Communicative Problems of Interpreting during Crosslinguistic Interactions between Non-Sesotho-speaking Doctors and Monolingual-Basotho Patients in Lesotho Hospitals: A Linguistic Approach

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Abstract

This paper investigates the linguistic and communicative problems between doctors and patients who do not share a common language in Lesotho hospitals. The study was conducted in out-patient departments of two hospitals, one at the St. Joseph's Hospital in Roma and the other at the Quthing Hospital. The study found out that doctors and patients who did not share a common language relied exclusively on the linguistic services of an ad hoc interpreter. The study also found out that ad hoc interpreters, including family members, friends and other healthcare staff members such as nurses committed serious linguistic errors which potentially impacted not only on the cross-linguistic doctor-patient communication but also on diagnosis and the negotiation of medical outcomes. These problems were detected in the discourse verbally translated from the primary participants' source language into the target language, which emerged from the interpreted renditions

Key words: cross-linguistic medical interactions, ad hoc Medical Interpreting, Discourse/Conversation analysis, Communicative problems, Negotiation of medical outcomes, Source language, Target language, Renditions.

1. Introduction and Background

Good doctor-patient communication is a central aspect of the successful healthcare process (Ainsworth-Vaughn (1998 and Roter and Hall, 1992). That is, verbal communication is the primary means through which doctors are able to comprehend and assess their patients' chief illness symptoms. Communication also enables doctors to gather crucial and relevant information regarding patients' socio-cultural beliefs about their illness. It also enables doctors to provide advice on what patients should do regarding the need to adhere to the prescribed medications as well as on how to change their lifestyles. Additionally, doctor-patient communication has been found to be therapeutic. Accordingly, communication between doctors and patients is essential and requisite. In cross-linguistic medical consultations, in which doctors and patients do not share a common language, the role of the medical interpreter is indispensable. Various studies have shown that the facilitating role of the medical interpreter is crucial for creating some shared understanding of the illness and treatment plans between doctors and patients (Hsieh, 2006; Davidson, 2000; and Downing and Swabey, 1992).

A study by Flores *et al.* (2003) has documented a number of linguistic errors made by *ad hoc* interpreters. According to these authors, such errors ranged from *distortion of meaning, omission, substitution, editorialization,* to *addition* of information. Their study also found out that *ad hoc* interpreters frequently distorted the original meaning(s) of the primary interlocutors' utterances by using an incorrect word or phrase. Additionally, the results of their study show that *ad hoc* interpreters' linguistic errors were most likely to impact negatively on medical outcomes. These include misinformation regarding diagnosis, medical prescriptions, as well as follow-up visits.

According to Flores *et al.* (2003), a linguistic error of omission, on the one hand, occurs when the medical interpreter leaves out an important piece of information that is crucial to the goals of the medical

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interaction. On the other hand, additions occur when the interpreter adds a word or phrase or even his or her own opinion to the original utterance from the primary interlocutor (cf. Flores, 2005).

The therapeutic relationship between doctors and patients relies primarily on effective doctor-patient communication. On the one hand, effective verbal and non-verbal communication is necessary and crucial for patients to be able to narrate their illness symptoms, to make the necessary enquiries about diagnoses, treatment plans and adherence (Steward, 1995). On the other hand, successful verbal and non-verbal communication places doctors in a unique position to obtain information regarding the patient's chief illness concerns. Thus, as can be realized from the foregoing argument, a successful verbal and non-verbal exchange of information between doctors and patients involves a give-and-take, reciprocal and dynamic interactional partnership between doctors and patients (ibid., pp. 1423-1433). That is, doctor-patient communication requires a two-way, collaborative exchange between doctors and patients.

Most importantly, effective communication between doctors and patients is fundamental to building a positive doctor-patient rapport, which is, in turn, a necessary foundation for a successful doctor-patient relationship and health care (Roter, 1983). For these reasons, it is argued that successful clinical practice is a function of good verbal and non-verbal communication between doctors and their patients (Harmon *et al*., 2006:310-315). That is, communication is a critical component of any medical consultation. The reason is that information exchange principally lies at the centre of doctor-patient consultation (Cohen-Cole, 1991).

This study shows that there are various factors which can negatively affect effective communication between doctors and their patients. Chief among them is the absence of a shared linguistic and cultural background between doctors and patients. The lack of a common language between doctors and patients has some tremendous negative impact on how the latter access health care and how the former delivers it. These communication barriers adversely affect the clinical relationship between doctors and patients while, at the same time, negatively impacting on the negotiation of meaning and medical outcomes between the primary participants to the medical encounter.

In most cases, interpreters are called in to facilitate communicative interaction between doctors and patients who do not share a common language (Platt and Keating, 2007:303-308). This study also shows that frequent communication breakdowns occur between doctors and patients. These breakdowns negatively influence medical outcomes. Interpreting in Lesotho's healthcare is fundamentally conducted on an *ad hoc* basis since there are no laws that regulate the practice and conduct of interpreters in hospitals (The Lesotho Medical, Dental, and Pharmacy Council, 2008). For example, the study shows that frequent linguistic errors committed by *ad hoc* medical interpreters negatively affect the doctor's ability to gather information about the patient's chief illness concerns. This, in turn, seriously compromises the doctor's ability to make accurate medical diagnosis (Lee *et al.*, 2002:464-483). The study also shows that, in most cases, miscommunication between doctors and patients who do not share a common language makes it impossible for doctors to give their patients advice regarding their diagnosis and treatment instructions and recommendations.

Language differences are an added challenge to providing services in a setting where doctors and patients from different linguistic and socio-cultural backgrounds come together. A study by Blanchard (2007:537-542) strongly supports this point. For instance, she has documented a number of linguistic errors made by *ad hoc* interpreters such as family members, non-medical staff, and friends. Her study found out that patients, who use *ad hoc* interpreters such as young children, or non-medical staff, or friends, are frequently faced with serious medical challenges. For example, her study reports that patients who rely on the services of *ad hoc* and untrained medical interpreters very often do not understand their diagnosis as well as treatment plans due to linguistic barriers and poor interpretation. Additionally, her study concludes that there are direct correlations between language barriers, cultural barriers, and medical outcomes. With regard to cultural barriers, Blanchard's (2007:537-542) found that young children are often embarrassed

and refrain from interpreting such culturally taboo words and concepts as menstrual cycle either for the patient or for the doctor.

A similar study by Schapira *et al.*(2008) shows that accurate and complete interpretation is indispensable to both patients and doctors. To illustrate this point, Schapira *et al.* (2008:588) state that:

> … interpreters allow patients and physicians to understand and exchange vital information about the experience of illness, characteristics of the disease, and personal beliefs and values. Armed with an accurate understanding of facts as well as preferences, a doctor can formulate a diagnosis, provide a prognosis, and, after deliberating with the patient, propose an appropriate plan for treatment…. (P)physicians need to be able to trust that the interpreter will deliver a precise rendition of the physician's assessment and plan for treatment, clarify possible misunderstandings, and facilitate rapport among all participants in a meeting or conference.

From the foregoing argument, it can be realized that the most critical duty of a medical interpreter is to facilitate communication between doctors and patients who do not share a common language. In other words, the use of medical interpreters pre-eminently enables doctors and patients who do not share a common language to negotiate meaning as well as to achieve their medical goals during their face-to-face verbal communication (Wadensjö, 1998). According to Schapira *et al*. (2008), medical interpreters also have a duty to resolve potential misunderstandings between doctors and patients who lack a common language. Additionally, the authors argue that professional interpreters have to facilitate rapport between these primary participants to the cross-linguistic medical encounter.

However, various studies have shown that linguistic errors frequently occur during medical interpreting, which impact on the cross-linguistic medical interaction and the negotiation of medical outcomes. For example, a study by Flores *et al.* (2003). investigated communicative problems associated with *ad hoc* interpreting during cross-linguistic interaction between doctors and patients who did not share a common language. Their study found that there are observable problems and challenges inherent in ad hoc interpreting. Sampson (2006:104) defines an *ad hoc* medical interpreter as follows:

> [A]n untrained person who is called upon to interpret, such as a family member interpreting for her parents, a friend, a bilingual staff member who is pulled away from other duties to interpret, or a self-declared bilingual individual who volunteers to interpret. These individuals may not have sufficient language capability or knowledge of medical terminology and confidentiality issues to function adequately as interpreters.

From the foregoing operational definition, it can be realized that *ad hoc* interpreters are bilingual persons who lack certain training and skills crucial for placing them in an appropriate position to conduct interpreting duties. As a result of this lack of skills and professional training, this study shows that linguistic errors directly impact negatively on the negotiation of medical outcomes (Flores *et al.*, 2003; Angelelli, 2004; Hsieh, 2006; Sampson, 2006; Davidson, 2000 and 2001).

Another study by Jacobs *et al.* (2001) found out that linguistic barriers negatively affect the cross-linguistic medical interactions in various ways. For example, their study discovered that there is a direct correlation between linguistic barriers and patients' access to healthcare. The authors established that because of their inability to read, write, or speak English, patients are not in a position to communicate effectively with their doctors (Pöchhacker and Shlesinger, 2001; Wadensjö, 1998; and Gile, 1994). The results further demonstrate that language barriers negatively affect the patients' ability to obtain quality healthcare from their providers, thereby putting the former at risk (see also Woloshin *et al.*, 1995 and Cicourel, 1993).

Additionally, the study by Jacobs *et al.* (2001) further found that patients who do not share a common language with their doctors tend to have poorer adherence rates than those who speak their doctor's language (Angelelli, 2004; Knapp-Pothoff and Knapp (1986; Hsieh, 2006). The authors discovered that

patients' reduced understanding of their medical diagnosis correspondingly leads to poorer follow-up visits to their doctors than those who share the latter's language (Wadensjö, 1998; Gile, 1994; and Mason and Steward, 2001). Thus, their findings suggest that poor interpreting during cross-linguistic medical interactions exacerbates rather than improve doctor-patient interaction and the intended clinical outcomes. Conversely, the authors found out that good interpreting improves the quality of communication between doctors and patients who lack a common language and reciprocally improve the quality of healthcare for the patients (Wong, 2000; Jacobs *et al.* 2001; Mason, 2004; and Pöchhacker, 2004).

Furthermore, the absence of a shared language between the primary participants, viz. doctors and patients, increased the need to engage the services of a linguistic and cultural mediator, albeit on an *ad hoc* basis. As such, this study shows that linguistic errors of *omission, addition, substitution, editorialization,* and *distortion* of meaning may have an enormously adverse impact on the cross-linguistic medical interactions between doctors and their patients.

These studies have several important implications to the present study. For example, according the Lesotho Medical, Dental, and Pharmacy Council's Report, 2008), over eighty percent of doctors who work in Lesotho's hospitals do not share a common language with their monolingual-Basotho patients (see The Lesotho Medical, Dental, and Pharmacy Council's Report, 2008). This presents medico-linguistic challenges during the cross-linguistic medical interactions between doctors and patients who do not share a common language. Specifically, the main purpose of this study was to explore the mediated interactions between non-Sesotho-speaking doctors and monolingual-Basotho patients in two out-patient departments of the St. Joseph's and Quthing hospitals.

Methodology

The study adopted Gile's (1994) mixed-qualitative method of discourse and conversation analysis to examine the ways in which the direct participation of *ad hoc* medical interpreters such as family members, nurses, and assistant nurses influenced the cross-linguistic communication between doctors and patients who did not share a common language. It used five linguistic categories used by Flores *et al.* (2003) to analyse specific areas within the medical interaction in which linguistic errors were committed by ad hoc medical interpreters. This study used the linguistic categories mentioned above to investigate the extent to which linguistic problems impacted on cross-linguistic communicative interactions between doctors and patients who lacked a shared language in Lesotho hospitals.

In addition, all the participants in this study granted their expressed permission to participate in the study in writing. Permission from the hospitals was secured after the research proposal was accepted by the Institutional Review Boards of the participating medical institution. Their permission was secured through separate forms, which were uniquely designed according to each category, such as doctors, nurses, and family members. Audio-recordings and direct observations of verbal exchanges among the participants were made after permission was secured. Thirty-two cross-linguistic medical interactions were observed and audio-recorded in the out-patient departments of the two participating hospitals, namely, the St. Joseph's and Quthing hospitals. The linguistic errors were then classified according to the linguistic categories identified in the study by Flores et al. (2003). The audio-recorded data were transcribed following the Gail Jefferson Transcription System (1984). The data were collected over a period of nine months by this researcher.

The Findings

The results in the extract that follows demonstrate linguistic errors of *omission* and *addition*. Extract 1 exemplifies incidences of omission and addition simultaneously committed by the *ad hoc* medical interpreter during the cross-linguistic medical consultation. The results in Extract 1 demonstrated how these linguistic errors of substitution, omission, and addition negatively impacted on the medical interaction as well as on the negotiation of medical outcomes by doctors and patients who lacked a common language.

Additionally, the linguistic errors of *addition,* and *omission* illustrated in Extract 1 were analysed within a single stretch of medical interaction among the participants-at-talk.

Extract 1: Substitution, Addition, and Omission of Information

1. **D:** (Reads and gazes at the medical interpreter) Her blood sugar level is 12.3 (.)

2. **I:** Is that fasting blood sugar? (.)

3. **D:** Oh yes! (Nods) It's fasting blood sugar (.) Did she eat anything today? (.) Let's confirm (.)

4. **I:** (To the patient) U n'u s'u jele pele u khuoa mali? (.) (Did you eat in the morning before they took your blood sample?) (.)

5. **P:** (Shakes her head) Ee! (.) (No!)

6. **D:** (Whose gaze is fixed on the medical interpreter) Mm? (.) She did eat? (.) She did not drink anything? (.)

7. **I:** No (Shakes her head and looks at the patient) Joale tsatsing lee u n'u s'u tlile chekapong? (.) (And today you have come for a medical check-up?) (.)

8. **P:** (Nods) E (.) (Yeah) (.)

9. **I:** Feela mathata a hao a mang ke afe? (.) (But what are your other problems?) (.)

10. **P:** Mathata ona ha ana ho tlohela ho ba teng ka ha re ntse re le batho ba mangole (.) (Feela tsatsing lena ke tlile chekapong (.) (Health problems will not cease to exist because I suffer from painful knees (.) But today I've only come for a check-up) (.)

11. **I:** (Looks at the doctor) She's come for the check-up (.)

12. **D:** Okay! (Nods and writes) The diagnosis is (reads) diabetes mellitus and ((inaudible))

Analysis of Extract 1

Drawing from the analysis of Extract 1, it can be realized that the interpreter takes control of the medical interaction by substituting the doctor's questions with her own. For example, she replaces the doctor's questions "*Did she eat anything today? (.) Let's confirm (.)"* in turn 3 with her own before interpreting the patient's response in turn 5. In turn 6, the doctor has to repeat his initial questions because the medical interpreter has failed to interpret the patient's response for him in turn 5. Immediately after she has interpreted the patient's response to the doctor in turn 7, the medical interpreter begins to ask the patient questions of her own, which include *And today you have come for a medical check-up? (.)* in the same turn-at-talk. This question is an addition made by the *ad hoc* medical interpreter to the doctor's initial elicitation in turn 3. Additionally, the medical interpreter further asks a different question in turn 9, whose primary semantic function is to solicit additional illness problems from the patient, namely, *But what are your other problems? (.).* In turn 10, the patient responds that she also has some problems with her knees, which are painful.

However, the patient's additional illness problems, which emerge from the discourse in turn 10, are not included in the medical interpreter's rendition in turn 11. In other words, although the response has been provided by the patient in turn 10, the *ad hoc* interpreter has omitted the patient's verbal contribution in turn 11. For instance, the interpreter's rendition only includes the medical check-up as the principal reason for the patient's medical consultation. This linguistic error of omission committed by the *ad hoc* medical interpreter in her rendition in turn 11 has left out crucial information provided by the patient in turn 10. But, because of a language barrier, the doctor accepts the interpreter's rendition as it is and writes it down into the patient's medical history records in turn 12. In other words, the patient's response regarding her additional illness problems are omitted by the medical interpreter's verbal translation in turn 11.

Firstly, this study has shown that medical interpreters often depart from their linguistic conduit role by linguistic *addition* and *omission* of information, which is evidenced in the emerging discourse by primary participants, namely, doctors and patients. For example, this departure from the conduit role is evidenced in the ad hoc medical interpreter's utterance *But what are your other problems? (.)* in turn 9 in which she solicits additional illness problems from the patient without the doctor's instruction. Secondly, the results further illustrate that the omissions and substitutions of the doctors' and patients' verbal inputs negatively affect the negotiation of meaning and medical outcomes by the primary participants to the medical encounter.

For instance, the *ad hoc* interpreter's verbal translation in turn 11 has omitted a potentially crucial information from the patient *Mathata ona ha ana ho tlohela ho bateng ka ha re ntse re le batho ba mangole (.) (Feela tsatsing lena ke tlile chekapong (.) (Health problems will not cease to exist because I suffer from painful knees (.),* which the patient verbally contributed in turn 10. Lastly, it is also evident that an exchange of roles between the doctors and medical interpreters occurs whenever the latter takes control of the distribution of turns-at-talk during the cross-linguistic medical interactions. As a consequence, the this study finds that the linguistic errors of *addition* and *omission* committed by *ad hoc* medical interpreters' renditions can affect the medical interaction between doctors and patients who do not share a common language in various ways.

The results of this study have further shown that all these linguistic errors, which mark the communicative conduct of the *ad hoc* medical interpreters have the potential to affect the negotiation of medical outcomes. For example, the results in Extract 1 have demonstrated the fact that the negotiation of meaning and medical outcomes through the interpreter by doctors and patients negatively affect the flow of the medical interaction and its primary goals (Stivers, 2000).

In the next extract, examples of substitution errors are provided. According to Flores *et al.* (2003), the linguistic error of substitution occurs whenever the medical interpreter replaces the primary speaker's word or phrase or even the whole verbal utterance with his or her own (Flores, 2005). This is illustrated in the example that follows in Extract 2.

Extract 2: Substitution

D: (To the patient) Okay! What else? (.) How do you feel? (.)

1. **I:** Hape? (.) (What else?) (.)
2. **P:** Molala oa ka! (.) (My neck!) (.)
3. **I:** (To the doctor) Neck pain
4. **D:** (Nods and writes) Okay! What else? (.)
5. **I:** (To the patient) O batla ho tseba hore ah ape u ikutloa joang? (.)
6. **P:** Hape maoto a na a ka a ruruhile! (.) (And also my feet are swollen!) (.)
7. **I:** (To the doctor) Swollen feet (.)
8. **D:** (Nods and writes) Okay! (.) Let's give her Bruffen and one injection (Continues to write)

Analysis of Extract 2

In this discourse fragment, the doctor wants to know the patient's additional chief illness concerns with his *Okay! What else? (.)* in turn 1. Nevertheless, this question is only partially reciprocated in the *ad hoc* medical interpreter's rendition in turn 2, which successfully elicits the patient's response *Molala oa ka! (.) (My neck!) (.)* in turn 3. This is a partial elicitation because the interpreter has substituted or replaced the doctor's last interrogative utterance, namely, *How do you feel? (.)* in turn 1.

However, the results in Extract 2 also show that the medical interpreter has changed the doctor's initial question from the second into the third person *O batla ho tseba hore hape hore na u ikutloa joang? (.)* in turn 6, thereby substituting the doctor's use of the second person singular into the third person singular number. This linguistic substitution by the medical interpreter in this turn-at-talk serves to create a distance between the doctor and his question. Additionally, by substituting the doctor's *you* with the third person *He,* the interpreter replaced the doctor's direct question with an indirect elicitation in this exchange.

This finding supports the fact that although the medical interpreters' primary role is to facilitate communication between doctors and patients who do not share a common language, their interpreting conduct is problematic. For example, the linguistic errors of substitution, addition, and omission of the primary participants' original messages are still an added challenge to the cross-linguistic medical encounters as illustrated in the two extracts above. Additionally, these findings support those illustrated in the study by Flores *et al.* (2003). In the next discourse fragment in Extract 3, further linguistic errors committed by the *ad hoc* medical interpreters are presented. These linguistic errors are classified as *editorialization.*

Extract 3: Editorialisation

1. **D**: (Looks up at the patient) Pain is sharp and acute on the onset (Writes) (.) This could be angina (.) Tell her to go to the Counselling Unit (.) They give her advice on how to control her anger (.)
2. **I**: (To the patient) Ngaka o re mokhoa oo u hlalosang bohloko boo ka oona ho na le lefu la pelo mono (.) (The doctor says the way you describe your pain relates to angina) (.)
3. **P**: (Nods) Oo! (.) (Yeah!) (.)
4. **I**: (Nods) Mm! (.) U tsebe hore pain eno haele joalo e bontša hore e ka 'na ea ba pelo ea hao ha e fumane mali hantle (.) Joale ntho e etsahalang ke hore u leke ho loantšana le khalefo ea hao (.) Ha u ultoa e ka u tl'o halefa kapa motho enoa oa halefisa u suthe sebakeng seno! (.) (Mm! (.) You should know that when you experience the pain like that it could be that your heart is not getting enough supply of blood (.) Now what is happening is that you should try to control your anger (.) If you feel that you're getting angry or that someone is going to make you feel angry, you must get out! (Fixes her gaze on the patient) (.)
5. **P**: (Nods) Mhm!
6. **I**: Ee! (Nods) Ha u halefile u heme kapele kapa u noe metsi a foofo! (You should breathe faster and take lukewarm water!) (.)
7. **P**: (Nods) Oo! (.) Okay!
8. **I**: Kapa u suthe sebakeng seno! (Or you should move away from that place!)
9. **P**: Mhm! (Nods, her face downwards)
10. **I**: Hobane lefu lena la pelo le u tšoereng le kotsi haholo 'me lea bolaea! (.) (Because angina is a very dangerous and deadly disease!) (.)
11. **P**: Ee! (Nods) (.) (Yeah!)
12. **I**: Ee! (Nods) Joale hee u tla lokela ho ea ka Thusong ho Mok'hanselara (.) Ke motho e mong eo u ka buang mathata a hao le eena (.) U tla u thusa ho u qobisa khalefo eno e ngata (.) (Now, you will have to go to the Counselling Unit to see a Counsellor (.) A Counsellor is someone with whom you can discuss your problems (.) And he or she will help you find ways of controlling your anger (.)
13. **P**: Oo! (Nods, stands up and goes out) (.) (Okay!) (.)
14. **D**: (Nods and smiles at the patient and waves) Okay! (.)

Analysis of Extract 3

As can be realized from the medical exchange above, the doctor's original message in turn 1 has been substantially editorialized by the *ad hoc* interpreter throughout their verbal interaction with the patient. For example, the medical interpreter's first utterance in turn 2 represents only a partial version of what the doctor was saying in English. Additionally, the results in this discourse fragment show that from the second utterance up to turn 10, the *ad hoc* interpreter has substantially editorialized the doctor's initial utterance. For example, over and above informing the patient that she has angina, the interpreting nurse has now decided to include the following, which are her own personal views:

(a) that she should try to control her anger (e.g. in turn 4);

(b) that she should go away from any situation that may hurt her feelings (e.g. in turn 4);

(c) how dangerous the angina is (e.g. in turn 10);

(d) that it is deadly (e.g. turn 10);

(e) that she should take some lukewarm water whenever she feels the chest pain (e.g. turn 6);

(f) That she should breathe faster (e.g. turn 6)

The findings of this study suggest that except in her first utterance in turn 1 and her last utterance in turn 10, the *ad hoc* interpreter's verbal exchange with the patient is full of a series of utterances whose sole function is to express her own views on how dangerous and deadly angina is. In addition, the results in Extract 3 further illustrate how the interpreter expresses her own views on how the patient should conduct herself. This editorialization also includes the interpreter's personal advice on how the patient should conduct herself, especially in an emotionally stressful situation. For example, she advises the patient to move away from any situation that is potentially, emotionally stressful in turn 8.

Although there may be "nothing wrong" with the pieces of advice in the nurse's rendition, it can be argued that the medico-professional advice on how the patient should try to control her emotions of anger should have been provided by the doctor and the counsellor(s) or expert(s) in the Counselling Unit. This was suggested, in the first place, by the doctor in turn 1.

Furthermore, as for the *ad hoc* interpreter's encouragement that the patient should take some lukewarm water to neutralize her chest pain or angina, this study argues that such piece of advice ought to have come from the doctor's instruction(s). It is argued that if lukewarm water can cure or neutralize chest pain or angina (as the interpreter's rendition in turn 8 suggests), then there would be no need for the patient (and other angina patients) to consult the doctor about this deadly disease. This is in stark contrast to the interpreting nurse's own observation in turn 6 that angina is (1) dangerous, and (2) deadly. That is, if angina is considered to be *dangerous* and *deadly* as suggested by the results from the emerging discourse in Extract 3, then it may be argued that taking lukewarm water should, of necessity, have been included as part of the treatment recommendation by the doctor himself instead of the ad hoc medical interpreter.

Additionally, the study finds that, by editorializing the doctors' original utterances, the *ad hoc* interpreters' renditions could also pre-empt the advice that the professional counsellors could give to the patient. This is evidenced in the *ad hoc* interpreter's personal pieces of advice on how the patient should control her emotions, especially anger, in order to minimize the latter's chest pain or angina. Based on the analysis of Extract 3, this study has found out that these pieces of advice, which comprise substantial editorialization of the doctors' initial recommendation could have a negative impact on the way(s) in which the patients interpret or understand their chief illness symptoms as well as the treatment options offered by the ad hoc interpreters such as drinking of lukewarm water to minimize chest pain or angina in contrast to the initial treatment recommendations. Needless to mention that these personal views provided as pieces of advice to the patients by the *ad hoc* interpreters were probably materially based on their lay experiences

rather than on their professional or clinical expertise (see Davidson, 2000; Elderkin-Thompson, and Waizkin (2001); Bolden, 2000; Hsieh, 2006; and Angelelli, 2004).

Moreover, this study argues that angina patients would generally have no reason why they should pay for medical expenses and waste their time in long waiting queues while they could simply take lukewarm water at their homes whenever they experience the symptoms of angina in the form of chest pain. Additionally, it is also argued that patients would have no reason to consult the professional counsellor if the interpreters have the professional and medical capacity to provide their own advice or views on how patients should control their chest pain, especially if and when caused by their anger. It is also further argued that ignoring the doctor's medical prescription written in the patient's medical history booklet, and editorializing the medical prescription in the form of lukewarm water instead, might in itself be potentially dangerous to the patient.

Thus, this study finds that editorialization is one of the linguistic errors committed by *ad hoc* medical interpreters during the cross-linguistic medical consultations between doctors and patients who do not share a common language in Lesotho hospitals. The study finds that these linguistic anomalies, which are classified as editorialization, are evidenced in the interpreter's rendition, especially in turn 6 of the discourse fragment above. For example, the doctor's initial message is found to be substantially editorialized in the *ad hoc* interpreter's rendition from turn 2 to turn 10. Additionally, based on the close analysis of Extract 3, this study finds that editorialization by the *ad hoc* interpreter largely includes her own personal views in contrast to the doctor's initial treatment recommendations in turn 1. Thus, this study argues that the linguistic errors such as editorialization may negatively impact on the primary participants' (viz. doctors' and patients') negotiation of meaning and their negotiation of treatment outcomes (Flores *et al.*, 2003 and Angelelli, 2003).

In the discourse fragment that follows in Extract 4, the study demonstrates the fact that *ad hoc* medical interpreters sometimes use an incorrect word/phrase during their verbal translation of the primary participants' original messages. The results of this study also show that *ad hoc* interpreters often include a complete statement that does not exist in the particular target language into which they are verbally translating on behalf doctors and patients who do not share a common language during their cross-linguistic medical interactions. Extract 4 illustrates the fact that these linguistic errors, which include words or phrases or even whole statements in the interpreters' renditions are distortions of meaning that may adversely affect the negotiation of meaning and medical outcomes by the primary interlocutors.

Extract 4: Distortion of meaning

1. **D:** What did they say at the CW and QII?
2. **I:** (To the patient) Ngaka o re na ho ile ha thoe'ng ha u n'u ile sepetlele (.) (The doctor wants to know what they said when you were at the hospital) (.)
3. **P:** Ho ile ha thoe ke na le serame sa masapo (.) (The doctor said that I had arthritis) (.)
4. **I**: (To the doctor) She says they told her that she has coldness of the bones
5. **D:**(Angrily) The what?!!! (.) Which doctor was that?! (Takes the patient's medical history booklet and reads again) No-o-no-oo! (.) Yaah!! I see!! (Nods and continues reading) I think I know what they told her, not this! (.) There is the correct medical term for it!! (.)

Analysis of Extract 4: Distortion of Meaning

In Extract 4, the doctor in turn 1 wants to know what the doctors at both **CW** and **QII** hospitals said. This question follows the patient's claim that she had visited the two hospitals about the same problem regarding her endless pain in her legs and her backache. Had the doctor not consulted the patient's medical history records and read (in turn 5, this overt distortion of the patient's meaning from the source language (viz. Sesotho) into the target language (viz. English), the crucial meaning intended by the patient in turn 3 would

have been lost in the *ad hoc* interpreter's verbal translation in the next turn-at-talk. Thus, this study finds that there were distortions of the primary participants' original meaning, which could seriously and negatively affect clinical diagnosis by doctors.

In addition, following the doctor's question, a glaring linguistic error of distortion occurs in the *ad hoc* interpreter's rendition in turn 4. The interpreter's verbal translation as *"She says they told her that she had coldness in her bones (.)"* evidently distorts the patient's original meaning in her response in turn 4. This results in evoking the doctor's anger, which is evident in his first two utterances in turn 5.

Furthermore, the results in this discourse fragment also show that although the doctor does not share the patient's native language, namely, Sesotho, he suspects that the medical interpreter's rendition is erroneous in turn 4. For example, the interpreter's literal translation in turn 4 arouses the doctor's suspicion. This, in turn, forces the doctor to cast doubt on the accuracy of the interpreter's verbal translation of the patient's initial message in turn 3. The results of this study further illustrate that the inaccurate and evidently anomalous rendition by the *ad hoc* interpreter in turn 4 has further necessitated the need for the doctor to re-read the patient's medical history record in order to find out what was actually said by the doctors in the two **CW** and **QII** hospitals previously visited by the patient.

It is through the reading of the patient's medical history records that the doctor was able to remedy the miscommunication that emerged from the *ad hoc* interpreter's rendition in turn 4. For example, the doctor's suspicion of the accuracy of the interpreter's rendition has enabled him to determine what was actually said and what the patient's chief illness complaint initially was in turn 5. This study finds that the medical term for *"coldness of the bones"* is, in actual fact, arthritis.

Thus, based on the analysis of Extract 4, this study argues that the *ad hoc* interpreter's linguistic distortion of the patient's original message previously in turn 2 not only impacts negatively on the primary participants' negotiation of meaning but is also one which could seriously and negatively affect understanding of the patient's real illness problem(s). Furthermore, this distortion of meaning by the *ad hoc* interpreter has the potential to result in misdiagnosis by the doctor had he not been suspicious of the accuracy of the interpreter's rendition and felt a strong obligation to re-read the patient's medical history record. Thus, the study finds that linguistic distortions of one of the primary participants' original meaning can negatively affect diagnosis, thereby leading to incorrect diagnosis and incorrect treatment outcomes, which could potentially be medically harmful to the patient (cf. Flores *et al.*, 2003 and Blanchard, 2007).

The findings further showed that the linguistic mediation of *ad hoc* interpreters impacted immensely on the face-to-face doctor-patient interactions, diagnosis, and the negotiation of medical outcomes. These errors emerged from the *ad hoc* interpreters' renditions of the primary participants' discourses, viz. non-Sesotho-speaking doctors and their monolingual-Basotho patients (cf. Elderkin-Thompson, *et al.*, 2001). The errors committed by *ad hoc* medical interpreters ranged from omissions, additions, distortions or alterations of the primary participants' linguistic exchanges when verbally translated from the source language into the target language.

Discussion

The results of this study have demonstrated that linguistic errors can seriously affect many areas of the medical consultation between doctors and patients who do not share a common language (cf. Downing and Swabey, 1992; Davidson, 2001; and Cicourel, 1993). Additionally, the analyses based on the five linguistic categories used in this study have shown that these linguistic errors found in the *ad hoc* interpreters' renditions can directly and negatively affect the negotiation of meaning as well as medical outcomes by the primary participants within the cross-linguistic medical encounter in Lesotho hospitals. For example, using such linguistic categories as editorializing, omission, substitution, addition, and distortion of meaning, this study has discovered that such linguistic errors have the potential to influence not only the flow of exchanges between the non-Sesotho-speaking doctors and their monolingual-Basotho patients but also that these errors could negatively affect the negotiation of outcomes by the primary participants, namely, the

doctors and patients who lack a shared language during their cross-linguistic medical interactions (cf. Flores *et al.*, 2003 and Blanchard, 2007).

For instance, using the third linguistic category, viz. editorialization, a close analysis of Excerpt 3 has demonstrated that the *ad hoc* interpreter's linguistically erroneous renditions could potentially change the treatment recommendation prescribed by the doctor in writing his treatment plans. This is in contrast to the standards of good medical practice for professional interpreters strongly espoused in the report on the Standards for Performance and Professional Responsibility for Contract Interpreters in the Federal Courts (2011). According to this report, medical interpreters are neither allowed to discuss nor offer their own opinion concerning a matter in which they have been engaged, even when that message is categorized as privileged information (see Roy, 2000).

With regard to one of the first linguistic categories discussed in Extract 1, this study finds that the linguistic errors of omission frequently occur whenever *ad hoc* medical interpreters fail to ask for repetition or clarification even when the doctor's or patient's original utterance was not fully understood or not heard (cf. Angelelli, 2003; Pöchhacker and Schlesinger, 2001; Cokely, 1988 and De Jongh, 1992). Thus, it is argued that *ad hoc* medical interpreters tend to ignore and omit the original messages provided by one of the primary participants in the cross-linguistic medical interactions, which they did not entirely hear or understand. The study further illustrates that the linguistic errors of omission committed by the *ad hoc* medical interpreters can cause serious problems in the ways in which the listeners (doctors and patients without a shared language), can make it difficult, if not entirely impossible, for doctors and patients to decode and interpret each other's utterances emerging from the interpreted discourse (see Metzger, *et al.*, 2003 study on the relationship between medical topics and omission).

With respect to the fourth linguistic category, namely, the distortion of the primary participants' original meaning illustrated in Extract 3, this study finds that the *ad hoc* interpreters' renditions could seriously and adversely affect the ways in which treatment outcomes were interactionally negotiated by the primary participants (see Jacobs *et al.*, 2001). Two studies by Jacobs *et al.* (2001) and Flores *et al.* (2003) support this finding. For example, these authors found that many linguistic barriers frequently occur in situations in which doctors and patients do not share a common language. This includes, *inter alia*, the frequent distortions of meaning by the medical *ad hoc* interpreters.

Conclusions

This study has shown that the *ad hoc* medical interpreters commit common and manifold linguistic errors during cross-linguistic medical consultations. The previous sections have examined factors relating to the issue of the linguistic errors committed by the *ad hoc* medical interpreters during interactions between the non-Sesotho-speaking doctors and their monolingual-Basotho patients. These errors were classified and analysed at five levels of linguistic categories using Flores *et al.* (2003) classification. They include *omission, substitution, addition, editorialization,* and *distortion* of meaning (ibid., 2003). The study showed that linguistic barriers negatively impact on healthcare in a number of ways.

Firstly, patients affected by such linguistic barriers are barely able to access adequate healthcare from the doctors who do not share the same language with them. It is concluded that because of a language barrier, patients feel reluctant to fully report their illness symptoms. Based on the findings of this study, it is further concluded that the patients' inability to speak their doctor's language leads to their lack of understanding of the treatment recommendation explained to them by the *ad hoc* medical interpreters.

Secondly, this study concludes that the language barriers possibly put patients at greater risk of medical errors that result from poor or inaccurate interpretation. Thirdly, this study further concludes that reduced quality of care as a result of communication barriers can correspondingly contribute to patients' lack of satisfaction with healthcare delivered to them. This, in turn, may negatively and seriously affect their future follow-up visits to the hospital. Fourthly, this study further concludes that poor interpreting

denies the patients the much needed access to health care (Metzger, 2005). It is shown that linguistic errors not only affect the face-to-face doctor-patient interaction but also medical outcomes.

Next, it is concluded that this communication gap, therefore, renders it impossible for doctors to maintain a productive doctor-patient therapeutic relationship (ibid., pp. 464-483). This leads to lack of trust between doctors and patients and may result in patients' complaints and dissatisfaction with the medical care that they receive from their doctors. These negative factors, which are related to poor communication between doctors and patients who lack a common language, may lead to poor follow-up visits, in particular, and a tremendous erosion of trust in the entire health care system, in general (Brown *et al.*, 1999: 822-829).

Lastly, this study concludes that whereas *ad hoc* medical interpreters are an indispensable element of successful communication between doctors and patients who do not share a common language, the linguistic errors they routinely commit during the cross-linguistic medical interactions can have serious negative implications and consequences on the negotiation of meaning as well as medical outcomes.

Recommendations

From the foregoing conclusions, it is recommended that the government should promulgate a legislation that should regulate standards of professional conduct and good practice by medical interpreters. The study further recommends that the absence of any legislation to provide guidelines on medical interpreters' conduct in Lesotho's hospitals contributes to the medical problems, which emanate from the linguistic barriers within the cross-linguistic medical interactions between doctors and patients who do not share a common language. Coupled with this problematic legislative vacuum is the persistent absence of interpreter accreditation and certification in the Lesotho hospitals, which are viewed in this study as substantial contributing factors to the linguistic and medical problems encountered by non-Sesotho-speaking doctors and their monolingual-Basotho patients on a daily basis in Lesotho hospitals. Thus, based on the results of this study, it is further recommended that a law requiring accreditation and certification of medical interpreting be promulgated with a view to professionalizing interpreting services in Lesotho's healthcare.

Lastly, it is further recommended that interpreter certification and training should be made a sine qua non for entry into the Lesotho's medical profession, especially if it is done with a view to facilitating understanding between doctors and patients who do not share a common language. Additionally, it is recommended that non-Sesotho-speaking doctors should be required by law to attend some elementary courses in Sesotho before they could start to interact with their monolingual-Basotho patients in the consulting rooms. Introducing such a crash Sesotho program for the former may potentially bring forth immediate benefits such as minimizing communicative problems between the primary interlocutors as well as reducing possible unforeseen medical problems resulting from poor interpreting as well as to avoid any communication breakdowns between doctors and patients who do not share a common language in Lesotho hospitals in future.

References

Ainsworth-Vauhn, N. (1998). *Claiming Power in Doctor-Patient Talk*. Oxford: Oxford University Press.

Angelelli, C. (2003). "The Interpersonal Role of the Interpreter in Cross-Cultural Communication: A Survey of Conference, Court and Medical Interpreters in the US, Canada and Mexico". *The Critical Link3: Interpreters in the Community*, Amsterdam and Philadelphia: John Benjamins Publishing Company.

Angelelli, C. V. (2004). *Medical Interpreting and cross-cultural Communication*. Cambridge: Cambridge University Press.

Arora, N. (2003). "Interacting with Cancer Patients: The Significance of Physicians' Communication Behavior". *Social Science & Medicine*, 57 (5):791–806.

Blanchard, J. (2007). "Who Decides, Patient or Family?: Guidelines for proceeding with a plan of care when family members have conflicting opinions about the patient's wishes and the patient does not speak the same language as her physicians". *Virtual Mentor*, Vol. 9, Number 8: 537-542.

Bolden, G. (2000). "Toward Understanding the Practices of Medical Interpreting: Interpreters' Involvement in History Taking". *Discourse Studies*, 2 (4): 387-419.

Brown, J. B., Boles, M., Mullooly, J. P., and Levinson W. (1999). "Effect of Clinician Communication Skills Training on Patient Satisfaction: A Randomized, Controlled Trial". *Annals of Internal Medicine*, 131 (11): 822–829.

Cicourel, A. V. (1993). "Hearing is Not Believing: Language and the Structure of Belief in Medical Communication". In A. Todd & S. Fisher (Eds.), *The Social Organization of Doctor-Patient Communication* (2nd Edition). Norwood, NJ: Ablex Publishing Corporation.

Cokely, D. (1988). "Introduction." In D. Cokely & N. B. Frederickton (Eds.) *Sign Language Interpreter Training Curriculum.* University Of New Brunswick.

Cohen-Cole, S.A. (1991). *The Medical Interview: The Three Function Approach*. St. Louis, MO: Mosby Year Book.

Davidson, B. (2000). "The Interpreter as Institutional Gatekeeper: The Social-Linguistic Role of Interpreters in Spanish-English Medical Discourse". *Journal of Sociolinguistics*, 4 (3): 379-405.

Davidson, B. (2001). "Questions in Cross-linguistic Medical Encounters: The Role of the Hospital Interpreter". *Anthropological Quarterly*, 74 (4): 170-178.

De Jongh, E. M. (1992). *An Introduction to Court Interpreting: Theory and Practice.* New York: University Press of America.

Downing, B. T. and Swabey, L. (1992). "A Multilingual Model for Training Health Care Interpreters". *Paper Presented at the National Conference on Health and Mental Health of Soviet Refugees*, Chicago.

Elderkin-Thompson, V., R. Silver, C., and Waizkin, H. (2001). "When Nurses Double as Interpreters: A Study of Spanish-speaking Patients in a US Primary Care Setting". *Social Science & Medicine*, 52: 1343-1358.

Flores, G. (2005). "The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review". *Medical Care Research and Review*, 65 (255): 1-46 [Available online on]:

http://mcr.sagepub.com/cgi/content/abstract/62/3/255

Flores, G., B. Laws, S. J. Mayo, B. Zuckerman, M. Abreu, L. Medina, & E. J. Hardt (2003). "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters". *Pediatric*, 111 (6): 6-14.

Gile, D. (1994). "Methodological Aspects of Interpretation and Translation Research". S. Lambert and B. Moser-Mercer (Eds.) *Bridging the Gap: Empirical Research on Simultaneous Interpretation* (39-56). Amsterdam and Philadelphia: John Benjamins.

Gwyn, R. (2002). *Communicating Health and Illness*. London: Sage.

Harmon, G., Lefante, J., and Krousel-Wood, M. (2006). "Overcoming Barriers: The Role of Providers in Improving Patient Adherence to Anti-hypertensive Medications". *Current Opinion on Cardiology*, 21 (4): 310–315. [Pub Med].

Hsieh, E. (2006). "Interpreters as Co-Diagnosticians: Overlapping Roles between Service Providers and Interpreters". *Social Science and Medicine*, 64 (4): 13-27.

Jacobs, E. A., D. S. Lauderdale, D. Meltzer, J. M. Shorey, W. Levinson, & R. A. Thisted (2001). "Impact of Interpreter Services on Delivery of Health Care to Limited-English-proficient Patients". *Journal of General Internal Medicine*, 16: 468– 474.

Jefferson, G. (1984). "Transcription Notation". In J. M. Atkinson and J. Heritage (Eds.), *Structures of Social Action* (ix-xvi). Cambridge: Cambridge University Press.

Lee, S. J., Back, A. L., Block, S. D., and Stewart, S. K. (2002). "Enhancing Physician-Patient Communication". *Hematology: American Sociology of Hematological Education Program*. Vol. 1: 464–483. [Pub Med]

Knapp-Pothoff, A. and Knapp, K. (1986). "Interweaving Two Discourses – the Difficult Task of the Non-professional Interpreter". In Juliane, House and Shoshana Blum-Kalka (Eds.). *Interlingual and Intercultural Communication: Discourse and Cognition in Translation and Second Language Acquisition Studies* (pp. 151-168). Tübingen: Narr.

Mason, I. (2004). "Conduits, Mediators, Spokespersons". In Christina Schäffner (Ed.) *Translation Research and Interpreting Research*. Toronto and Clevedon: Multilingual Matters Ltd.

Mason, I. and Steward, M. (2001). "Interactional Pragmatics, Face and the Dialogue Interpreter". In Ian Mason (Ed.) *Triadic Exchanges: Studies in Dialogue Interpreting* (pp. 51-70). Manchester: St. Jerome.

Metzger, M. (2005). "Interpreted Discourse". In C. B. Roy (Ed.) *Advances in Teaching Sign Language Interpreters* (100-122). Washington, DC: Gallaudet University Press.

Metzger, M., S. Collins, V. Dively, & R. Shaw (Eds.) (2003). *From Topic Boundaries to Omission: New Research on Interpretation*. Washington, DC: Gallaudet University Press.

National Council on Interpreters in Health Care (2004). "A Code of Ethics for Health Care Interpreters: A working Paper for Discussion", [available on]: http:www.ncihc.org.

Platt, F. W., and Keating, K. N. (2007). "Differences in Physician and Patient Perceptions of Uncomplicated UTI Symptom Severity: Understanding the Communication Gap". *International Journal of Clinical Practice*, 61 (2): 303–308.

Pöchhacker, F. (2004). *Introducing Interpreting Studies*. London and New York: Routledge.

Pöchhacker, F., & M. Schlesinger (2001). *The Interpreting Studies Reader*. London and New York: Routledge.

Roter, D. L. (1983). "Physician/Patient Communication: Transmission of Information and Patient Effects". *Medical Journal*, 32 (4): 260–265.

Roter, D. L., and Hall, J. (1992). *Doctors Talking with Patients/Patients Talking with Doctors*. Westport, CT: Auburn House.

Roy, C. (2000). *Interpreting as a Discourse Process*. Oxford: Oxford University Press.

Sampson, A. (2006). "Language Services Resource Guide for Health Care Providers". *National Health Law Program*. Washington, DC: Cross-Cultural Heal Care Program.

Sainath, N. (2011). "Twisted Translation: Using Friends and Family Members as Medical Interpreters " [available online]:

http://www.clinicalcorrelations.org/?p = 4109.

Schapira, L., Vargas, E., Hidalgo, R., Brier, M., Sanchez, L., Horecker, K., Lynch, T., & Chabner, B. (2008). "Lost in Translation: Integrating Medical Interpreters into the Multidisciplinary Team". *The Oncologist, Vol. 13 No. 5*: 586-592. Available from:

http://theoncologist.alphamedepress.org

Standards for Performance and Professions Responsibility for Contract Interpreters in the Federal Courts (2012),[Available online]:

http://www.sdnyinterpreters.org/doc/ethics

Stewart, M. A. (1995). "Effective Physician-Patient Communication and Health Outcomes: A Review. *CMAJ*, 152 (9): 1423–1433.

Stivers, T. (2000). *Negotiating Antibiotic Treatment in Pediatric Care: The Communication of Preferences in Physician-Parent Interaction*. [Unpublished doctoral dissertation] University of California, Los Angeles.

The Lesotho Medical Dental, and Pharmacy Council (2008). Report: 1-109.

Wadensjö, C. (1998). *Interpreting as Interaction*. London and New York: Longman.

Woloshin, S., Bickel, N. A., Schwartz, L. M., Gany, S., & G. Welsh (1995). "Language Barriers in Medicine in the United States". *JAMA*, 273 (9): 724-728).

Wong, E. (2000). "Filtering the Doctor-Patient Relationship through a Translator". *The New York Times*, (6th April, 2000).