



The unseen language communication breakdown impact in the two KwaZulu–Natal based hospitals

Thabani Robert Khumalo and Rosethal Lolie Makhubu
Durban University of Technology
41-43 M.L. Sultan Road, Durban 4000
South Africa

Abstract: This paper aims to examine the interpreting services provided during consultations in the medical settings. It looks broadly at the communication deficiencies created by the difference in the languages spoken by both medical practitioners and the patients during consultations. For several times the researcher's personal experience has shown that isiZulu speaking patients are frequently consulted by English speaking doctors whenever they visit medical institutions. Consequently, as a result of this situation, these isiZulu speaking patients with limited English proficiency find it difficult to fully express all their medical conditions to the English speaking doctors vice versa due to the existing language barriers. These language barriers are most likely to give rise to inferior medical assistance to isiZulu speaking patients. Furthermore, the nurses find themselves being ad hoc interpreters in this regard based on the assumption that they are bilingual. However, their linguistic and interpreting ability are not considered. The study therefore investigates the possible shortcomings and also looks at the implications most likely to occur as a result of reluctance in the provision of professional medical interpreting services also by professional personnel. The data is collected from medical practitioners (doctors and nurses) and patients. From the results obtained, the researchers therefore draw possible recommendations in order to address the identified shortcomings.

Keywords: Language difference, inaccurate diagnosis, treatment non-compliance, medical interpreting

I. Introduction

Interpreting in the medical settings in South Africa still remains the outermost informal activity occurring during consultations. According to Lesch (2007:79) the main sources of interpreting services is still provided by nurses, nursing assistants, auxiliary staff and community volunteers if not family members of the patients. According to Angelelli (2007:63) interpreting in the medical field involves a unique type contextually bound communication in two languages, which normally takes place under pressure. Nevertheless, it has been over two decades now ever since it was announced that indigenous languages are now recognized as official languages and acquire equal access and recognition in the new Republic of South Africa (RSA). However, it is very unfortunate that the interpreting profession still suffers an extreme lack of recognition even in critical and life threatening institutions like hospitals and clinics.

Could this suggest that we as a nation are just turning a blind eye in such critical matters or illiterate about the significance of such services being made available at a professional level? Furthermore, most health care workers can only speak one language fluently as compared to other languages. It is therefore obvious how this can lead to major problems when it comes to providing adequate health care (Schemmer and Mash 2006:1084). Where there are no proper interpreting services to facilitate communication between a health care provider and a patient, it will lead to a degree of miscommunication and disempowerment. The service rendered will only be a disadvantage for the patient because the patient's access to information and help is blocked effectively (Pienaar 2006:44) and (Saulse 2010:4).

II. The linguistic situation

According to the 2011 census it is estimated that 22.7 % of the South African population speak isiZulu while only 9.6% of the population speak English as their home language (South Africa. Info: 2012). In KwaZulu – Natal, isiZulu is the home language of 77.8% of the population and English as a home language is sitting at 13.2 %. However in 2008 a report that was published which showed that in 2007 only 35.1% of the doctors in public healthcare were African (Department of Labour 2008:28). Likewise, the aforesaid percentage of African doctors does not specify as to how many of these doctors are isiZulu speaking doctors. As a result, it is rather safe to assume that not all of them are isiZulu language speakers or neither fluent isiZulu speakers as per the language communication is concerned regarding effective language communication during medical consultations.

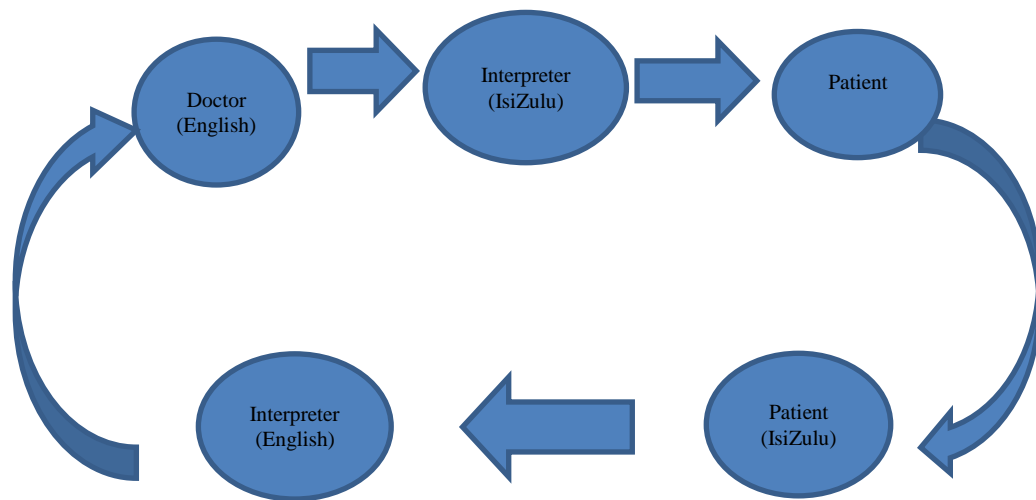
The reality of the public health system in KwaZulu - Natal therefore is that in the region of 70% of doctors and specialists are unable to speak isiZulu while well over 70% of the population of the province are isiZulu mother tongue users. Furthermore, "among the any acts and regulations emanating from the Department of Health since 1994 are a number designed specifically to correct the imbalance between rural/ urban/ private provision" (Department of Labour 2008:47). Therefore with that being stated as one of the aims of the healthcare service's

aim, surely means for effective communication should also form part of these aforementioned aims. Especially in the case of the rural settlements, efficient interpreting services are in great demand. This is because there is also a high percentage of illiteracy as well, which is another contributing factor to poor language communication in the medical sector. There are places where people cannot even utter one meaningful sentence in English. Therefore these people depend highly on the interpreters for better healthcare delivery. As further discussed above that there is a very limited number of doctors who are isiZulu speakers, this means that both parties require these services to be readily available at all times during medical consultations.

III. Medical interpreting situation

In a presentation by Bancroft on 20 January 2013, medical interpreting is defined as interpreting in settings where healthcare services are provided. She further distinguishes it from community interpreting by defining community interpreting as that form of interpreting that supports access to public or community services. On the other hand, Saulse (2010: 13) argues that there is a difference between medical interpreting and healthcare interpreting as defined by Bancroft. She defines medical interpreting as a type of interpreting that includes the setting in which health care interpreting usually takes place, as well as any other setting related to the medical profession. These settings may include events such as conferences held by the United Nations and other events which include discussions on medical matters. She further states that “medical interpreting is thus the overall term encompassing any interpreting that takes place in a medical setting, which may or may not include a patient”. She then states that health care interpreting, on the other hand, usually takes place with a patient present. However, this seems to be a matter of how each of these authors chooses to define and distinguish medical and healthcare interpreting according to their understanding of the matter. In the end though, the results of it all involve better or worse service delivery to patients. Thus, whether patients were involved or not, they are directly or indirectly linked to the impact of either of the presence or absence of either of the two types of interpreting. These forms of interpreting therefore do not seem to be distinct from one another.

Likewise, as defined in Bancroft’s presentation on 20 January 2013, community interpreting is a form of interpreting that supports access to public or community services. According to Corsellis (2008:4) “public service refers mainly to those services that are provided for the public either by the local or central government”. These include legal, health, and a range of other social services such as housing, education, welfare and environmental health. Saulse (2010:14) states that the purpose of community interpreting is to provide access to any public service to a person who does not speak the majority language spoken in that service. She further illustrates a mechanism which this form of interpreting results in. She says both of these types of interpreting (medical and community interpreting) are bi-directional, meaning that interpreting takes place between two languages where each language functions as both the source language (SL) and target language (TL). For example:



Interpreting in the medical setting has increasingly become a focus of attention as a significant area of speciality practice (Pöchhacker and Kadric 1999:161). Often times in South Africa, interpreting services are not provided at a professional level in medical institutions. If one happens to be fortunate enough to be provided with such services, they are either provided by the nurses or general working staff members such as hospital cleaners or even by family members of the patients. However, none of these people are professionally trained medical interpreters. This is also supported by Pöchhacker and Kadric (1999:161), Drennan (1996:343) and Lesch (2007:75) when they state that the main sources for interpreting services are still nurses, nursing assistants, auxiliary staff and community volunteers if not family members. Therefore this makes the entire interpreting session very informal. The nursing staffs who interpret also complain that their role is not recognised, it keeps them away from their work and they are not paid for it. This practice is merely based on the assumption that they since they can speak both the languages of the doctors and patients and they can interpret.

The aforementioned complaints of the nurses show that health care interpreters require more than just a linguistic knowledge; they also need to have knowledge of the medical terms and most importantly, they need to have empathy and sensitivity for the doctor – patient relationship. Similar to any other professions, ‘healthcare interpreting is a distinctive and specialized area of practice. Interpreters working in healthcare facilitate communication between providers and patients or families who do not share a language’ (NCIHC 2005:2). This shows clearly that there is indeed a demand for suitably qualified interpreters to execute these prescribed specialized duties. This would make a positive impact towards a more improved healthcare service delivery, as qualified interpreters have the ability to understand patient’s socio-cultural perspectives of health problems (Pöchhacker and Schlesinger 2007: 12).

Saulse (2010:7) argues that besides the fact that ad hoc interpreters do not have the theoretical knowledge of interpreting; health care interpreters should also possess certain qualities. In the case of liaison interpreters, interpreters should have a good knowledge and grasp of the target language (they interpret into) as well as the source language (the language they interpret from). They should also have sufficient knowledge on the subjects that they interpret. Lastly, interpreters should know how to interpret. These basic traits set the norm for all interpreters: anything above the norm suggests an interpreter who is qualified; anything below the norm suggests the opposite, an interpreter who is unqualified.

According to Levin (2006:1076) where language barriers exist, there is patient dissatisfaction. These barriers have been identified in various countries including South Africa as the core sources of unsuccessful therapy. Language difficulties result in reduced patient understanding of diagnoses, medication and follow –up as well as non –adherence to medical advice. This appears to be a direct contravention of a very favourable constitution, especially in a country like South Africa where eleven official languages are equally recognised by the constitution and by right should “enjoy parity of esteem and must be treated equitably” (Republic of South Africa 1996:4). Erasmus (1999: 145) further states that in the case of a medical setting, it is very important to know that the communication problem experienced by the two parties is not simply a matter of language, but of power as well. The difference in power is directly related to class, race, culture and/or gender as well as to knowledge differences between the medical professional and his lay patient. Furthermore, community or medical interpreters are accountable to the community rather than the institution at which they work. This is because they do not only convey the message between both parties involved but also represent the interest of public service clients, assess their needs and help them obtain the care to which they are entitled (<http://www.bls.gov/oco/ocos175.htm>).

IV. Bilingual personnel versus qualified interpreters in the medical setting

Quite often people assume that if an individual can speak more than two languages that person can therefore interpret. As a result of this assumption, in most hospitals, nurses, general personnel, family members and cleaners are used as interpreters for doctors and patients (Lesch 2007:75 and Pöchhacker and Kadric 1999:161). This is astonishing, as one cannot help but wonder if the information rendered is anywhere close to being accurate. “Interpreting is a profession where - like medicine, teaching and law - the client’s welfare is affected directly because interpreting has its own particular kinds of knowledge, skills and practices which require particular ethical considerations” (Gentile et.al 1996:57).

However, according to Edlow (1996: 456) having interpreting services provided by healthcare providers including the family members and general working staff members is an advantage because it reduces the need for interpreters and the patient can form a better relationship with the doctor. Furthermore, in a study which was conducted in one of the hospitals in the Western Cape by Drennan (1996), results suggest that individual units would not be able to support full-time interpreters. Hence, it appears that the majority of patients with limited English proficiency are being assisted through the use of family members, cleaners and other inappropriate or untrained people (Drennan 1996:344).

Now the greatest concern is that, how can a doctor and a patient relationship be formulated and nourished if there is not sufficient communication or similar level of understanding due to the language barrier and socio economic status? Besides that, the high expectations of interpreting arise in part of the complexity of determining meaning in situations where there are multiple levels at which the meaning can be constructed. Furthermore, omissions or inaccuracy could be of great detrimental factors in the medical setting (Drennan and Swartz 1996:170). Hale (2007:35) argues that untrained interpreters may not understand all procedures and various forms of questioning or different modes of delivery in various settings. Likewise, professionals working with interpreters rarely understand the complexity of the task and the interpreters’ needs in producing an accurate rendition. She further states that professional interpreters have a responsibility to acquire the necessary language and interpreting skills to gain an understanding of the settings in which they work in and the specific requirements, of the purposes for which language is used in each and every setting and to abide by a code of ethics.

In a study conducted by Athorp and Downing in 1996, where a professional interpreter and a nurse were used to interpret in different consultation rooms it clearly appeared that the interview with the professional interpreter compared favourably to the other event, with the interpreter's utterances on the whole being accurate to the doctor's-patient's turns.

They also discovered that the nurse often assumed a caregiver role and reduced the number of direct interactions between the doctor and the patient. This is in line with the role of a nurse as an information provider and care giver. The study was concluded by them stating that there is great benefit for the medical profession in using the services of professional, trained interpreters, as opposed to untrained bilinguals (Hale 2007:58).

Another example to substantiate this argument would be again of Dimitrova where he also conducted a study on the analysis of the work of a professionally trained medical interpreter and discovered that every turn was interpreted accurately and the interpreter always used the first person (Hale 2000:56). That study also found that untrained, ad hoc interpreters always interpret what comes naturally at the time simply because they want to offer a summary of what they feel is relevant. This again compromises the accuracy of the target message which is the most significant component in the patient and doctor communication process (Scott 2009: 1). That is why Lesch (2007:76) suggests that healthcare interpreters must undergo a more specific medical interpreting training which might be of assistance to them with the relevant terminology and this will enhance the communication flow. According to Candlin and Candlin (2003:137) the severe lack of qualified medical interpreters is almost endemic in healthcare worldwide in such a way that pragmatic, ethical, clinical and ideological issues inevitably arise. This has also been proven to be the case here in South Africa. Often times when one visits the medical institutions, such services are either provided by people who are considered bilingual or not provided at all. Both the medical practitioners and patients have to struggle for better communication.

V. Study methods or research approach

The data for the study was collected from two hospitals i.e. King Edward VII and R.K. Khan Hospitals. Both the medical institutions are situated in the eThekweni metropolitan region in the province of KwaZulu - Natal.

The following methods were used to collect data:

- Questionnaires were furnished to twelve (12) Doctors who are not isiZulu speakers consisting of six (6) participants from each hospital.
- Another set of questionnaires were given to twelve (12) nurses who were confirmed by both the doctors and patient to have been the ad hoc medical interpreters during consultations. Again the number was divided into two in per a hospital.
- Interviews were conducted with twenty (20) isiZulu speaking patients; a similar division of the number of participants also took place in per a participating hospital.

VI. Discussion

Based on the data collected from all three groups of the participants in the study, the study has discovered that there are indeed some language barriers existing in the medical sector as a result of the difference in languages spoken by both medical practitioners and patients (isiZulu and English). It is also evidently clear that all the three parties (patients, nurses and doctors) involved in the consultation process are not satisfied with the language communication. This is because it was firstly stated by the doctors that indeed they found the communication process with limited English speaking patients very difficult. Also in the events where nurses were used as ad hoc interpreters for both parties as they are considered to be bilingual, but still some nurses had some interpreting difficulties due to their linguistic inability to speak English fluently as well, and as result the message suffered from a lot of omissions and inaccuracies.

According to Karliner *et al.* (2008:1559) the use of bilingual individuals to act as interpreters in the medical setting negatively affects health quality services. Nolan (2005:6) also argues that the aforesaid interpreters may not always be bilingual, as being bilingual requires an early exposure to both languages, which appears not to be the case for the nurses whom are regarded as bilinguals and expected to interpret. This has also been supported by Ngo- Metzger *et al.* (2007:324) where they state that even with the use of ad hoc interpreting services, the quality of health services given to the patient and the degree of health education received is found to be below the expected standard. Also some of the doctor participants stated that "nurses understand occasionally limited leading to inaccuracies and omissions" which is also a confirmation that the nurses are not truly bilingual.

Furthermore, patients seem to give lengthy information to the nurse in the presence of the consulting doctor, but a nurse will only convey a very short summary of what was being said by the patients, which obviously shows that there has been a severe omissions taking place in the dialogue. Having mentioned the reasons above, it would therefore seem unfair to hold the nurses accountable for any inaccuracies or omissions in the message during their course of interpreting. This is because in some of the responses given, it was discovered that interpreting is a profession on its own, therefore nurses cannot be expected to perform such duties exceptionally because they do not have all the relevant and required skills to do so. It is therefore evidently clear that with all the language communication barriers experienced, the diagnosis and treatment prescription end up being

inaccurate and causing inferior medical assistance. Again the responses given by the doctors and patient participants in this study confirmed another part of the hypothesis which stated that “isiZulu speaking patients frequently encounter non-isiZulu speaking doctors in consultations”. This is because almost one hundred percent of the responses given confirmed this to have been the case which still exists. Although there were also doctor participants who stated that they understood isiZulu, but it was discovered that their level of understanding was below average. This is because it also appeared that they only understood the minor basics of isiZulu, which are not very much of great assistance during medical consultations with patients for effective diagnostic process. Furthermore, according to some of the responses given by the patients whereby they stated that the doctors use *isifanakalo* which again is found to be more confusing to some of the patients is also an indication of inferior medical services given to limited English proficient patients. This was also confirmed by the responses given by the majority of the patients, whom it was also ascertained that their level of the English command was quite poor due to various reasons. One of the most prominent reasons given for poor English command was that of illiteracy as some of the patients were never afforded an opportunity to attend school. As for those who were given such opportunities, it was however also not adequate acquire sufficient linguistic knowledge which would have enable them to speak English fluently.

It was further noticeable that none of the participants from all three categories of the targeted populations has ever witness a worse case as a result of language communication breakdown. Unlike in some of the cases in the globe and in some parts of the country where this has been witnessed more than once and where some of the bad experiences resulted in a lifetime changes especially for the patients. Such cases include, errors in surgical procedures e.g. amputations of the wrong body parts or names being mispronounced and resulting to patients being not attended at all. Therefore, these are some of the actual and potential consequences which could also be suffered in the hospitals in the province, if not already by other patients who utilize these public health facilities but never participated in the study as a result of language communication breakdowns.

Another area of concern was that of the nurses being demanded to interpret for doctors and patients. The results obtained show that indeed they are not happy about being forced to render these services due to the fact that it keeps them away from their original nursing scope of practice, especially in instances where they are giving treatment to the admitted patients. It is said that, they have to leave everything and attend to the doctor and the patient involved in order to render the interpreting services this is also confirmed by Schlemmer and Mash (2006:185) and Lesch (2007:75). It was also discovered that interpreting does not form part of the nurses’ scope of practices. The nurses emphasised the fact that their main scope of practice was strictly for patient care rather than interpreting, which was found to be a challenge to the majority of the nurses due to the specialised medical jargon in use. As a result, some patients expressed dissatisfaction of the medical services given to them as some of them noticed that their explanations were summarized when conveyed to the English speaking doctors.

According to the National Patients’ Right Charter, “every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision – making on matters affecting one’s own health” it also states that “everyone has a right to be given full and accurate information about the nature of one’s illnesses, diagnostic procedures, the proposed treatment and risks associated therewith and the costs involved” (HPCSA: 1 and 3). These are indeed the most favourable and significant rights for both parties involved in the therapeutic process. However, the unfortunate reality is the fact that these seem to exist on paper only, as the actual situation encountered in the public health facilities in the daily basis proves to be the opposite of what is written on the charter. This is because from the responses given by the participants, it is clear that such significant information is not fully communicated to them. Also it shows that the patients are not afforded efficient information and being given an opportunity to make their own decisions based on what they have been told or diagnosed with by the doctors. Not to mention the fact that accurate diagnosis is achieved after sever language communication difficulties. These difficulties are also compromising the accuracy of diagnosis as it was said that the nurses omit so much information which is considered critical in this stage. According to the Health Care Interpreting in the News (2011:1) patients may even present symptoms unrelated to the real problems and the diagnostic doctor relies heavily on skilful questioning. However, with all the aforesaid challenges in the diagnostic process it seems almost impossible to achieve accurate diagnosis. It was further noted that this was not the case for all the patients, as some of the responses given indicated that some of the doctors do go an extra mile in explaining the situation to the patients some with the help from the nurses and some without. However, again the responses given by the majority of the patients indicated that critical decisions e.g. surgical procedures are made on their behalf, rather than allowing the patients themselves to decide on the issues affecting their health or allowing for a second opinion as enshrined in the charter. This again is an impact of the language communication breakdown caused by the difference in languages spoken by doctors, nurses and patients in the hospitals. Also the lack of professional medical interpreting services is the main cause of this unpleasant situation. If ever such services were provided by suitably qualified personnel, some of the errors would be prevented from occurring. Also patients would have more detailed information regarding their illnesses.

Nevertheless, the medical staff participants also felt that indeed language difference has an impact on the treatment compliance. Although their personal ratings on treatment compliance were above average and creating exceptionally well acceptable situation, but there was still an existing gap as patients still do not fully comply with the prescribed treatment. Some of the doctors stated that proper understanding of treatment and its importance needs to be explained in a manner that is easily understood by the patient. This is because the lack of the treatment understanding could also result in high risk difficulties such as defaulting the treatment or consuming an over dosage of the prescribed treatment. Therefore, the only possible way to ensure that such risks are prevented is by other no means except effective language communication achieved by speaking the mother tongue language of the patient. This allows both speakers to have a mutual understanding of the situation at hand and enables the patient to ask all the necessary follow up questions for better understanding and a caregiver is also able to provide all the necessary medical information.

VII. Conclusions

In conclusion, the findings of the study all boiled down to the fact that there was a massive lack on the provision of professional interpreting services which as a result led to the patients not being able to describe their medical conditions to the English speaking doctors. The results obtained from the study also proved language barriers to have a severe bad impact on treatment compliance and other significant therapeutic processes. Also as a result of the lack of these services the doctors were limited to make proper diagnosis, further advice significant information to the patients due to the language barrier experienced.

VIII. Recommendations

Based on the study findings the following initiatives are recommended:

- Implementation of proper language units in the hospitals and other public entities should come into effect. These language units will cater for both translation and interpreting services to the public. This way the public will have full access to information and this significant information will be accessed through the use of a language of choice (mother tongue) without any linguistic limitations.
- Appointment of professionally trained interpreters to render medical interpreting services in the medical institutions. Having these personnel will improve the healthcare system by ensuring quality healthcare, especially with regards to accurate diagnosis which is the fundamental stage of the therapeutic process. Furthermore, having professionally trained interpreters will allow the nurses to practice their scope of practice more efficiently without any disturbances caused to them as it is the case.
- Training of medical staff members is also required in order to clarify the roles of the medical interpreters particularly where there are one on one consultation between the doctors and patients taking place.
- As a short term solution, a medical bilingual dictionary should be made available in order to assist the nursing staff members with interpreting of the terms, especially the ones they regard as difficult and do not have direct equivalence in either of the two languages in question.
- South African indigenous languages must not only be recognized on paper (constitution), but the equal use of these languages must come into effect as enshrined in the South African constitution.

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