FACTORS AFFECTING THE SUCCESS OF MEDIATED MEDICAL INTERVIEWS IN SOUTH AFRICA

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ABSTRACT

The majority of health interactions in South Africa are mediated by a third party whose role is little understood. Studies on the role of the interpreter in health interactions suggest a number of factors which influence the success of the process. The effectiveness of communication between doctors and patients does not just depend on the training or experience of the interpreter but on a range of factors including the type of interaction, illness variables, and relationships between the participants, as well as the site of practice. The research reveals at least two distinct profiles of practice – one which facilitates the mediated process and one which inhibits communication. A number of guidelines are suggested for improving cross-language interactions.

INTRODUCTION

'Even at its scientific best, medicine is always a social act.'[1]

At the heart of effective diagnosis and treatment lies the medical interaction between physician and patient. More than 80% of these interactions in South Africa take place across linguistic and cultural barriers. Many of these interactions are mediated by the presence of a third party. The impact of this third party, together with linguistic barriers, poses the largest single obstacle to health care in most medical settings.[2] However, little is known about this process, or about how to identify and measure the important variables or minimise the barriers to effective health care.

This paper reports on a series of studies which have been conducted at various sites in South Africa on the mediated medical interview, and presents a summary of results, using illustrations from the data. Broadly, the goals of this research were to describe and analyse cross-language interactions between health professionals and patients, and to understand the role of the interpreter in this process, as well as the perceptions of the different participants (patients, health professionals and interpreters) regarding the role of the interpreter and the language dynamics of medical interviews.

METHODS AND PARTICIPANTS

Table I presents a summary of this body of research.

Research has taken place at a number of different sites involving a number of different languages (Zulu, Xhosa, Setswana), a number of diseases and different health professionals. The study aimed to capture the dynamics of communicative and interpersonal interactions. We used qualitative methods including ethnographic descriptions of the sites studied, video-recordings of interactions and interviews with the participants. Data analysis included transcription, translation and back-translation, and the prime method of analysis of the data was conversation analysis which allows for detailed consideration of verbal and non-verbal behaviours.[3-6] These methods have allowed a multi-dimensional perspective, combining direct evidence from the interactions with the perceptions of the participants around language issues.

RESULTS

Not surprisingly this research has demonstrated a wide variety of institutional language practices, great linguistic diversity within the settings, and differences in the preparedness of clinicians and the mediators.[7-9] There is often a mismatch between the languages of the health-care providers and the patients. While existing language legislation promotes the use of interpreters in all health-care sectors, common practice indicates that in most cases a trained interpreter is usually not available and at best, interpreting is performed in an *ad hoc* way using nurses, family members or fellow patients.[7,10,11] Figure 1 reflects the type of interpreter used at three sites, a tertiary hospital, a secondary hospital and a community health clinic (CHC).[12] No formal interpreters were used at any site. Nursing staff invariably interpreted at the CHC, but did not consider it their role at the tertiary and secondary hospitals, resulting in either no interpreting or the use of family, friends, cleaners or other health professionals.

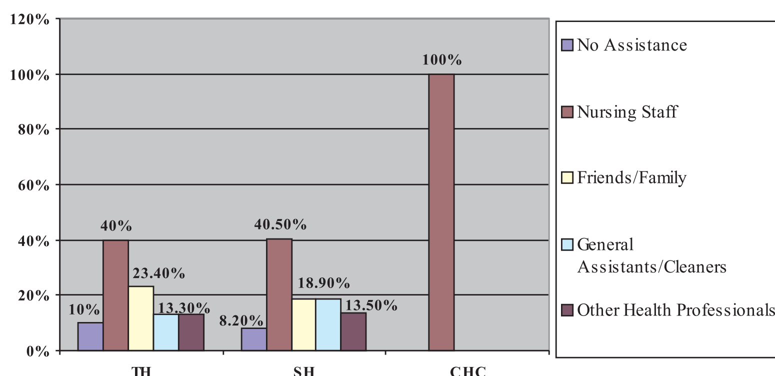

Fig. 1. Most frequently used ad hoc *mediators at three sites (tertiary hospital (TH), secondary hospital (SH) and community health clinic (CHC)).*

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Table I. Completed research on the use of interpreters in the health-care setting as part of the health communication project

Study	Date	Title	Participants	Number	Site	Illness	Methods	Language	Findings
Cilliers	2005	Talking about medical talk: Exploring experiences regarding communication in HIV/AIDS health care in a tertiary health care setting	Caregivers Counsellors Doctors	11 4 4	Tertiary outpatient HIV clinic within hospital, Cape Town	HIV	Descriptions of communication experiences. Thematic analysis. Interviews	Xhosa	Facilitative conversation style. Context factors
Evans	2000	The communicative, interpersonal and therapeutic dynamics of the audiologist-interpreter-caregiver triad in interpreted aural rehabilitation consultations	Audiologist Interpreter Caregivers	1 1 4	Community-based clinic, Cape Town	Hearing impairment	Qualitative MAT	Xhosa	Case history feedback and counselling
Evans	2001	Towards culturally appropriate speech-language and hearing services: Exploring the cultural narrative in initial consultations with Xhosa-speaking patients.	Clinicians Interpreter Caregivers	2 1 16	Community clinic, Cape Town	Hearing impairment	Interviews MAT Cultural narrative	Xhosa	Cultural narrative is more appropriate
Evans & Penn	2006	Development and valuation of communication skills training workshops for counsellors and health professionals working with patients with HIV/AIDS	Counsellors Patients		Tertiary outpatient HIV clinic within hospital, Cape Town	HIV	Pre-post intervention study Interviews	Xhosa	Communication skills training of counsellors is effective in improving patients' understanding
Fisch	2001	Interpreting practices in health care: An investigation of differences across trained and untrained interpreters in initial assessment interviews within the field of speech-language and hearing therapy	Clinicians Interpreters Caregivers	1 6 6	Community-based rehab sites, Cape Town	Speech-language	MAT CA - de Picciotto Interviews	Xhosa	Differences between trained and untrained interpreters

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Table 1 continued from previous page

Study	Date	Title	Participants	Number	Site	Illness	Methods	Language	Findings
Prince	2004	Interpreting and the clinician: A conversation analysis of the interpreted consultation in a paediatric hospital	Doctors Interpreter (trained) Caregivers	3 1 3	Red Cross Children's Hospital	Developmental clinic	CA interviews	Xhosa	Institutional interactions, need for training
Schwartz	2004	Communication in health within the South African context: Current practices employed across three levels of health care	Interpreters Health profs Caregivers	80 surveys 62 interviews	3 sites: Tertiary hospital Secondary hospital Community health clinic (Western Cape)		Interviews Surveys		Impact of site on language attitudes
Sithole	2004	Dynamics of using an interpreter in a multicultural context with an aphasic patient	Therapists Interpreter Patient	1 1 1	Wits Speech Therapy Clinic	Aphasia	CA	Zulu	Interpreter's cultural knowledge of client facilitated information exchange. Control of roles
Sishi	2001	Towards cultural speech, language and hearing therapy: A comparison of the use of the clinical cultural narrative and the traditional case history in an initial diagnostic interview	Caregivers Therapists Interpreter	8 2 1	Community clinic and hospital, Cape Town	Speech-language	Qualitative Interviews	Xhosa	Cultural narrative
Steenkamp	2004	In search of effective communication through interpreters: Facilitators and inhibitors to effective communication in mediated medical consultations within the South African paediatric HIV care context: A conversation analysis approach	Doctors Interpreters Caregivers	2 2 2	Red Cross Children's Hospital	HIV	CA	Xhosa	Facilitators and inhibitors
Watermeyer	ongoing	Pills of wisdom: Exploring pharmacist-patient interactions in an antiretroviral clinic	Pharmacists Patients Caregivers Interpreters	1 26 5 1	Rustenburg Provincial Hospital, North-West Province	HIV/AIDS	Interviews Recorded interactions CA	Tswana English Afrikaans	Communication strategies to aid understanding Use of props and demonstration

MAT – mistranslation analysis tool, CA – conversation analysis

At one site, a pharmacist said:

'No, most of the time I don't give up, if the patient and I can't understand each other, and the method of the tablet showing is not working, I tell them "byt vas" and I go and look for any possible somebody that can help me (laughs). Anybody, anybody in sight that's willing to help, even if it's another patient. I don't care…if it's another patient. I mean, the patient needs to understand me. So now I try my best to find anybody I can get hold of.'

Depending on the context, the mediator in such clinical interactions is often expected to assume multiple roles including those of linguist, cultural broker, research assistant, counsellor, patient advocate and institutional gatekeeper.[13-16]

Very often nurses are put into the role and this may be perceived as problematic by the nurses themselves as well as by the patients and the doctors.

MO: *Well, I think it will be a very big help if we get (interpreters), because at this moment we're using the nurses as interpreters and I mean, they're overworked as well, so if we call them from doing their work, then the whole system falls apart.*

In many interviews patients expressed dissatisfaction about the fact that nurses had not addressed them in their home language. Nurses expressed resentment about being used as a 'tool' for the doctors. Some of our findings seemed to confirm the observation that the nursing profession has negative attitudes which are often illness-specific and may inhibit or unduly influence patient participation and opinion.[17,18]

On the other hand at sites where language services are part of the job description and where nurses were made to feel part of the team, the interpreting function was conducted with willingness – a fact reflected in the following impression from a nurse at a community site:

'… when I'm with the medical officer and the patient, then the patient normally says, "Oh, I'm so glad, you know, because I'm so nervous, I can't speak this English and I can't understand this English, you know" and then she say, "Oh, I'm glad you're one of, one of me now like".'

When nurses are not available and other patients are used as interpreters, both patients and doctors have concerns about confidentiality.

At many of the sites trained counsellors have been introduced to assist the medical team with the functions of the clinic. These are trained by NGOs but results have shown that the role of such mediators is not well defined and is often less efficient than desired. They have less formal training than other health professionals, have no formal hierarchy in the workplace, their position is emotionally challenging and they often experience a feeling of isolation.[16,19] There is often a clash between the perceptions of counsellors and the health system for which they work.[12,16]

In general it has been found that the *ad hoc* interpreting procedures often result in omissions, substitutions, condensations and distortions of information resulting in reduced understanding and awareness of patient diagnosis, as well as increased patient dissatisfaction. In some contexts up to 40% of the utterances within a medical interview contain translation errors, many of which have negative implications in terms of accuracy and efficacy of medical service.[7,9,19-21] At sites where there were trained interpreters, the errors seemed to be fewer and have a smaller impact than the errors made by untrained interpreters, but errors of major clinical significance affecting diagnosis and treatment planning still exist. Such accuracy seemed to depend as much on other factors as on the level of training such mediators received. These factors are linked very strongly to a number of interactional and contextual aspects discussed below.

Type of interaction

Firstly, the purpose or genre of the medical interaction appears to make a vast difference. We found for example that there were fewer errors in interpretation during the history-taking procedure component of the medical interview than in the counselling session.[7,9] The history-taking procedure in itself is specific to the medical context, and lends itself to a questioning procedure often limited to short and specific routines, easier to control when three parties are present.[5,6,22] Counselling and recommendations are more likely to be more open-ended and involve the discussion of options, and therefore seem to increase the likelihood of making errors. Similarly, it would appear that the genre of gaining informed consent for a study trial (such as a treatment or vaccination trial) has many potential pitfalls including complex issues of randomisation and equipoise, and that translation issues interfere with the task, as the language of the protocol is often prescribed by international drug trials.[23,24]

Illness

Secondly, there are particular linguistic demands which are illness specific and which have the potential to affect the interactions. As Levin[25,26] has shown in relation to respiratory illness, some of the meanings of terms used by the doctors and patients do not correlate.

In the field of HIV we have a number of similar examples. For example, there seems to be regular confusion regarding the use of the terms 'positive' and 'negative' in our data.

'I wish counsellors, nurses, doctors and others… would explain clearly how the viral load is related to being positive… counsellors should be trained properly and patients should be taught the terminology and understand what they mean. She thought she had a disease called CD4 but did not relate it in any way to being HIV positive… we don't have words like that in Setswana.'

Similarly we have found some confusion regarding other common terms.

For example, when a patient was asked about the medicine she had received she said:

'You don't get medicine here. Only pills and that green syrup for the children?'

Many patients show very limited understanding of other aspects such as the concept of CD4 count. In a series of interviews with caregivers at antiretroviral (ARV) rollout sites[27] only 12 out of 45 participants at one site were able to explain what a CD4 count was. Patients show an imperfect understanding of treatment issues as well.

'I just give my child all these tablets without knowing the reason. I will probably end up giving him all the tablets we come across, because even the ones that I have, I don't know what they are for. I just want my child to get better. I don't want this HIV and TB because I don't know how he got it.'

Similarly the characteristics of the disease in context influence the process. These have been well documented and include the impact of stigma and difficulties around issues of disclosure.[28-30] Those individuals enrolled in large-scale vaccination and microbicide preventative trails have often shown a poor understanding of the components of the trial.[24]

Institutional variables

Finally, institutional variables play a very important role in the success or failure of the communication interaction. The data suggest a marked difference in communication effectiveness between some of the settings studied. Interestingly, patient and staff satisfaction seems linked neither to the resources available at the site, nor to security of tenure in the positions staff held, but apparently to the relationships between staff at that setting.[12] This suggests the vital influences of systemic and organisational aspects. At different sites nurses use a different profile of languages which accounts for different perceptions about roles and functions in health interactions.

At a community-based clinic, for example, a doctor describes the role of the nurse in interpreting:

> *I think they're perfectly happy to do it, personally. I mean they're trained nurses, but they don't take blood pressures or do anything. They sit with us and interpret. I mean, they actually switched roles now.*

The development of trust between the medical officer and the mediator appears to be related to factors such as training and field-specific knowledge of the mediator. In addition, the relationships that develop are important in that they may allow for trust to develop between medical officer and mediator and hence the relinquishment of power. The more frequently individuals work together, the more likely they are to form a good working relationship.

> ***MO:*** *You've got to generate trust and so what happens is that to get the most out of someone, they've actually got to spend some time around you to trust them.*

Whereas nursing staff at other sites felt used by doctors, at the community clinic in question the nurses felt part of the medical team, and saw interpreting as part of their job description and as a function highly valued by the doctors.

Profiles of the 'good' and 'bad' mediated interview

Combining the evidence from the interviews together with the perceptions of doctors, patients and interpreters has allowed the emergence of two typical profiles of interaction.[32] The one scenario allows for the development of a common goal, the relationship of trust, the tackling of issues of stigma and disclosure, the incorporation of cultural models of explanation and negotiation around management. In this pattern, the role of the third party is often one which combines the functions of interpreter as well as counsellor and cultural broker. The physician acknowledges and values that role and provides an opportunity for the relationship to develop. Such doctors showed sensitivity to the language needs, difficult life circumstances and health-care expectations of the patients. A facilitative conversational style emerges which helps balance the significant power difference between doctors and patients. This includes a willingness to repair breakdowns in the interaction, reference to language issues and facilitating non-verbal strategies such as gaze and gesture. An opportunity is provided to rectify possible breakdown.

The other profile, framed largely around the medical questioning framework of the institution, is often inhibited by institutional structure including space and time factors, and is not facilitative. Quite often the participants appear to have entirely different agendas and expectations. This profile is characterised by an essentially doctor-dominated communication with a focus on biomedical disease. During such interactions there is little opportunity for patients to express their concerns or to obtain sufficient explanations. Patients often misunderstand such doctors' messages but do not attempt to 'repair' the conversation - an attitude interpreted by the doctors as passive or submissive. Interpreters are perceived as being there to support the doctor rather than to assist the patient, and contradictory information is ignored.

The methods we have used have helped us distinguish these styles and their impact and have also helped us develop training materials for medical students and for health professionals at specific sites. Such materials draw on specific verbal and non-verbal facilitators such as seating, eye gaze, body posture and gesture and include text and video examples (using actors) of the data. Some examples of such facilitators appear in Appendix A together with a series of recommendations for improving the language of the mediated interaction.

Table II lists a summary of strategies which have been found to be useful in improving communication in the sites under study.

Table II. A summary of strategies which have been found to be useful in improving communication in the sites under study

Before the interview begins

- Assess setting
- Establish relationship of trust with mediator (including disclosure)
- Ensure appropriate training for mediator (not just fulfilling the role of interpreter but also as cultural broker)
- Be aware of impact of noise, interruptions, privacy, seating
- Have a discussion on language issues: establish participant's language history. Even if the participant speaks English as one of their languages, preferably the interview should be conducted in his/her home language with English version as back-up
- Have a discussion of roles and expectations with each participant

During the interview

- Present information in short manageable chunks with pauses for clarification.
- Highlight topic changes
- Be sensitive to non-verbal aspects
- Stop and ask if clarification is needed
- Bring important things to the front
- Create time for an opportunity for patient's story to emerge
- Provide flow talk which is social and not only linked to aims of interview

After the interview

- Debrief session between doctor and mediator
- Assess the comprehension by culturally relevant methods including narrative, open-ended questions
- Send home suitably adapted materials (including simplified or illustrated version).

THE WAY FORWARD

The results of the research project suggest that it may be possible to improve communication in health settings in South Africa through proper training and establishment of consistent teams, and that efforts should be made to enlist the expertise of language specialists

in research and at treatment sites to facilitate this training. Evidence of the impact of such training may be found in the results of an intervention study which examined the impact of counsellor training on the accuracy of comprehension in potential subjects for a treatment trial.[33] The training which incorporated the encouragement of home language and the use of pictures and visual support resulted in increased comprehension on the part of the participants and improved confidence on the part of the counsellors, exemplified by the following perceptions:

> ***C1:*** *'Firstly for me to explain it in Xhosa was much better. Secondly this took a more short time than in English. Thirdly I did even feel that I needed to refer to my own knowledge, what I know and what I am doing now, then I can make some more examples than before.'*

Pleasingly our research has also shown that South African health professionals often appear to be using a wider variety of strategies to ensure understanding of their patients than some of the monolingual same-language interactions recorded in developed countries. In an ongoing study which examined the interactions between 26 pharmacists and patients at an ARV clinic in North-West province,[27] it was found that both verbal and non-verbal strategies were used on a regular basis to enhance delivery of the message. The daily contact with diversity seems to prime all parties in the interaction towards flexibility. An example from a pharmacist is illustrative:

> *By repeating instructions, explaining that the virus will become resistant and this might be their last chance... We give info on side-effects, questioning patients, continuous training of health workers and counsellors. Implementing adherence tools, e.g. posters, diaries, video and we would like to use a checklist as an adherence tool (time permitting). If time permits, we motivate them by checking on the improved CD4 count.*

CONCLUSIONS

Communication challenges occur in every doctor-patient interaction, but these challenges are magnified in certain contexts. The first is when there is a diversity of language and cultures. The second occurs in the context of a disease such as AIDS with its specific vocabulary and its envelope of stigma. Yet the goal of effective communication is not remote. Positive evidence exists that a combination of systemic changes, as well as insight into the process, can significantly influence patterns of interaction and outcomes for the patients, the health team and the institution.

Emerging data suggest that when there are consistent teams in place and when the medical team, which includes the interpreter or counsellor, has site-specific and illness-specific communication training, there is increased efficiency of communication and increased satisfaction for all concerned, despite linguistic and cultural barriers. This does not depend simply on having a trained interpreter in place, but it does depend on the health triad having a common identified goal of good communication.

In conclusion, the mediated health interaction may be viewed very much like a dance between its participants. It improves with practice; it is dynamic, interactive and particular. Its efficiency depends on skills and on attitudes of co-operation and trust and also a willingness to be influenced by others with expertise in matters of linguistic and cultural concern and an understanding of the barriers present in the context imposed by culture, site and disease.

South Africa provides a profoundly rich and diverse context, which demands a merging of scientific and artistic sensibilities, as well as quantitative and qualitative methods. There are daily reminders that: 'the notion of disease... is not only a linguistic construct that presumes to index objectively a common human experience, but is also an expression or a moral universe bounded by culturally and historically specific norms, values and beliefs about that which is good, bad and beautiful in the world.'[34]

APPENDIX A

How to tailor language for each participant:

Written: Suggested readability index is Grade 6-8. Avoid embedded sentences. Check vocabulary and cultural meanings of critical items.

Spoken: Choice of spoken language, length of sentences, consistency of terminology, clarity checks, strengthened feedback loops. Use strategies such as repetition and rephrasing shorter length of utterance per turn, slower speech rate, use literal language analogies and examples, cross checks.

Support: Use videotape, larger type face, pictorial representation.

Non-verbal: Seating, gaze, body posture, head movements, gesture.

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Declaration of conflict of interest

The author declares no conflict of interest.

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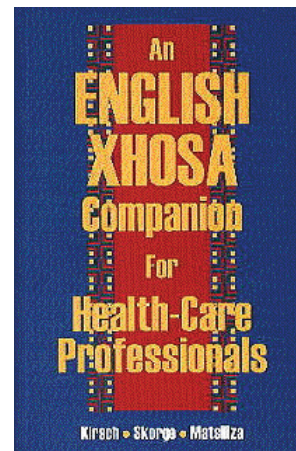
An English-Xhosa Companion for Health-Care Professionals

B Kirsch, S Skorge, N Matsiliza

ISBN: 0-7021-3452-X, 1996, 558 pp, soft cover, R130



'No other country in the world supports the licensing of professionals who cannot communicate in the language of the majority of the people they serve.' *(Dr M Ramphele, vice chancellor of the University of Cape Town, addressing a special assembly to adopt and affirm the university's new mission statement)*
This phrase book, compiled in consultation with several health-care professionals and language experts, is essential for health-care personnel unable to communicate with Xhosa-speaking patients. After covering introductory exchanges aimed at putting patients at ease, the book moves on to taking histories and physical examinations. It guides readers through explaining the nature of special investigations and procedures, and it covers basic health education. The English text is directly opposite its Xhosa equivalent throughout, and contrasting typefaces assist learners in identifying components of Xhosa words and sentences. To help the diagnostic and care process, questions elicit 'yes' or 'no' responses. This invaluable, pocket-sized handbook contains charts on Xhosa pronunciation, a comprehensive reference section and an English–Xhosa vocabulary.

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