses who can speak some Xhosa, or sometimes the people who are cleaners here and I never felt good about this, but then what do you do when you are sick and need help."
2	"You see, nurses used to be asked to assist, but what was worse was when another patient was asked to interpret for you ; it was bad because you would hear other patient talking about something very similar to what you told the doctor in privacy; that is very bad I tell you."
3	"I used to try on my own, I respond to things that I hear and just not worry about what I don't understand. I used to go home feeling confused because I know most of the things the doctor said I did not follow."
4	"I used to nod and nod all the time without understanding a thing, you see I was afraid to ask for help."

Generally the informants felt that these approaches were inadequate and did not come near to matching the interpreters' manner of interrpreting. For example, one had this to say:

"although the nurses were translating information, they used to be very hurried and would rush back to their own work even when one is trying to ask or say something."

On asking how they perceive the caring or treatment at the hospital(s) since the introduction of the interpreter service, perceptions were very positive. But what captures all the responses succinctly is the following one:

> "Young man, I'll be very honest with you, I have been visiting this hospital I am sure you were also not born then. Doctors were all white and Coloured, nurses were all white and coloured and very few blacks those days. The problem was that when you or your child needed an operation you would not understand or know what was written on the papers: they ask you to write your name or put an X on. It was always said it was for your child's good but now with the help of the interpreters, you get to know exactly why you writing your name on these pieces of paper they give you, they even advise you to go and discuss things with your husband; things were never like this before, truly."

8.11 Health provider perceptions:

Out of 25 self-administered questionnaires issued to hospital A, 23 completed questionnaires were returned, and out of 25 questionnaires issued to hospital B, 16 completed questionnaires were returned. This resulted in the analysis of 39 completed questionnaires, giving a response rate of 78%.

Table 4.

8.12) Health provider reply distribution breakdown:

Category	%	Freq
Nurses	: 56 %	(22)
Doctors	: 33.3 %	(13)
Social workers	: 7.7 %	(3)
Hospital manager(s)	: 2.6 %	(1)
Total staff	: 100 %	39

Table 5.

8.13) **Demographic profile of professionals who responded:**

Gender	:	**Females**	**80%**
	:	**Males**	**20 %**
First language	:	**English**	**60.1 %**
		Afrikaans	**16.0 %**
		* **Other**	**1.9 %**

* [German; Portuguese; Chinese]

In table 6 below the health providers were asked to recall approximately how many patients they have attended to with the assistance of an interpreter in the previous month and their responses were added up from both hospitals.

Table 6.

8.14) **Approximate frequency distribution of patients needing interpreter assistance by professional category in one month:**

Category	Frequency	%
Nurses	**1231**	**(53.6)**
Doctors	**857**	**(37.3)**
Social workers	**110**	**(4.8)**
Manager(s)	**100**	**(4.3)**
Total	**2298**	**100%**

The possible reason for this vast variation in the use by health profesionals lies in the fact that a significant number of the patients who visit these hospitals are from the primary care Community Health Centres and therefore need to be screened by primary health care nurses before they get attention from a doctor and are presenting for referral with advanced medical conditions.

Table 7.

8.15) Communication technique(s) normally used by professionals before the arrival of the interpreters:

Technique	Frequency	%
By gestures or mime	18	13.6
Speak simple English	27	20.4
Translated leaflets	2	1.5
Use member of staff who speak Xhosa	35	26.5
Use patient's friend or relative	25	18.9
Use patient's child	5	3.9
Other *	20	15.2
Total	132	100 %

* : (untrained translators and other patients)

Table 8.

8.16) Satisfaction of health providers with interpreter service:

Level of satisfaction	Frequency	%
Very satisfied	29	74.0
Quite satisfied	9	23.3
Not satisfied at all	1	2.7
Total	39	100%

The reason(s) behind this dissatisfaction expressed by one health professional lies in fact that some of the professionals are not used to working with trained and qualified interpreters and moreover the problem of poor communication with non-English and non-Afrikaans speaking Xhosa patients has never been viewed as a problem by them. For example, one response that captured this attitude was that "we used to get the basic information that we need from patients by using simple English and gestures, there is no problem with this."

Table 9.

8.17) Effect of interpreter service on quality of patient care as perceived by health providers:

Level of effect	Frequency	%
Has improved quality of care significantly	35	89.7
Has no effect at all	4	10.3
Has worsened quality of care	0	0.0
Total	39	100

A high percentage of health providers who believe the intervention has improved their quality of patient care more than before the intervention claim that they spend quality time getting or obtaining information from their encounters with patients. Since the arrival of the interpreters the problem of nodding and saying yes all the time by patients is a thing of the past.

Table 10.

8.18) Effect of interpreter service on efficiency in patient care as perceived by health providers:

Level of effect	Freq	%
Has improved efficiency significantly	36	92.3
Has had no effect	3	7.7
Has hampered efficiency	0	0.0
Total	39	100

A high proportion of health providers noticed that they are spending less time consulting with one patient than before. For example, some doctors indicated that they used to spend between 10 to 15 minutes but now spend 8 to 10 minutes with one patient. Most of these health providers cited the problem(s) of having to walk up and down the corridors looking for someone who is able to speak Xhosa and willing to translate, and also not being quite sure whether the patient or guardian understands what they (health providers) are trying to explain to them (patient\guardians). Now they spend more time dealing with the health problem(s)

presented by the patient. Therefore, a 'hit and miss' situation has been significantly reduced, leading to both health provider and patient\guardian satisfaction.

Table 11.

8.19 Effect on communication between health providers and patients since the introduction of the service:

Improvement level	Frequency	%
Has noticed improvement	37	94.9
Has noticed no improvement	2	5.1
Has worsened the situation	0	0.0
Total	39	100

On asking how the interpreter service has changed the situation, 47.6% of the respondents claimed that they no longer have to use sign language and 47.3% claimed that they communicate far better with their patients\ guardian now that the interpreter service is in place. 8.3 % felt that they are doing a far better and fulfilling job now that the interpreters are constantly assisting.

8.20 **Strengths and weaknesses of the interpreters:**

8.21)

Strengths	Comments of health providers
1	27% said that the interpreters have good communication skills, are compassionate and have good cultural understanding of the patients.
2	97.4% claimed that the interpreters are good at giving comprehensive history of the patient's health related problems.
3	94.9% said that the interpreters have the ability to establish rapport with the patients, and are professional in handling the clinical encounter.
4	87.4% said they would like to keep working with the interpreters and only 2.6% were not quite certain or hesistant to work with the interpreters.

Weaknesses

1	64% claimed that the interpreters are not available after hours
2	30% said that the service is not available on weekends
3	6% were not satisfied with the interpreter knowledge of biomedical terms

8.22) **Observations by researcher:**

Observation of patients on arriving at the hospital(s):

The reception area in any hospital is a critical point where the lasting impressions or perceptions of the patient are formed about the hospitality or inhospitality of a hospital. In both institutions the majority of the receptionist or clerks are Afrikaans or English speakers. This caused immense communication problems for Xhosa speaking clients and visitors especially when it came to the calling of and pronouncing Xhosa names. The interpreters came to the rescue of many a patient whose name was badly pronounced or called. The following example captures some of these situations. An Afrikaans speaking receptionist calls out a Xhosa patient's name:

"Nom.....,Nommm,.....No.....qonnnn...diso Myesa"

No response. Patients continue talking to each other. This calling continued a couple of times without a response from patients. Ultimately an interpreter is called to help call the name.

"Nomqondiso Myeza" the interpreter calls out, and immediately someone responds.

This anacdote captures the non-official duties the interpreters have to undertake on a daily basis.

On top of this were the ongoing conflicts between patients and health providers over hospital procedures such as no smoking rules, use of sanitary material by patients, misunderstandings between staff and patient over appointment times, sometimes with racist undertones, tea, lunch time and other hospital etiquette or procedures that the interpreter s are called upon to resolve.

8.23) **Observing language use on notice or sign boards:**

In both hospitals the information on the notice board is mostly written in English and Afrikaans. A number of Xhosa speaking patients and guardians were observed wandering up and down the corridors carrying folders not knowing what to do or where to take them next. These patients would carry on like this until they ask other Xhosa speaking patients

who might know better, or the cleaners and, on a number of occassions, would stop the interpreter for directions and explanations.

8.24) Comparison with the NLP base-line study 1996:

The data acquired from the baseline study is written in italics. Although the baseline study did not cover all the variables used to measure perception in this paper, we will therefore compare that which is measured in both studies.

	1996	1997	Change
1) Time spent with one patient :	*10 - 15*	8 - 10	5(min)
2) Need the service of an interpreter:	*100*	97.4	2.6 (%)

3) 1996 All interpreting done by nurses or general staff

1997 All interpreting done by community health interpreters

4) In both studies 1996\97 all patients assisted have low literacy levels

5) In both studies 1996\97 all nurses interviewed felt that the interpreters are doing a vital task

6) Doctors in both studies believe that the interpreters are performing a good job but need to be trained more in biomedical concepts and social work skills. *Supposedly to be more technically equipped (my italics).*

9. Discussion:

The main findings of this paper are that the CHIs intervention scheme has improved the communication divide between the health provider and their clients, and has also improved the effectiveness, efficiency of patient management and has led to both patient and health provider satisfaction within the clinical encounter. It is in keeping with other evaluation studies done internationally for example in Canada O'Neil(1989), in Belgium Verrept and Louckx (1997)

However, the presence of CHIs is not free of difficulties. As a new category of health personnel within the hospital they face a number of challenges from other health personnel and the general hospital culture.

The following utterance by one interpreter sums this up:

> "You know what? It's a pity, as much as I get fulfilment in what I do, some doctors need to understand something - we are also humanbeings, we need breaks in between like everyone else you know. They can't just call us during our tea time, lunch time we need to get our strength back by resting a bit so that we can serve them and the patients well."

This account shows the insensitivity or lack of understandung of some of the health providers about the needs and what is expected from the CHIs. Sitting and chatting to one's colleagues during appropriate times cannot and must not be construed as idleness. This is all more the reason it is important that health providers should be trained in working with the interpreters and valuing them as valuable members of the health profession.

Health professionals should also be aware that cultural differences in beliefs about health and illness will affect the language used by patients to describe symptoms, states of health and illness. Body imagery, health and illness metaphors may be substantially different from those used by patients who are of English or Afrikaans speaking background. For example the guardian who said in one of the encounters "**utsho entla ngezantsi**" used an expression that is considered 'deep' Xhosa which literally translates as 'the patient does it from top and bottom'. Also there are many different beliefs about blood and the role of blood in maintaining health or causing illness. These could lead to such phrases as 'Nurse, this child's blood is very weak' or 'I don't like this child's blood at all'. Such expressions might sound strange or nonsensical to someone who has no knowledge of the Xhosa language and what is the role of blood in an individual's state of health within the Xhosa cultural set-up. These problems are what Mtuze(1993) refers to as difficult cultural issues or concepts. Varoni and Gas in Kaschula(1995) concur with Mtuze's assertion and further add that "The less the interlocutors know about each other on linguistic, social or cultural level the less likely are they to understand each other. Such misunderstandings are particularly

pronounced between native and non-native speakers of a language, they may have radically different customs, modes of communication and interacting, notions of appropriateness and of course linguistic systems." Another common behaviour of the Xhosa patient as identified by some health providers is that of saying yes, yes or nodding to everything irrespective of whether s\he understands something or not. This behaviour is what Ozzi Diaze-Daque(1982) calls the "nodding syndrome" of patients. What he means by this is that this is a patient who nods in agreement out of fear of embarrassment because he or she does not understand and because s\he is in a strange environment.

Furthermore, dimensions such as time and space are not addressed in the same way or to the same extent in different cultures. For example, time in the African cultural context tends to be understood in or depicted in terms of significant or major events in a person's or community's life (e.g. drought; rainy season; birth or dirth in one's family ; night and day) and not so much in calendar days or hours of the clock. These are differences that health providers need to realise and understand when they deal with their African patients.

The many and diverse ad hoc measures normally used by health providers to communicate with their Xhosa speaking patients such as gestures or mime, use of patient's friend(s), untrained translators has doubtful consequences. Faust and Drickey(1986); Diaz-Duque(1982); Marcos(1979) criticize these techniques as being full of errors ranging from inaccurate and misleading information of some of the patient's discourse. Therefore, using untrained translators is clearly unacceptable and potentially dangerous because a completely different unrepresentative medical history of a patient might be presented, leading to an inaccurate diagnosis and management that might result in deterioration of the condition or even poisoning of the patient, with the result of more visits to the hospital or even death.

There are no easy solutions to learning to cope, understand and avoid cross-cultural communication difficulties of this kind. Peoples' perception of appropriate behaviour in medical interactions and their beliefs about health are influenced by their socialisation

which always occurs within a specific cultural context. As such, people are unwilling or unable to change this learned behaviour. Learning to recognise and deal with these difficulties is through experience and regular contact with such issues. Nevertheless, it is important for health providers to be aware of the culturally specific meaning of many phrases or metaphors, since a failure to do so may lead to misdiagnosis, ineffective treatment and even a worsening of a patient's condition. From a public health point of view this will be counterproductive in that it will lead to increased costs in terms of having to treat the same condition all over again, or even worse, a worsened condition that might need prolonged therapy that stems from earlier misunderstanding. These costs in terms of time, finance, energy and infrastructure will not only be incurred by the health service alone but by the patient and his\her family will suffer a great deal.

Therefore, the presence of the CHIs within the health sector is perceived by the staff, interpreters and the patients as being long overdue, since their service is actively assisting in putting caring back into health care. Talking in non-technical language, empathising with and reassuring the person are just as important as drugs towards the recovery of the person. Katon and Kleinman(1981) argue that: "If a patient feels that their personal understanding of their condition is heard, respected, given weight in decisions regarding treatment and feel welcomed, then satisfaction with the encounter will occur and speedy recovery is most certain." What is implicit in this argument is that language is an important integral part of health care provision and not only drugs, surgery and other invasive technologies or therapies. These new therapies or technologies tend to obscure the powerful and complementary role of verbal communication in the clinical encounter, such as history taking and the establishment of a diagnosis. As a result, good and comprehensive quality care can be compromised by the inappropriate use of language or by inadequate verbal communication. This argument is closely related to the African understanding of health and ill-health, which views the two concepts as having 'social construction' and as such the environment in which one lives and interacts (communicate with others) which has a significant impact on one's well-being or absence thereof.

Although these factors of language and culture might seem to some health providers unimportant in terms of eliciting the right information from a patient, Sluzki(1975) has pointed out that it is important to be aware of the class-culture of the patient and the service provider (interpreter; health provider) because the patient might feel inhibited by the cultural '**alien**' (my emphasis) person whose religion, culture, social status will render him or her not suitable for the patient's belief system in terms of values and religious inclination. The patient may then fear to be judged by this 'alien', leading to withholding of vital information resulting in misdiagnosis and wrong treatment of the patient.

10. Conclusion:

This study has shown that Community Health Interpreters undoubtedly contribute positively to the patient\health provider relationship. The health interpreter can advise non-English speaking patients on a number of available and appropriate services within the hospital environment and make explicit the patient's fears and needs to the health provider. It has become clear that more often than not it has been the health provider who benefited most from the service, as some health providers claimed: "The service has made their job much easier and a lot of their time is saved from wandering in the corridors to get someone to interpret for them." However, the fullest benefit of community interpreting can only be realised if the existing power divide between the health provider and the patient that restricts and maintains the unequal relationship is overcome. This ideal situation can be striven towards by empowering the patient to take part in health care decision making. The interpreter must enable the patient to obtain relevant information from the health provider. This requires as a pre-requisite full co-operation from the health providers and hospital administrators. It is therefore important for health providers and managers to recognise the value and importance of the health interpreters as a vital link between the health service and the community, and not

merely a convenient individual to make their lives easier, when it comes to dealing with the non-English and non-Afrikaans speaking disempowered patient.

11. Limitations of the study:

1) Due to limited resources not enough time was spent with each client, probing further some of their responses was not possible.

2) The doctors' response rate was relatively low compared to other health providers. This could result in bias or a limited view or perception of what the health providers think about this intervention.

12. Recommendations:

This study has established the need for and importance of Community Health Interpreters within the public health sector. Therefore, I recommend that:

1) Public health Care institutions providing a service to a large non-English or non-Afrikaans speaking clientel should consider employing health interpreters.

2) The health interpreter service should be formalised, officialised and be a recognised profession within the Public Health Care sector.

3) Health providers should be trained in how to work and cooperate with interpreters.

4) Both the health providers and the patients should be made familiar with the role of the interpreter who is an important and sometimes crucial member of the health team.

5) There should be training in health care for interpreters who do not have any medical or nursing background. This training should include the general ethical obligations that are binding on people who work within the health care setting.

6) Health providers need to be educated in the whole area of communication and learn their patient's language (or a general communication course).

7) Health providers should learn something about popular beliefs, traditional healers, and socio-cultural barriers that interfere with the delivery of health care.

8) Interpreters or their trainers should develop a system of note taking during consultations, such as symbols, and non-language specific cues to aid their memories and ensure that interpretation is complete.

9) There should be an aggressive marketing campaign or popularisation of the community health interpreter scheme in the community at large via Community Health Committees;

10) A strong working relationship with health providers outside the hospital context should be developed so that patients such as TB patients for example are not lost between the primary , secondary and tertiary health service network.

11) Training in the skills of communicating with the deaf and dumb patient\guardian should be considered (sign language training).

Appendix A

Notes:

Care: In this paper means compassion and concern for the welfare of others (The chamber dictionery .New Edition)

Culture:

Is the customs, traditions arts, social institutions and particular forms of intellectual expression as in literature (written and oral). Advanced Oxford Dictionary-New addition) .

Language:

In this paper is viewed as a system of sounds, words patterns used by humans to communicate thoughts and feelings as well as systems of gestures used to convey information.

Community Health Interpreter:

Is someone who facilitates access to public health services for people whose first or preferred language is not the officially used, they are, then, liasing between a professional or service provider and user, whose access to such service is more often than not hampered by communication barriers that goes beyond language. This barrier is multi-faceted, it includes culture, class, race often gender and above status (Sanders:1990).

Translation:

Is to express something spoken or written in another language in simpler terms or words (Advanced Oxford Dictionery-New edition) .

Advocacy:

Generally refers to "the act of interceding or speaking on behalf of another person or group" (van Esterik:1985). Pain(1985) on the other hand describes advocacy as - explicit intervention of a mediator on behalf of others. By definition therefore, advocates are those who occupy a position in the socio-political structure of an institution or society that enables them to challenge authority.

Human rights:

Are those things that individuals are entitled to, by virtue of being human-beings. These rights are aimed at promoting respect among humanbeings and harmonising society (Moeketle:1996) .

Client:

In this paper a client is viewed as someone who seeks and uses the expectees of another person to solve their own problems. Therefore, health providers and patients are clients of the health interpreter.

Hospital A Is Red Cross Childrens Hospital
Hospital B Is Mowbray Maternity Hospital

Appendix B

The eleven officially recognised languages under the New South African Constitution compiled by Schuring and Prinsloo under the auspices of the Human Science Research Council in 1990:

Languge	Number of Speakers	Percentage of the population
Zulu	8 541 137	21.93%
Xhosa	6 891 359	17.69%
Afrikaans	6 188 981	15.89%
Tswana	3 601 609	9.24%
North Sotho	3 437 971	8.82%
English	3 432 042	8.82%
South Sotho	2 652 590	6.81%
Tsonga	1 349 022	3.46%
SiSwati	926 094	2.37%
Ndebele	799 247	2.05%
Venda	763 247	1.95%
Other	323 919	0.97%

Source: Human Science Research Report 1990

Appendix C

QUESTIONNAIRE (D) No.....

Title:

An evaluation of a community interpreter scheme for Xhosa speaking patients at the Mowbray Maternity and Red Cross Childrens' Hospital.

I am a Public Health Student from UWC. I am evaluating the effectiveness, appropriateness and efficiency of the community interpreter scheme within this hospital. I will be very greatful if you could fill in this questionnaire. Your views and experiences will help me find out the extent to which the scheme is addressing the problems of poor communication between health professionals and patients who speak little or no English. Your comments and views will be treated in the strictest confidence.

Thank you very much for your cooperation.

1. Demography:

a) Name: b) Profession: c) First language
b) Hospital:

2. Statistical information:

a) Approximately how many patients on average spoke Xhosa in your ward last month?
.....

b) Approximately how many of them needed an interpreter? .....

3. Communication technique:

a) How do you usually communicate with Xhosa speaking patients? Please tick below

i) by gesture or mime
ii) speak simple English
iii) use translated leaflets
iv) language cards
v) use member of staff who speak patient's language
vi) patient's friend or relative
vii) patient's child
viii) other, please specify.....
.....

b) How satisfy are you with the way the interpreters do their interpreting? Please tick below

I) very satisfied
ii) quite satisfied
iii) not satisfied at all

5. Quality,effectiveness and efficiency of treatment:

a) how does the presence of an interpreter affects the quality of care you are able to offer? please tick below:

i) Has no effect at all
ii) Has improved quality of care significantly
iii) Has worsen quality of care

b) how has the presence of the interpreter affected the effectivenessof patient care? please tick below:

i) Has improved effectivity significantly
ii) Has had no change in effectivity
iv) Has regressed effectivity of care

c) how has the presence of an interpreter affected the effeciency with which you deal with you patients? Please tick appropriately below:

I) Has improved efficiency significantly
ii) Has had no effect on effeciency
iii) Has hampered effeciency of care

d) have you noticed any improved or change since this scheme was introduced? YES\NO
If yes, please explain.....
.....
.....
.....
.....

6. Assesment of interpreters' weakneses and strengths:

a) what do you think or observed as the interpreters' weakneses?
.....
.....
.....

b) what do you think or observed as the interpreters' strengths?

.....
.....
.....

c) would you be happy to work with them again? YES\NO

Can you explain why?.....
.....
.....

d) are there any improvements you can suggest to improve their interpreting? YES\NO
If yes, please elaborate.....
.....
.....
.....

PATIENT: INTERVIEW SCHEDULE

I am a Public Health student from UWC, I am evaluating the perceptions of the patients on the effectiveness, appropriateness, efficiency and quality of the community health interpreter's shceme
within the public health hospitals. I will be very greatful if you can answer the following questions Your views, comments and experiences will help me and the management of this scheme to understand to what extent the schem addresses or not addressing the problem of poor communication between health professionals and the patients and also develop and improve the training programme. Your answers will be treated in strictest confidence.

Thank you for your cooperation.

Perceptions about the service:

. Do you know there is an interpreter service in this hospital?
. Since when did you know about this?
. How did you come to know about this?
. What do you like most about this service? and Why?
. What don't you like most about this service? and Why?
. How do you feel when you are visiting the hospital since the introduction of this service? and why?
. Would you mind telling me what do you think must be changed in this service? and Why?

. How do you feel when the interpreter is present in the consulting room? and Why?
. How do you feel about the service of the interpreters? and Why?
. How often do you use the or request the service? and Why?
. How do you feel when an interpreter of the opposite sex comes to interpret for you? and Why?
. How do you feel when an interpreter younger or older than you comes to interpret for you? Why
. How do you feel when an interpreter who is not religious interpretes for you? Why?

. Do you have faith in the interpreters? and Why?
. What did you do before if you had communication problems with health providers? Please explain.
. Did this help as much or did it help better than the interpreters' service? Please explain
. Was this different from this service ? and How was it different?
. Has the caring in this hospital changed since the introduction of this service? How?

. What particularly worries you about this service? and Why?
. How do you think it can be changed?
. Before the introduction of this service did you have to bring your child quite often(or did you

have to come back or go somewere else with same problem)? Why?
. Do you mind telling me what do you think was the cause of this?

Quality of the service:

. Do you know anyone who had a problem with this service [friends or relative(s)] and what sorts of problem(s) are these? (Acceptability)
. Is this service an answer to some of your problems when you come here? Please explain.
. Do you ever ask for any other health related information from the interpreters? and Why?
Do you mind telling me what do you do when you have a problem with this service? (Are there formal channels for complaining that you know of?).
. Do you know of any service operating somewhere like this one? If yes, how does it perform compared to this one?
. Do you or do you know of any patient who sits in the committee or management of the interpreters? If no, why don't you?
. Have you ever had a problem of getting an interpreter when you needed one in the last five months? If yes, can you remember why they could not come and assist you ?

Clients view on the management of the service:

. Do you know who employs the interpreters? YES\NO, If yes can you tell me.
. Do you think who employs them would make any difference to the way they assist you? If yes, how, if no can you explain why?
. Do you sit or do know of any patient who sits in the committee or management of the interpreters? If no, why don, you?
. Would you like to sit in the management of the interpreting service? YES\NO, If yes, why, if no why not?

INTERPRETER INTERVIEW SCHEDULE

I am a Public Health student from UWC, I am evaluating the Community Health Interpreter Scheme within this Hospital. I will be very greatful if you can the following questions for me. Your views and experiences will help me and the management of this scheme to find out to what extent the scheme is addressing the problem of poor communication between health personnel and their patients who are Xhosa speakers who speak little or no English at all and also to help the scheme's management in developing and improving the training programme of the interpreters. Your views will be treated with strict confidentiality.

Thank you very much for your cooperation.

Knowledge duties and responsibilittes:

1. Would you mind explaining or discribing to me what do your see you role or duty as an interpreter\health advocate is here?
2. Would you mind telling me what was the aim of your training as an interpreter ?
3. Do you mind telling me what is the difference between advocacy and translation
4. Have you ever worked as an interpreter before (volunteering or paid job) you get this job? If yes, where was this and what sort of interpreting was it?
5. Are any skills you have acquired in your training for this job? If yes, what sort of skills are these?
6. Do you think these skills are helpful in your work? If yes, please explain how? If no, why not?
7. Do you ever experience problems or difficulties in work at this hospital? If yes, what sorts of problems are these ?
8. Do you think you are making use of these skills your day to day work? If yes, can you explain it to me? If not why not?

Knowledge of rights at work:

1. Do you know what are your legal rights as an interpreter are in Hospital? If yes, can you tell me what are they?
2. Do you know what are the patients legal rights in Hospital? If yes, can you tell me what are they?
3. Do you ever inform patients about their rights? If no, why not?
4. Did you receive any information\advice on the possible pressures\problems you may encounter in your work? If yes, can you tell me what sorts of pressures are these?
5. Do you mind telling me why patients got send to you or you are invited to speak on their behalf in this hospital?

Skills Development:

Are you trained to interpret for deaf and dumb people? If no, what do you do if they need or seek your assistance?

Were you trained in how to deal with verbal abusive clients (health provider and patients)? If yes, how do you deal with them? If no, what do you do?

Would you as an advocate\interpreter feel comfortable correcting the health provider if you feel there is cultural insensitivity or racism or if the information asked or provided by the health provider too long and complex to interpret?

Do you ever ask for time to do things properly? (explaining things to patient or doctor)

Do you ever interrupt, when things are going wrong or you are being misunderstood? If yes, can you explain? If not, why not?

Do you ever tell the health provder other things not asked about the patient's situation? (eg. another illness at home, death, spouse left home, separation etc) If yes, please explain. If no, why not?

Do you think the health providers need to know about traditional or alternative therapies by patients in addition to the therapy given the doctor or nurse? If yes, please explain why. If not, Why not?

Counselling and cultural issues:

Would you mind explaining it to me what do you understand about the concept counselling?

Have you ever been asked to counsel a patient\care-giver before? If yes, what was this in connected with?

How often do you have to counsel patients\care-givers with such problems?

Do you ever explain to the health provider certain gestures, expressions that the patient\care-giver display during an interview? If yes, explain why? If not, why not?

Do you ever stop an interview if people are getting angry or the problem cannot be resolved? If yes, what do you do afterwards?

What do you do if a patient refuses to talk because of your gender or age? and why do you do that?

Do you ever get support either from your organisation or colleagues if you are facing difficulties? If yes, what kind of support? If not do you know why not?

Is there someone in authority you can turn to or approach immediately within the hospital if you are having problems? If yes, who is this?

Health information and health promotion:

Do you mind telling me what do you understand about Primary Health Care approach?

Would you mind telling me what do you understand about the Provincial Health Plan?

Do you mind telling me how much do patients want to know about disease processes?

Are you familiar enough witht the biomedical terminology? If no what it is that you still want to know?

Do you mind telling me why did you want to be a health interpreter?

Do you mind telling me how you heard about this health interpreter scheme?

.Ethical issues of interpreting:

.What do you understand about the concept of informed consent?
.What do you understand by term confidentiality?
.Whose duty do you think it is to break bad news to patients? and why?
.What do you think are the most common or serious problems that health providers and interpreters experience in working together?
.What do you consider as exceeding your role as an interpeter\advocate in this hospital?
.Do you ever have short briefings before an encounter? If yes, what sort of briefings are these?
.Do you ever take notes during an encounter ? If yes, can you explain? If no why not?
.Do you interpret everything said by the clients (Dr &Patient)? If yes, what sorts of things? If no, why not?
.Do you mind telling me what do you do with patients who cannot explain what is wrong with them or their charge?
.Have you ever been asked by a health provider to interprete only what is relavent information in an interview? What sort of information was this?
.Have you ever been asked by a health professional whether a behaviour displayed by a patient is 'normal'?

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