COMMUNICATION STRATEGIES IN MEDICAL CONSULTATIONS IN THE LIMPOPO PROVINCE OF SOUTH AFRICA

Fawole, Adebola Abosede
Department of Translation Studies and Linguistics,
University of Limpopo, South Africa,

Fawole, Olufemi Adeniyi
Department of Sociology,
University of Ilorin, Nigeria
+2347030744918; femifawole.2010@gmail.com

&

Aliyu, Kolawole Taofeek
Department of Sociology,
Obafemi Awolowo University, Ile-Ife, Nigeria.

Abstract
Communication during consultation could prove rather challenging particularly when patients and medical staff do not speak the same language. The use of English as a language of communication in medical consultation may prove problematic in societies where English is not the official language, as in South Africa. This study adopted the qualitative research design using the research tools of audio recordings, interviews and observation to collect data from 19 doctors, 13 nurses and 35 patients in 10 hospitals in the Limpopo province of South Africa. Conversation analysis was used to analyse data collected through audio recordings of interviews and doctor- patient interactions. From the analysis of the recorded consultations, the communication strategies were identified. Recommendations were made based on the communication between English-speaking foreign medical doctors in the Limpopo province with a focus on the communication strategies.

Keywords: Communication strategies; Communication analysis, Euphemisms, Consultation

Introduction

The South African Constitution provides for 11 official languages namely English, Afrikaans, isiNdebele, isiXhosa, isiZulu, siSwati, Sesotho, Sepedi, Setswana, Tshivenda and Xitsonga. The policy further indicated that the promotion of multilingualism will allow people the use of the language they understand best and feel comfortable speaking when accessing health care. To ensure this, the Department of Health commits to the provision and use of "professionally qualified and competent interpreters and translators" in the healthcare system as well as affording staff opportunities to improve their proficiency in the English language as a means of enhancing their job performances.

English is language of business or 'working language', the medium of instruction in schools and some government institutions has opted for its use as the sole official language (Anthonissen 2010). However, in spite of the seemingly widespread use of English language, many still speak little or no English in some parts of the country. From the 2011 National Department of Health language policy, it becomes clear from 2000 statistics quoted that English language is one of the predominant languages in only three out of the nine provinces in the country. These provinces are Gauteng with 12.5% of her population having English as the predominant language; and (Naidoo, 2012). Some areas like Northern KwaZulu-Natal, Transkei in the Eastern Cape and rural Limpopo fall into the category of those with many people speaking little or no English (Anthonissen 2010). The study focuses on the province of Limpopo where the main indigenous languages are Tshivenda, Sepedi and Xitsonga. Against this background of language distribution and the need to use English as the language of communication during consultation with English-speaking foreign medical doctors, problems are bound to occur and strategies must be devised to in order to promote better communication between doctors and patients.

When people interact using a second language there is always the possibility that both may struggle to clearly express themselves verbally and nonverbally so as to be understood by the other person. Thus, they use different methods to achieve their desired objectives. These methods are referred to as "communication strategies", a term coined by Selinker (1972). Scholars are unable to agree on a single definition of communication strategies and there may be as many as there are scholars in the field of second language acquisition and teaching. Faerch and Kasper (1983) defined communication strategies as potentially conscious plans for solving what to an individual presents itself as a problem in reaching a particular communicative goal. The need for communication strategies arises when a speaker desires to communicate a message to the listener and believes that he/she does not have the required linguistic and sociolinguistic structure to convey the message and he/she therefore needs to choose to avoid or not attempt to communicate or finds alternative ways of conveying the message (Tarone, 1981).

Communication challenges do exist when patients and doctors do not speak the same language. The use of English as the language of communication in medical consultation may prove problematic due to the influence of culture and mother tongue leading to differences in pronunciation, use of vocabulary and semantics. The use of culture bound words like metaphors, euphemisms, idioms, local names of different symptoms in relation to the health belief system and other cultural beliefs is also a problem as these cannot be easily translated into the English language or understood by a stranger in the community.

Communication during consultation should have the ultimate intention of building trust on the side of the patient. This trust may, in turn, help the patient to understand the process of his or her disease and to accept a diagnosis and a consequent adherence to treatment. Lack of training of the healthcare provider in issues of intercultural communication may lead to misunderstanding between healthcare professionals and patients during medical consultation.

Medical consultations are considered intergroup communication where interlocutors are from different groups (in this case doctors and patients) and each

participant is aware of the norms guiding such interaction (Watson and Gallois 1998). Thus, each party seeks to use communication strategies which ensure the success of the interaction. In any medical consultation, doctors are advised to adopt seven key communication tasks (Makoul *et al*, 2001). The key tasks rest on the building of a cordial relationship between the doctor and the patient which is thus the first task the doctor has to accomplish. A patient-centered approach is advocated for in consultation with the focus on the patient illness. The doctor-patient relationship is to be seen as a partnership which should be extended to the patient's family and other support networks. The remaining six tasks when accomplished strengthen the relationship established between the doctor and patient. They are ordered sequentially as they occur in consultation. First, the doctor commences the discussions and gives the patient the opportunity to clearly state the health concerns. Secondly, the doctor is to gather information from the patient using open-ended questions, active use of non-verbal techniques to encourage the patient to give all necessary information. Thirdly, the doctor needs to understand the patient's perspective by acknowledging the patient's ideas and beliefs about the illness as well as exploring issues relating to family, gender, spirituality. Fourthly, after listening to the patient, the doctor needs to share information with the patient in the language that the patients understands, check that the information is well understood and offer clarifications when needed. Fifthly, both patient and doctor need to agree on a treatment plan. Lastly, the doctor needs to provide closure for the patient by inquiring about other concerns the patient may have, summarizing the treatment plan and discussing follow-up where needed. The medical doctor needs to adopt appropriate communication strategies. When this is done, there may be an expectation of patients' satisfaction, adherence to treatment suggestions and subsequent return for later appointments.

The development of effective communication strategies becomes more important in intercultural communication. Foreign medical doctors experience difficulties in the area of language, emotions especially in providing support for patients and cultural norms (Jain and Krieger 2011; Fiscella, Roman-Diaz, Lue, Botelho and Frankel 1997). In the area of language, the doctors may have the problem of understanding due to the differences in pronunciation, use of colloquialism, idioms, accents and body language among other factors. Foreign doctors are often confused about the right and acceptable ways to comfort patients in the host culture. Eid and Diener (2001) noted that emotions are experienced differently in collectivist and individualistic societies. To combat these difficulties, the doctors need to develop coping strategies. For the international medical graduates in the United States of America, these strategies included learning to pronounce words the American way, learning meanings of slangs, repeating sentences, speaking slowly and verifying if patients understood what had been said. To compensate for the linguistic inadequacies, most doctors used body language like maintaining eye contact when speaking with patients.

The communication strategies of the foreign medical doctors in South Africa have not been studied. It is important to note that intercultural communication in South Africa is not necessarily between foreigners and South African citizen alone but also between South Africans themselves due to the multicultural and multilingual landscape of the country. Some of the strategies used include the learning of the local language, repetition and verifying that message is understood and the use of interpreters (Ellis

participant is aware of the norms guiding such interaction (Watson and Gallois 1998). Thus, each party seeks to use communication strategies which ensure the success of the interaction. In any medical consultation, doctors are advised to adopt seven key communication tasks (Makoul *et al*, 2001). The key tasks rest on the building of a cordial relationship between the doctor and the patient which is thus the first task the doctor has to accomplish. A patient-centered approach is advocated for in consultation with the focus on the patient illness. The doctor-patient relationship is to be seen as a partnership which should be extended to the patient's family and other support networks. The remaining six tasks when accomplished strengthen the relationship established between the doctor and patient. They are ordered sequentially as they occur in consultation. First, the doctor commences the discussions and gives the patient the opportunity to clearly state the health concerns. Secondly, the doctor is to gather information from the patient using open-ended questions, active use of non-verbal techniques to encourage the patient to give all necessary information. Thirdly, the doctor needs to understand the patient's perspective by acknowledging the patient's ideas and beliefs about the illness as well as exploring issues relating to family, gender, spirituality. Fourthly, after listening to the patient, the doctor needs to share information with the patient in the language that the patients understands, check that the information is well understood and offer clarifications when needed. Fifthly, both patient and doctor need to agree on a treatment plan. Lastly, the doctor needs to provide closure for the patient by inquiring about other concerns the patient may have, summarizing the treatment plan and discussing follow-up where needed. The medical doctor needs to adopt appropriate communication strategies. When this is done, there may be an expectation of patients' satisfaction, adherence to treatment suggestions and subsequent return for later appointments.

The development of effective communication strategies becomes more important in intercultural communication. Foreign medical doctors experience difficulties in the area of language, emotions especially in providing support for patients and cultural norms (Jain and Krieger 2011; Fiscella, Roman-Diaz, Lue, Botelho and Frankel 1997). In the area of language, the doctors may have the problem of understanding due to the differences in pronunciation, use of colloquialism, idioms, accents and body language among other factors. Foreign doctors are often confused about the right and acceptable ways to comfort patients in the host culture. Eid and Diener (2001) noted that emotions are experienced differently in collectivist and individualistic societies. To combat these difficulties, the doctors need to develop coping strategies. For the international medical graduates in the United States of America, these strategies included learning to pronounce words the American way, learning meanings of slangs, repeating sentences, speaking slowly and verifying if patients understood what had been said. To compensate for the linguistic inadequacies, most doctors used body language like maintaining eye contact when speaking with patients.

The communication strategies of the foreign medical doctors in South Africa have not been studied. It is important to note that intercultural communication in South Africa is not necessarily between foreigners and South African citizen alone but also between South Africans themselves due to the multicultural and multilingual landscape of the country. Some of the strategies used include the learning of the local language, repetition and verifying that message is understood and the use of interpreters (Ellis

Another case is that of a woman who tells the doctor that when she 'sees the moon', she experiences many pains. (*I experience pains during my menstrual flow)*

The extract below illustrates effect of culture on the consultation process as documented by Mandla (2009) in the Eastern Cape.

Doctor: Take off this rope; I can't examine you with it around your neck. Don't you see that rash is caused by your allergy to this animal's hair?

Patient: This is not a rope. It is my medicine. It has nothing to do with this rash.

When the patient is unable to communicate in English language due to low proficiency, the need for an interpreter arises, creating other problems in the communication process. These may include omission of information by the interpreter who in most cases are nurses who are often second language users of English. The study is aimed at identifying the communication strategies employed by the English- speaking foreign medical doctors when communicating with patients and interpreters.

Methods

The study focused on the communication between English-speaking foreign medical doctors, their patients and interpreters making it germane to understand what transpires in the consultation rooms when such intercultural and inter-linguistic interactions take place. Data for most of the studies reviewed were collected through the use of questionnaires and interviews. This often presents the situation investigated from the point of view of the respondents without giving a holistic view. This study employs the use of audio recording in addition to the use of questionnaires and interviews to gain an in-depth understanding of the communication strategies used by English-speaking foreign medical in medical consultation. To achieve this the study was designed as a descriptive study which used Conversation Analysis (CA) both as a data gathering and data analysing tool. CA developed in the field of Sociology provides researchers the opportunity to study naturally occurring interactions. If communication between doctors and patient is to improve there is need to understand what happens during consultation. CA as a research method focuses on the analysis of conversation as they occur under natural situations and not in a scientific prearranged environment (Hutchby and Wooffitt 2008:12).

The use of CA in the analysis of doctor- patient communication often involves the collection of large scale data. This makes it possible to identify general "recurrent and systematic patterns" so that conclusions are not drawn from an individual's personality or disposition (Drew, Chatwin and Collins 2001:60). This explains the collection of data from different categories of participants through audio recording, interviews and observation giving the opportunity to view the issue from different perspectives as characteristics of qualitative studies.

A total of thirty-five consultations were audio-recorded for this study. These consultations also involved interviews of nineteen doctors and thirteen nurses. The nurses served as interpreters for the doctors where necessary. Verbal consent was given by the all the respondents to participate in the study.

Results

All categories of participants were asked to mention the efforts they had noticed the English-speaking foreign medical doctors were making to communicate better with patients during consultations. The responses were coded using the N-VIVO software. Five (5) themes emerged from the analysis. These are clarification strategies, continuation strategies, interpersonal strategies, knowledge strategies and avoidance strategies.

Discussion

The fact that the doctors, nurses and patients were able to identify the strategies employed during consultations lends credence to the definition of communication strategies by Faerch and Kasper (1983) as plans that are consciously made by people to solve problems they encounter when communicating with others. The English-speaking foreign doctors are aware of the problems they encounter in consulting with patients from different linguistic backgrounds when an interpreted is used or even when the consultation is in a common second language and they consciously take steps to communicate more effectively. The focus of the interlocutors was not on speaking grammatically correct sentences in English or the local language but ensure that the hearer understood what was said.

Clarification Strategies

Doctors using clarification strategies allow patients to state their preference of language, understanding of illness or disease and their expectations from the doctor. Giving patients the opportunity to vocalise their understanding of their problems and expectations gives the doctor an opportunity to establish what the patient actually wants. Macdonald (2004) cautioned that doctors should be aware that they do not fully understand their patient's conceptualization of their problems and should therefore provide patients with the opportunity to tell their own stories in their own words. The need to explain, repeat, ask more questions and using examples cannot be over emphasized in medical communications more so in an intercultural setting. Doctors due to differences in pronunciation of some words often need to repeat or ask patients and interpreters to repeat what they said. These strategies ensure that the patients do understand the doctor's questions and treatment plan. Labhardt, Schiess, Manga and Langewitz (2008) reported that patients remember their diagnosis when they are clearly stated during consultation. An impetus to follow a treatment plan is an understanding of the illness, thus patients are more likely to comply with treatment and medication when they are clearly explained to them. Repetition was also found to be used by doctors with both patients and interpreters. This was also identified by Ellis (2004) and Jain and Keiger (2011) by doctors in South Africa and the United States respectively. The use of repetition requires patience from both the speaker and hearer. The doctor needs to be patient and persist along a line of questioning until the answer sought is received indicating that it was understood; and the patient and interpreter must not see the repetition from the doctor as a negative sign of inattentiveness.

Continuation Strategies

Continuation strategies are used to ensure that a total breakdown does not occur during consultations. A main strategy used here is calling for an interpreter. The strategy has many problems as has been investigated by several researchers. However, this study moves beyond identifying the problem inherent in the communication process to identifying ways of solving the problems encountered in both monolingual and interpreted consultations. The doctor asks the nurse to interpret when he notices that a lot of un-interpreted conversation had occurred between the interpreting nurse and patient, assures the patient that they are there to help. The patients were not worried that the doctor did not speak the local language provided there was a nurse to interpret. This emphasizes the vital role nurses play in the communication process. However, these nurses do not receive any form of training in interpretation; a fact that could possibly account for the problems they encounter in interpretation. There are major concerns about the interpretations done by the nurses especially in the cases of extended turns; un-interpreted and ignored turns during consultations as well as trying to prescribe medication for the patient. The turns that are either ignored or not interpreted may be crucial in aiding the doctor make a diagnosis and recommend appropriate treatment. Mishler (1984) is of the view that discussions about the "life-world" during consultations may increase the patient's level of satisfaction with the consultation. The study found that most doctors tried to maintain eye contact with patients as a means of achieving better communication with them. Eid and Diener (2001) also reported the use of eye contact by foreign doctors as a means of compensating for linguistic inadequacies.

The patients perceived the doctors to be more attentive to them when they maintained eye contact. The doctors were found to use convergence strategies by learning and speaking the local language, being friendly with the patients and giving the patients enough time to express themselves during consultations. Most of the doctors took pride in learning and speaking the local language of where they practiced and noted that it made consultation easier for them and the patients. However, the success of this strategy is questionable from reports of mistakes made by doctors in the contextual use of local words, Mandla (2009). The patients identify these strategies of friendliness and patience as reasons why they like the doctors despite of the linguistic problem inherent in communication. This is akin to the submissions made by Giles, Coupland and Coupland (1991) that speakers who converge are considered competent and cooperative. The foreign doctors make efforts to present themselves as likable people. There were no cases of complementarity on the part of the patients as doctors reported that some patients who could speak English refused to use it as the medium of communication during consultations. A patient also noted that the doctors should learn the local language as they are the foreigners. This tends towards a display of power by the patient and requires further investigation on its effect on the communication during consultation. However, most patients were appreciative of the services rendered by the foreign doctors. The fact that there were only cases of convergence on the part of the foreign doctors and not complementarity strategies suggested that a third culture may not be easily developed in South Africa as its development requires active participation of all involved.

Interpersonal Strategies

The patients identified the fact that the doctors' use of time with them in consultation was a crucial factor for their sense of satisfaction with the foreign doctors. They noted that the doctors spent time to explain their sickness and treatment to them. Findings from research on use of time and patients' satisfaction have changed over the years. Morrell, Evans, Morris and Roland (1986) reported no difference in the levels of satisfaction between patients who spent five minutes and above in consultation with doctor and those whose spent less, while Puri, Gupta, Aggarwal and Kaushal (2012) report that patients who spent 12.4 minutes and above in consultation with the doctor were more satisfied than patients who spent 8.5 minutes or less. Although the patients in this study indicated that the doctor's use of time was a factor for satisfaction, the time used in consultation did not indicate this. Patients who spent little time as well as those who spent a long time indicated their satisfaction with consultation. This study therefore concludes that the communication between the doctor and patient is responsible for the sense of satisfaction. This is consistent with the findings by Gross, Zyzanski and Borawski (1998) that patients feel a sense of satisfaction and feel that enough time has been spent with them if the doctor engages them in conversations about everyday topics like the weather or jokes with them. These strategies were used by the foreign doctors and may account for the sense of satisfaction felt by the patients despite the short time spent in consultation. More research is needed in this area of the use of time, communication and patients' satisfactions.

Knowledge Strategies

Patients identified the display of medical knowledge as a factor facilitating communication with the foreign doctors. The doctors achieved this despite the fact that they did not use difficult medical terminology during consultations with the patients. Patients symptoms and treatment plans were explained in such a way that the patients understood. The fact that the doctor was able to identify the patient's illness, prescribe treatment that proved effective, ensured that the patient was more willing to listen to doctor and comply with future treatment. A study by Wang, Adams, Pasick, Gomez, Allen, Ma, Lee and Huang (2013) among Chinese-American and non-Hispanic white women substantiated this fact by showing that the medical knowledge that the doctors had about their condition and treatment proved more important than other factors.

Avoidance Strategies

The English-speaking foreign medical doctors employed avoidance strategies in various ways when it became obvious to them that communication with the patients could not continue at that present time. Thus, they selected patients based on their ability to communicate with them in the English language, refer patients to colleagues who speak the local language or ask the patient to bring an interpreter. These three strategies are used when there is no interpreter available. These strategies pose as barriers to access for patients who are unable to speak English. A fact also noted by Deumert (2010) when she noted that patients unable or uncomfortable when using the doctor's language are likely to access healthcare irregularly and only come to the hospitals at an advanced stage of their illness. One of the tasks in the seven key communication tasks advocated by

Makoul (2001) is listening and exploring the patient's views about family, gender and spirituality. Thus, when the doctor avoids listening or interacting with the patient on this level, a major communication task is left uncompleted. It is possible for doctor to communicate with patients with minimal response from the patient when close ended questions are asked. Communication becomes more difficult when the discussion necessitates sentences and may be a reason why the doctors avoid such discussions with the patients.

Recommendations

As a consequence of the outcome of this study, the following strategies are recommended.

Recommendations for the English-speaking foreign medical doctors

The study concluded that doctors used many converging strategies in communicating with the patients. It is recommended that foreign medical doctors continue to use strategies that converge with the patients as they to help create a rapport with both the patient and nurses. However, it is also important for the doctors to remain in charge of the consultations and use strategies that will ensure they get the complete information from the nurses to reduce un-interpreted and ignored turns during consultations. This requires sensitivity from the doctors to recognise which should be used at different points in time. The vast use of convergence strategies suggests that the doctors feel powerless in the consultation room despite the knowledge strategy.

The qualifying examinations organised by the Health Professional Council of South Africa (HPSCA) does not include an assessment of proficiency in the English language as a separate paper or require a certificate of proficiency from other examining bodies like the United States of America, Canada and Australia. It is recommended that the doctors write an English language proficiency test before they commence practice. This will reduce the number of doctors who begin work without the needed proficiency in the English language and remove the need for the doctors to learn English language on the job. It is recommended that due to the diverse linguistic and cultural nature of South Africa that orientation programmes be organised for doctors employed in different provinces in relation to the language and culture of the province. This should be done alongside the provision of bilingual medical dictionaries for the doctors.

Recommendations for nurses as interpreters

Interpretation in medical consultation is better done by professional interpreters. However, it is evident that professional interpreters are not available in the hospitals and nurses often do the interpretation. In order to reduce the problems inherent in using ad-hoc interpreters, it is recommended that nurses are trained to interpret preferably in the nursing school and on the job. Language practitioners should be consulted to develop a curriculum for interpreting as part of the basic nursing training. For nurses already working, it will be beneficial to organise courses on interpreting. Nurses need to be aware that they do more than interpret but also act as cultural brokers for the doctors. Proper training will provide interpretation close to a professional level at a reduced cost. A major

problem noticed is the insufficient number of nurses to help doctors interpret hence, the need to employ more nurses.

Recommendations for patients

The patients need to be educated about what to expect from the doctors. Most patients are used to the situations where interpreters are used. They however need to be taught strategies to use to ensure that the interpreters relate to them what the doctor says and what they say to the doctor. Strategies to be taught are those that are assertive without being offensive. Patients who understand and can speak English should be encouraged to communicate with the doctor in English.

References

Anthonissen, C. (2010). "Managing linguistic diversity in a South African HIV/AIDS day clinic". In Meyer, B. and B. Apfelbaum (eds.). *Multilingualism at Work: from policies to practices in public, medical and business settings*. John Benjamins: Amsterdam. pp. 107-139

Coupland, N., Coupland, J., & Giles, H. (1991). *Language, society and the elderly: Discourse, identity, and ageing*, (Language in Society, 18.) Oxford: Blackwell. pp. xi + 220.

Drew, P., Chatwin, J. & Collins, S. (2001). Conversation analysis: a method for research into interactions between patients and health- care professionals. In: Tritter, J. (ed.) *Health Expectations*. vol. 4 (1): 58 -68

Eid, M., & Diener, E. (2001). Norms for experiencing emotions in different cultures: Inter- and intranational differences. Journal of Personality and Social Psychology, 81, 869-885.

Ellis, C. 2004. The ethnographic I: A methodological novel about autoethnography. Walnut Creek, CA: AltaMira Press.

Faerch, C.,& Kasper, G. (1983a). Plans and strategies in foreign language communication. In C. Faerch and G. Kasper (Eds.), Strategies in interlanguage communication (pp. 20-60). Harlow, England: Longman.

Fiscella, K., Roman-Diaz, M., Lue, B. H., Botelho, R., & Frankel, R. (1997). "Being a foreigner, I may be punished if I make a small mistake": Assessing transcultural experiences in caring for patients. *Family Practice, 14*(2), 112-116.

Gallois, C., & Giles, H. (1998). Accommodating mutual influence in intergroup encounters. In M.T. Palmer and G.A. Barnett (Eds.), *Mutual influence in interpersonal communication: Theory and research in cognition, affect and behavior (Progress in Communication Sciences, vol. 14,* series editor G.A. Barnett, pp. 130-162). New York: Ablex.

Gross, D.A., Zyzanski, S. J., Borawski, E. A., Cebul, R. D., & Stange, K. C. (1998). Patient satisfaction with time spent with their physician. *J Fam Pract.* 47(2):133-7.

Hutchby, I & Wooffitt, R. 2008. *Conversation analysis*. 2nd edition. Cambridge: Polity press.

Jain, P. & Krieger, J. L. (2011). *Moving beyond the language barrier: The communication strategies used by international medical graduates in*

intercultural medical encounters. Patient Education and Counseling 84 (1), 98-104

Labhardt, N.D., Schiess, K., Manga, E. & Langewitz, W. (2009). Provider-patient interaction in rural Cameroon –How it relates to the patient's understanding of diagnosis and prescribed drugs, the patient's concept of illness, and access to therapy. *Patient Education and counselling.*76 (2):196-201

Macdonald, E. (2004). "An introduction to basics" in Macdonald E (etd) *Difficult conversations in Medicine.* Oxford: Oxford University Press

Makoul, G, Curry, R. H. &Tang, P. C. (2001). The Use of Electronic Medical Records Communication Patterns in Outpatient Encounters. *J Am Med Inform Assoc;* 8:610-615

Mandla,V. M. (2009). Intercultural communication in three Eastern Cape HIV\ AIDS clinics Unpublished M.A. Thesis Rhodes University

Meryn, S. (1998). Improving doctor- patient communication: not an option, but a necessity. *British Medical Journal.* June 316 (7149):1922-1930

Milubi, N.A. (1998). The role of a language in the new South Africa: a quest for relevance. Unpublished Inaugural lecture, University of the North.

Mishler E. G. (1984). *The Discourse of Medicine: Dialectics of Medical Interviews*, Norwood, Greenwood Publishing Group.

Morrell, D. C., Evans, M. E., Morris, R. W. & Roland, M. O. (1986). The "five minute" consultation: effect of time constraint on clinical content and patient satisfaction. *Br Med J (Clin Res Ed)* 292(6524):870–873.

Naidoo, S. (2012). The South African national health scheme. *J Public Health 34* (1): 149-150

Puri, N., Gupta, A., Arun K. Aggarwal, A. K., and Kaushal, V. (2012). "Outpatient satisfaction and quality of health care in North Indian medical institute", *International Journal of Health Care Quality Assurance,* Vol. 25 (8): 682 – 697

Selinker, L. (1972). *Interlanguage.* IRAL; International Review of Applied Linguistics in Language Teaching, 10:3 p.209.

Arone, E. (1981). Some thoughts on the notion of communication strategy. *TESOL quarterly* 15: 285 -295

Wang, J.H., Adams, I.F., Pasick, R.J., Gomez, S.L., Allen, L., & Huang, E. (2013). Perceptions, expectations, and attitudes about communication with physicians among Chinese American and non-Hispanic white women with early stage breast cancer. *Support Care Cancer;* 21(12):3315-25.

Watson, B. & Gallois, C. (1998). Nurturing communication by health professionals toward patients: A communication accommodation theory approach. *Health Communication,* 10(4), 343-355.