AFRICAN LANGUAGE VARIETIES AT BARAGWANATH HOSPITAL: A SOCIOLINGUISTIC ANALYSIS

by

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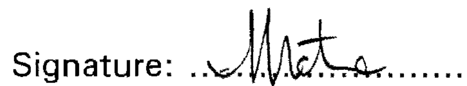
Declaration

I declare that AFRICAN LANGUAGE VARIETIES AT BARAGWANATH HOSPITAL: A SOCIOLINGUISTIC ANALYSIS is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

Signature: 

M C SAOHATSE

Date: 01/09/1997

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Summary

The initial purpose of this study was to describe and analyse the language situation at Baragwanath Hospital. This was seen as a microcosm of the language situation in urban South Africa. As such, this study set out to identify problems and offer suggestions in resolving the difficulties experienced in communication in this hospital as well as in other medical institutions in the rest of the country.

Before attempting such an investigation, a sound theoretical framework had to be established. In order to gain familiarity with the research field, concepts on sociolinguistics had to be researched and described. In order to apply particular concepts to the situation under investigation, the concepts had to be defined and interpreted first. This study has made a contribution to the theoretical debate regarding various sociolinguistic concepts, in that it has shown how these concepts apply to the South African situation.

The next step in the research process involved making a decision about which method would be most appropriate for collecting data. Therefore, various approaches were investigated in order to find the appropriate one. The techniques of data collection and the recruitment of respondents had to be refined before the main data collection process could begin.

Then began the journey of discovery. The detailed description of the language situation at Baragwanath Hospital presented in chapter 3 forms the crux of this study. This is the first time that such a comprehensive, qualitative description of the entire language situation in this hospital has been done.

An appropriate method for data analysis had to be devised. This entailed various levels of analysis and interpretation.

A description of the language situation at Baragwanath Hospital would have been incomplete without presenting a few of the various scenarios that took place in this hospital. Many important conclusions were reached during the course of the research. The most important of these were:

1. A huge communication problem exists at Baragwanath Hospital.

2. Either interpreters will have to be hired to overcome this problem; or nurses will have to be paid more for their interpreting services.

KEY TERMS:

Language varieties, Communication problems; Baragwanath staff-patient turnover; Language attitudes; Language interpreters; Promotion of indigenous languages; Language use in a speech community; Code switching; Doctor-patient relationship; Tsotsitaal and Iscamtho.

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CHAPTER 1

1. Introductory orientation

1.1 Research problem

Change is inevitable in society. It is, however, important to recognise that societies change in different ways and for different reasons. Differences lie in the culture, economic positions and the standard of education of the two or more societies that meet and intermingle. In South Africa, for example, since the abolition of the Influx Control Act, No. 68 of 1986, and the acceptance by government of an 'orderly' or 'positive' urbanisation strategy in April 1986 (Thomson and Coetzee, 1987: 48), there has been a significant increase in the mobility of black people within South Africa. Many people have moved from rural to urban areas in search of employment. Changes have often had economic and cultural consequences. The migration of people from farm to city over the past sixty years has in greater part been due to changing agricultural practices which have reduced the need for manual workers. The gold mines and industrialisation in the Gauteng area has attracted thousands of people. This migration in search of employment has increased the multilingual communication in urban societies in the country.

In South Africa, there are nine African languages among the eleven official languages. These were declared official in the Constitution (Act 200 of 1993), and in the New Constitution as adopted by the Constitutional Assembly on 8 May 1996. The nine African languages are: Sepedi, Sesotho, Setswana, isiXhosa, isiZulu, siSwati, Tshivenda,

Xitsonga and isiNdebele. For the purpose of this study they will be referred to as Northern Sotho, Southern Sotho, Tswana, Xhosa, Zulu, Swazi, Venda, Tsonga and Ndebele. The additional languages are English and Afrikaans.

All these languages, excluding Swati, are spoken at Baragwanath Hospital which is situated in the Johannesburg region. Baragwanath Hospital, "which is the largest hospital in the Southern hemisphere and one of the largest in the world, serves a community of approximately three million people," (Baragwanath Hospital year book 1995/1996: 5). The continuing influx of squatter populations, who also use the hospital, makes the population statistics only approximate.

During times of political violence in the area, Baragwanath's trauma unit is an accurate barometer of the situation because people from Soweto and Johannesburg who have suffered violent injuries, knife and bullet wounds, receive treatment from this hospital.

1.1.1 Reasons for the study

The researcher has been motivated by several factors.

Firstly, this hospital serves patients from the Gauteng area, as well as those from other Southern African countries such as Malawi, Zimbabwe, Mozambique, Botswana and Lesotho; a unique system of communication has arised from this situation. This huge hospital therefore, could be considered a microcosm of what is happening in the multilingual urban centres of South Africa.

Secondly, the researcher has been motivated by countless newspaper reports, describing unsatisfactory services rendered by hospitals. For example, patients dying because of the negligence of hospital staff members, or dying while waiting for doctors.

Thirdly, the researcher has been personally involved in a typical situation. She has had to take her father, who was very sick, to Baragwanath Hospital. The patient was examined by the doctor at the casualty department; he was then referred to ward 20 for a further examination before being admitted. The researcher was asked by the English-speaking doctor to interpret what her father and other patients nearby were saying, as the doctor could not understand any of the African languages. This was the first indication that there was a problem with communication between doctors and patients.

Fourthly, it was the researcher's concern to find out why the nurses were not helping English-speaking doctors with interpreting. It was important to find out whether nurses created boundaries for themselves between the services they felt they should render, and those they would rather not perform.

Fifthly, in medical settings such as Baragwanath Hospital, communication between patients and staff is crucial. The doctor and the patient should have clear communication with each other in order that the doctor would be able to ascertain a more accurate diagnosis. The accuracy of communication can be impeded when communicants are not familiar with one another's language. As a result, there is a need for a descriptive and analytic overview of the language situation in this hospital.

Lastly, as has already been stated, Baragwanath Hospital may be seen as a microcosm of the language situation in urban South Africa; this study may be of use in identifying and resolving some of the difficulties in communication not only in this hospital but also in the country at large.

1.1.2 The purpose of this research

The purpose of this study is to provide a qualitative as well as quantitative description of the language situation in the hospital. In providing this, it is important to identify the various languages spoken at the hospital as well as determining factors that contribute to the communication problems.

From the results of this research, suggestions may be made about which languages doctors and nurses, employed at Baragwanath Hospital, should acquire in order to be able to communicate more effectively with patients. Working on this hypothesis, a solution to some of the communication problems will lead to more accurate diagnoses, as well as better co-operation between patients and staff.

1.1.3 Objectives of this study

* To identify problems caused by the use of many languages at Baragwanath Hospital.
* To identify factors which contribute to this communication problem.
* To determine the causes of the communication problem in this hospital.

* To find solutions to this communication problem.

By identifying the problems, it is hoped that this research will possibly bring about a change in the attitude between patients and staff. To these ends, it is necessary to outline the existing situation and conditions at Baragwanath Hospital.

1.2 An outline of conditions at Baragwanath Hospital

1.2.1 Introduction

Baragwanath Hospital receives a brief description in this section. Certain departments in the hospital have been selected in this analysis in order to provide a broad picture of the hospital's organisational structure. They include the Paediatric Casualty, Operating Theatre, Orthopaedic Workshop and Maternity Hospital. Extensive research was undertaken in these departments and this will be discussed in more detail in chapters 3 and 4.

The hospital's geographical location and the population statistics, as well as its history are discussed in this chapter.

1.2.2 Geographical location

Baragwanath Hospital is situated to the south-west of Johannesburg on the southern border of Soweto, one of the largest townships in South Africa. To achieve a clear picture of the geographical location as well as the languages used at of this hospital, a brief description of

Soweto itself is necessary, because it is the community which is principally served by this hospital.

Soweto is a large multilingual community; one of the reasons for this is that it was structured according to the policy of ethnic division by the previous South African government. This created seeds of division. For instance, Dube Village was set aside for upper income earners (see Hellman, 1967:4). Naledi, Mapetla, Tladi, Moletsane and Phiri were reserved for the Sotho and Tswana-speaking people. On the other hand, Dlamini, Senaoane, Zola, Zondi, Jabulani, Mndeni and White City were areas specifically assigned to the Nguni-speakers, (that is, mainly Zulu and Xhosa-speaking people). Chiawelo was assigned to Shangaan and Venda-speaking people. (Hellman, 1967:4).

The ethnic composition of Orlando and Pimville consisted predominantly of Nguni-speakers. Dobsonville was initially a squatter camp, occupied by Tswana and Xhosa-speaking people as well as people who had moved or who had been removed from the inner city slums, such as from George Goch (Ntshangase, 1993:37).

Ntshangase (1993:38) says that when the Western Areas (a location of Johannesburg) was destroyed and its people relocated to Soweto, the result was the establishment of Diepkloof, Meadowlands, Rockville and Dube. The Native Resettlement Board (NRB) made it a point that Dube and Rockville were to be set aside as freehold townships. However some time later these freehold rights were withdrawn in favour of long leases, like the 30-year leasehold, which was later extended to the 99-year leasehold. Dube and Rockville locations were reserved for upper and middle income earners.

Professionals such as teachers, lawyers, doctors and nurses were among those who lived there.

People who were removed from Sophiatown and parts of Alexandra were relocated to Rockville, Diepkloof and Meadowlands. This great relocation took place because the so-called "black spots" adjacent to the white suburbs, west of Johannesburg were to be obliterated (Parnell, 1990; Lebelo, 1990).

By the late 1960s and the early 1970s, Soweto was a typical 'success story' of the apartheid policy which forced people to occupy specific sections of Soweto designated for specific ethnic groups. However, this did not last long. People began to mix across ethnic lines (Ntshangase 1993:39).

Even though inter-ethnic marriage and spontaneous social movement have dented the apartheid model, ethnic separation still affects most areas. Moreover there has been a massive informal movement into the Greater Soweto region with the formation of squatter camps as well as an influx, into the hostels. Ntshangase (1993:40) says the following:

> Hostels were set up as labour reservoirs for Johannesburg's capital.... These people, in the days of rife apartheid, could not qualify for the Section 10(1)(a), which gave an African the legal right to reside in Johannesburg, but could qualify to work in Johannesburg for specific periods so long as they would go back to the homelands after their contracts expired.

> Migrants in the hostels constitute totally different sections of the social geography of Soweto. These people have not been integrated, socially and geographically, into the urban culture.

The hostels are usually built on the outskirts of the township. They resemble prisons, with high walls and only one entrance.

The relevance of this information is that, because of these ethnic groupings as well as the nature of hostel accommodation, political clashes and violence in Soweto occur between township residents and hostel dwellers. People are injured and referred to Baragwanath Hospital for medical attention and treatment.

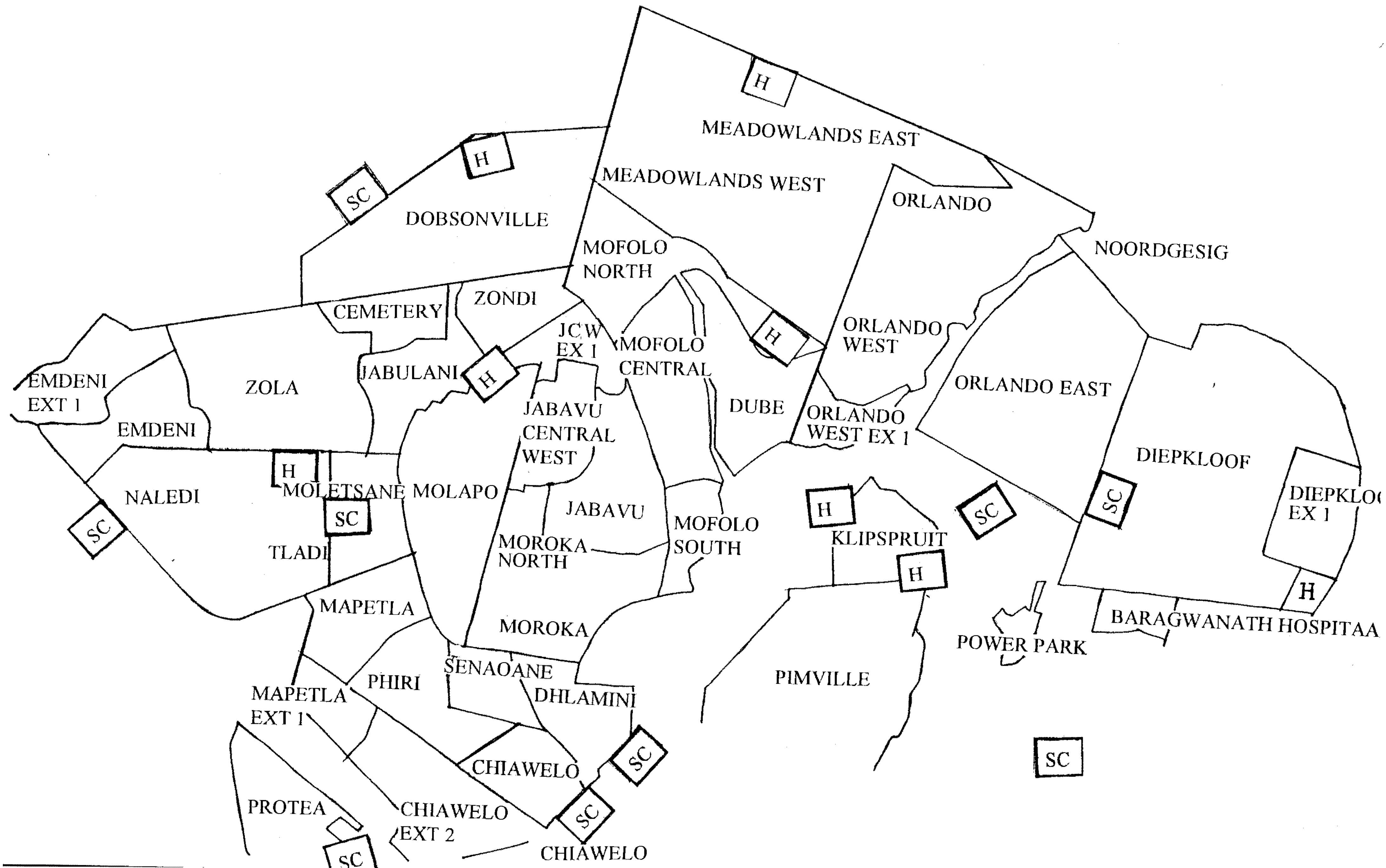
The squatter camps are mainly comprised of Xhosa-speaking people and the immigrants from the Frontline States: Mozambique and Zimbabwe. However, there are also people who were born in Soweto itself who reside in these squatter camps (Ntshangase 1993:41). Squatter camps were established because of:

1. the repealing of the Group Areas Act which provided an opportunity for the impoverished rural populace to come to the city where they could possibly find a better living;
2. the drought in the South African countryside;
3. the civil war in Mozambique and the drought both in Mozambique and Zimbabwe, and
4. the declining South African economy (Ntshangase 1993:41).

Unlike hostel dwellers, the populace of the squatter camps have been largely absorbed into the urban culture. This has happened because squatter camps are geographically integrated, rather than separated, from Soweto.

Figure 1.1 gives a geographical picture of Soweto and Baragwanath Hospital. Symbol "H" is used on the map to indicate hostels and "SC" to indicate squatter camps.

GREATER SOWETO



In Figure 1.1 the areas which are closest to the hospital: for instance Diepkloof and Orlando East are clearly demarcated. Baragwanath is built near the old Diepkloof location. Diepkloof Extension is now a new elite residential area occupied by upper income earners and professionals.

Table 1.1 below reflects: in the first column, the different areas in Soweto; in the second column, the languages spoken in these areas; in the third column, an indication of the relative incomes earned by the occupants; and in the fourth column, proximity of these areas to the hospital.

GREATER SOWETO

Table 1.1

AREA	**MAIN LANGUAGE**	**RELATIVE INCOMES**	**PROXIMITY TO THE HOSPITAL**
Diepkloof	Northern Sotho	Low income	0,2 km
Diepkloof Ext.	Nguni/Sotho Languages	Upper income	3 km
Orlando East	Nguni	Low income	4 km
Orlando West	Zulu	Low income	12 km
Orlando West Ext.	Nguni/Southern Sotho	Middle income	5 km
Pimville	Nguni/Southern Sotho	Low income	5 km

Pimville Selection Park	Nguni/Southern Sotho	Middle income	5 km
Meadowlands East	Tsonga/Venda	Low income	12 km
Meadowlands West	Tswana	Low income	15 km
Dube	Zulu	Middle income	13 km
Mofolo Central (Village)	Zulu	Low income	15 km
Mofolo North	Zulu	Low income	15 km
Mofolo South	Nguni/Sothern Sotho	Middle income	13 km
Jabavu Central West	Southern Sotho	Low income	14 km
Jabavu Central West Extension	Southern Sotho	Low income	14 km
Jabavu	Southern Sotho	Low income	14 km
Moroka	Southern Sotho	Low income	14 km
Moroka North	Northern Sotho	Low income	15 km
Dlamini	Nguni	Low income	14 km
Chiawelo	Tsonga/Venda	Low income	16 km
Senaoane	Zulu	Low income	16 km
Phiri	Southern Sotho Tswana	Low income	17 km

Molapo	Southern Sotho	Low income	16 km
Zondi	Nguni	Low income	17 km
Dobsonville	Tswana/Xhosa	Low income	20 km
Moletsane	Southern Sotho	Low income	21 km
Tladi	Southern Sotho	Low income	23 km
Naledi	Southern Sotho	Low income	24 km
Emdeni	Zulu	Low income	25 km
Zola	Zulu	Low income	23 km
Mapetla	Southern Sotho	Low income	20 km
Protea North	Nguni & Sotho Languages	Middle income	27 km

The table reflects 32 areas in Soweto. Column two indicates the languages spoken in different areas in Soweto (Dube, 1992:33). These languages are: Northern Sotho, Southern Sotho, Tswana, Zulu, Xhosa, Venda and Tsonga.

In column 3, table 1.1, the researcher used an approximate indication of incomes earned by patients who were interviewees. These were people from various parts of Soweto who provided information about their incomes (see appendix 2). An approximate earning of a total of R98 000 or above per annum could be considered an upper income bracket; approximately from R50 000-R25 000 per annum falls into the middle income bracket and approximately R24 000 or below per annum would be considered a lower income. These remain

approximate because of the fact that the people interviewed reflect only a small selection of Sowetans.

Column four shows the relative distance of these areas from Baragwanath Hospital. Diepkloof and Diepkloof Extension are the closest areas to the hospital; there are 18 areas more than 10km from the hospital; and there are 8 areas more than 20km from the hospital.

Conclusions drawn from the analysis of this table show that the majority of the residents of Soweto are low income earners, i.e. earning less than R24 000 a year. They probably cannot afford to go to private hospitals.

The relationship between low income and low educational level cannot be denied. Because of lower educational levels, it is also possible that many people from these areas have had limited exposure to languages such as English and Afrikaans. This will be discussed in chapters 3 and 5.

1.2.3 The patient population of Baragwanath Hospital

For the year 1994 to 1995, Baragwanath Hospital had 136 508 admissions, 1 211 591 outpatients, 18 632 births,4 391 deaths (Baragwanath Hospital year book 1994/1995: 106).

There are 12 Soweto Community Health Centres (SCHC) which are under the administration of the hospital. Patients who are critically ill are transferred from these SCHCs to the hospital itself.

This should give a clearer picture of the large population served by Baragwanath Hospital. Soweto Community Health Centres are listed in Table 1.2. The statistics for both the hospital and 12 SCHCs are represented by a total figure, as a comparison.

Table 1.2

STATISTICS FOR THE YEARS 1994/1995

PATIENTS	HOSPITAL NUMBERS	SCHC* NUMBERS
IN-PATIENTS		
GENERAL		
(MALE)	32 903	1 105
(FEMALE)	30 115	792
(PAEDIATRICS)	21 505	3 550
MATERNITY		
(MOTHER)	26 470	21 666
(BABIES)	18 632	11 358
PSYCHIATRY	6 881	
TOTAL	136 506	38 471
OUT-PATIENTS		
ORDINARY	294 951	728 219
ATTENDANCES	815 779	2 490 856
CASUALTY	100 861	-
TOTAL	1 211 591	3 219 075
BIRTHS	186 32	11 173
OPERATIONS	44 262	-

*SCHC : 12 SOWETO COMMUNITY HEALTH CENTRES

From table 1.2, there were 38 471 admissions for the years 1994/1995 to the SCHCs and over 135 000 to the hospital itself. Of course, some of the hospital admissions may have included the same people as at the SCHCs and who were later referred to the hospital for more treatment. Nevertheless the figures indicate a vast number of people moving through the corridors of this hospital situated in a growing part of South Africa.

1.2.4 The history of Baragwanath Hospital

Van den Heever (1991:1) states that soon after the discovery of gold on the Witwatersrand, John Albert Baragwanath arrived at the gold fields to make his fortune.

In the days when stage-coaches and ox-wagons were the chief modes of transport, Baragwanath started a refreshment post one day's journey from Johannesburg. At the point where the road to Kimberley joined the road to Vereeniging, there was good grazing and water. Soon he had established a small hostel, the Wayside Inn. However, to the drivers and stage-coach passengers it was 'Baragwanath's place' or just Baragwanath.

In 1939, the Union of South Africa went to war as part of the Commonwealth forces against Germany. Some South African troops left for Kenya in 1940 and were placed under Middle Eastern Command.

In the whole of British East Africa there was no medical infrastructure to serve the purpose of a military hospital. South Africa was therefore considered. Because of its size and centrality, the decision fell on Johannesburg. Here was a city with a medical school and well-established services. There was also an airport at the Baragwanath site which could be used for the air-evacuation of troops, and vacant state land adjoining the Diepkloof Reformatory that could be used for a hospital.

A hospital was built on an area of bare veld two miles from the airfield. The plan was to name this hospital the King George VI Military Hospital; but by the time the hospital was officially opened, it was already known to all as Baragwanath Hospital because of John Albert Baragwanath.

The opening ceremony of the new Baragwanath Hospital took place on 23 September 1942. Field Marshall Smuts, Prime Minister of South Africa, was the guest of honour; at the end of his speech, he made a statement that one day the war would end and this hospital would become an important civilian hospital for the people of Orlando and Pimville (Van Den Heever, 1991:1).

Over the next thirty years, the words of General Smuts came true. Baragwanath Hospital has grown in both size and status. Today it not only provides for Soweto, but also serves all parts of Gauteng, Lesotho, Botswana, Mozambique and Zimbabwe. As a civilian hospital, its main contribution has been towards improving the quality of the citizens' health and working conditions. Since 1948 doctors, graduating from the University of the Witwatersrand, have benefited significantly from the experience gained at Baragwanath. Over 200 nurses are trained here annually.

In order to indicate how Baragwanath Hospital grew in size and status, two examples will be discussed: the Operating Theatre and the Orthopaedic Workshop.

1.2.4.1 The operating theatres and the Orthopaedic Workshop

There are 27 operating theatres in the hospital complex. The main block - J D Allen Theatre Complex - has 17 operating theatres. The remaining 10 satellite theatres are: two, used for gynaecology, four for maternity, three for ophthalmology, and one casualty theatre (for minor cases). Furthermore, one theatre is now reserved for the treatment of burns and there is one neo-natal theatre.

The number of operations and related procedures per year is approximately 43 000. In the J D Allen Theatre alone, the average number of operations is 200 per theatre per month, with a total number of 74 doctors doing the operations. Approximately 70% of the cases are due to trauma: violent injury, gun shots, stabbings and motor vehicle accidents.

The Orthopaedic Workshop is responsible for the supply of all types of prostheses (artificial limbs), orthoses (orthopaedic appliances) and surgical footwear to serve approximately 15 000 patients per annum.

Opened in 1948 with a staff of three, the Orthopaedic Workshop is now one of the largest orthopaedic centres in the country, with a staff of 28. Together with the sub-centre at the Hillbrow Hospital, it provides a service to six outside hospitals, Cripple Care and other clinics in Greater Soweto.

This centre is the only training centre in this country, registered with the medical and dental council, specifically for black people. The first five students completed the Diploma Course in 1979 and are now registered prosthetists/orthoptists. Patients from neighbouring states are also treated at this orthopaedic centre.

1.2.4.2 The paediatric casualty section

A large number of sick children accompanied by their parents or relatives are treated in this section of Baragwanath Hospital. A brief description of the Paediatric Casualty Section is given, in order to illustrate the pressure experienced by the doctors and nurses in this hospital because of the large number of patients.

In this hospital, paediatric patients are those between the ages 0 - 12 years old for medical cases, and 0 - 9 years old for surgical cases. This Department is always full. Here, a diversity of languages is used.

Table 1.3 below shows the number of children admitted to the paediatric casualty for the month of July, 1996.

The table reflects: in the first column, the racial groups found in this section; the second column lists the actual number of out-patients; the third column gives the actual number of in-patients.

Children population in the paediatric casualty

Table 1.3

RACIAL GROUPS	OUT-PATIENTS	IN-PATIENTS
blacks	9 200	938
coloureds	25	14
indians	12	7
whites	6	4
TOTAL	**9 243**	**963**

The paediatric casualty section consists of a total number of 340 nurses and 77 doctors. In July 1996, the nurse: doctor: patient: ratio was 133:5:1.

Pettifor (1996 : 88) states the following:

> In the middle of 1994, our new Government of National Unity introduced free health care for all children under the age of six. This step was welcomed by many health care professionals involved in child health programmes. However, despite the elation over the decision, a number of practical problems associated with the change have been encountered. The new policy has also served to highlight how stretched child health services are in many areas. Many hospitals and clinics reported being flooded with patients and were unable to cope, while a number ran out of commonly prescribed medication.
>
> Attendance at our 24-hour Emergency and Out-patient sections rose by some 25% in the first couple of months after the implementation of the policy. Although those figures dropped a little in a few months.

Since implementation of the new policy stating that all children under the age of six should receive free health care, a number of problems have arisen.

Firstly, large numbers of children are being admitted to Baragwanath Hospital and other Government hospitals; this means that more doctors and nurses are required in order to improve services.

Secondly, because of the free medical care, large numbers of children are admitted. This has caused a shortage in the supplies of medicine; so far there are no funds to cover this shortfall.

Suggestions have been made in this study for the improvement of services in medical institutions; this may mean that the new policy implemented in 1994 by the Government of National Unity has to be revised. More doctors and nurses should be employed at Baragwanath Hospital and salaries for the hospital staff members should be increased. Because of the overload, many of the staff members are unable to deal with patients with the necessary time and care required. This will be discussed through the application of various scenarios in Chapter 3.

1.2.4.3 The maternity hospital and neo-natal intensive care unit

The maternity hospital and neo-natal intensive care unit are discussed in more detail in this chapter: a description of these units helps to illustrate the history of Baragwanath Hospital and the broad cross-section of various cultures and languages of the population it serves.

An integrated and comprehensive maternity service has been offered by the Baragwanath and Soweto Community Health Centres since January 1989. Baragwanath Hospital is a referral hospital for the 12 outlying community health clinics of which seven are delivery clinics as well.

Baragwanath maternity hospital was commissioned and completed in 1973. About 35 000 babies are born per year at Baragwanath and the clinics; 25% of all babies, and 33% of all black babies born in Gauteng, are born here.

The hospital has 371 maternity beds and 337 neo-natal beds of which 86 of the latter are for sick neo-nates and premature infants. The babies remain with their mothers unless they are ill. Mothers who have normal deliveries with no complications are sent home within 24 hours and placed in the care of a district midwifery service. The statistics for one month taken from the 1st June 1996 to 30 June 1996 indicate that 3 617 out-patients and 3 479 in-patients were admitted to the maternity department for that month.

Table 1.4: column 1 lists the language groups in the maternity section; column 2 indicates the total number of mothers admitted to that department for the month of June 1996.

Table 1.4 Patient population in the maternity hospital

LANGUAGE GROUP	TOTAL NUMBER ADMITTED
Tsonga	2 136
Zulu	1 540
Xhosa	1 020
Northern Sotho	909
Southern Sotho	754
Tswana	550
Venda	161
Coloureds	15
Indians	8
Whites	3
TOTAL	**7 096**

The figures indicate that Tsonga-speaking mothers are the highest number to be admitted to the maternity hospital, followed by those speaking Zulu, Xhosa, and Northern Sotho.

The reason for the high numbers of Tsonga-speaking mothers admitted could be the association between joblessness and the resultant high birth rate. From the research undertaken it appeared that the women from rural areas, especially the Tsongas, are particularly unskilled and very often without jobs. A different picture emerges when looking at other departments where Zulu-speaking patients predominate. The higher the educational level of a population, the lower the birthrate (Baragwanath Year Book 1994/1995) and conversely the lower the educational level the higher the birthrate.

These women look after their children at home while their husbands are working in the Gauteng area. Eighty percent of the total mothers interviewed (Table 1.4), are from the rural areas. Some of them reside in Soweto but still have homes in KwaZulu-Natal, Northern Cape, Eastern Cape, Northern Province. A small proportion of woman are from rural Mozambique and Zimbabwe.

From discussions with the researcher, it is clear that these women are not expected to use any contraceptives but are simply expected, by their husbands, to bear and look after children. This is despite the fact that there are local family planning clinics in their areas.

The picture given in the maternity department reflecting Tsonga speakers in the majority, differs from the picture we get from other departments, in that most other departments have more Zulu-speaking patients.

The staff members working in the maternity department comprise 51 doctors and 473 nurses, giving us the patient: nurse: doctor ratio of 139:9:1.

1.3 Summary of background study

From the information discussed so far, there is no doubt that Baragwanath Hospital is a complex entity with a high population density and high patient/nurse/doctor ratio.

In demonstrating this, lists of the patients admitted to the maternity wards (Table 1.4) as well as those admitted to the paediatric casualty department (Table 1.3) were given. From these, it was evident that many languages are involved in the day-to-day functioning of the hospital.

Baragwanath is the largest hospital on the African continent and one of the largest in the world; it has a high technological standard. It also serves many countries. For these reasons amongst others the researcher felt that the research should be conducted here.

1.4 Literature Review

It is necessary to review the literature on language contact, codeswitching and language attitudes that occur in a situation where a variety of languages are being used. Case studies conducted in other hospitals will also be discussed. This will help place the complex situation at Baragwanath Hospital into a context.

The term language variety as propounded in Hudson (1983:24) is "used to refer to different manifestations of the language". The linguistic items that

are used in each language variety make one variety different from another. This includes different repertoires, languages and dialects. Language varieties therefore include both standard and non-standard varieties of language.

Scholars such as Mfusi and Ntshangase, among others, carried out research in Soweto on various aspects of township languages. For instance, Mfusi's major point of emphasis was Soweto Zulu slang: A Sociolinguistic Study of an Urban Vernacular in Soweto (1990), while Ntshangase focuses on The Social History of Iscamtho (1993). These scholars' works focus on the non-standard language varieties that are gaining momentum in Soweto. The information from these studies is relevant to the researcher, as this has been conducted in Soweto itself. Notably, the study of Iscamtho is relevant, as some of the patients use it when communicating among themselves at Baragwanath Hospital.

1.4.1 Language Contact

Lieberson (1981) says that language contact between ethnic groups is a major source of linguistic diversity and that sociolinguistic consequences typically reflect the nature of the ethnic differences involved.

In his contributory volume of essays he argues that there is an inherent competition between languages in contact. Language contact is frequently accompanied by confrontation between people who speak different languages.

He points out that one of the aspects of racial and ethnic contact is the degree to which language sets groups apart from one another when mutual

intelligibility between the groups is low; language is a major force for the maintenance of ethnic divisions. On the other hand, where ethnic or racial groups share a common tongue, language provides a bridge between these two populations and an ethnic stepping stone towards the decline of other group differences.

He maintains that shared language is necessary in order that groups in contact assimilate and merge. However, mutually intelligible communication may result from language contact, when all language groups in contact are prepared to compromise. That is, different language speakers are prepared to learn and use languages other than their own in order to communicate.

Weinreich (1953) put forward his theory that a new language emerges, which he calls the third language; and he states that this language arises from bilingualism. This occurs as a result of what he calls the crystallisation of languages. He also discusses the psychological and cultural setting of a language contact situation. He elaborates on the mutual interference of languages that are in contact where he considers language contact as a facet of cultural diffusion and acculturation.

Weinreich (1953) concludes his work by recommending that every language should be exposed to the potential interference from its neighbouring languages. In studying this, the social setting of the language should not be left in the background. He further states that the study of language contact should include a variety of factors, such as the language structures as well as the socio-cultural factors.

1.4.2 Codeswitching

Codeswitching will be discussed in detail in chapter 4. Examples of conversations between patients and patients, patients and nurses, doctors and patients occurring at Baragwanath Hospital will be given.

Deliberations on language contact are incomplete without a mention of codeswitching. This sociolinguistic phenomenon occurs in speech when speakers switch from one language to another. Codeswitching is explained by different sociolinguists in different ways:

Eastman (1992:2) sees codeswitching as the use of an embedded language within the frame set of a matrix language. By matrix language, reference is made to the language in which the majority of morphemes in a given conversation occur. Sociolinguists like Gumperz (1972) and Hymes (1974) use the term codeswitching for bilingual and multilingual speakers. Two types of codeswitching are identified; situational and metaphorical.

Situational Codeswitching, as asserted by Downes (1984:62), predicts the variety a speaker may employ. It occurs when the languages used change according to the situation in which the conversants find themselves. They speak one language in one situation and another in a different situation. Downes (1984:62) gives an example of situational codeswitching in Hemnesberget where he states that speakers situationally codeswitch to the language called Bokmal when dealing with economic affairs, and codeswitch to the local language i.e. Ranamal, when dealing with local issues like church issues. Situational codeswitching takes place when a change in the topic causes a change in the code because the topic is normally associated with a particular situation.

Metaphorical Codeswitching on the other hand occurs when a change in topic requires a change in the language used.

1.4.3 Language attitudes

In the course of research, the researcher observed that there are different attitudes to different languages. Under the leadership of Hauptfleish, in the HSRC study, such questions of attitude arise. This showed that the study was relevant.

The HSRC (in 1977), conducted a study of the bilingual policy in South Africa in which the opinions of white adults in urban areas were sought. Attitudinal questions considered in this research ranged across a number of variables such as language identity (English or Afrikaans), sex, age, socio-economic status, bilinguality and the language milieu.

The following findings of this report indicate that at that time:

(a) There was a general feeling of satisfaction with the bilingual policy in South Africa, although the two language groups espouse different forms of bi- or multilingualism.

(b) Though both groups felt a definite need for a second language in the South African situation, the actual social spheres in which such needs are most strongly felt are not the same for the English speaking South African and the Afrikaner. The English speakers saw the need for bilingualism only as far as the administration of the country was concerned. For Afrikaans there was a need in all spheres, including the social aspect.

(c) The most influential variables have proven to be:

i) Socio-economic status (the higher the status, the greater the awareness of a need for the other language);

ii) bilinguality (the more bilingual a person, the greater his awareness of the role played by his second language); and

iii) language milieu (the more contact a person has with the second language, the more positive are his reactions towards that language. The milieu influence is strongly experienced as a child.

Schuring (1979) made a survey amongst urban and rural Blacks on their use of English and Afrikaans. His aim was to describe the situation as regards the use of English and Afrikaans in the Republic of South Africa. He based this on a few basic points:

(a) the ability to understand, speak, read and write the various languages;

(b) the different spheres in which the languages are used (family, neighbourhood, work, school, church, radio, among others);

(c) the attitudes towards the various languages and language groups;

(d) the biographical particulars of the informant:
sex, age, residence and so on.

The following points were the result:

1. Proficiency in English is relatively strongly focused on the reading and writing skills.

2. English is used more often than Afrikaans for reading and writing, whereas Afrikaans is used more often than English in communication with whites at work.

3. English seemed to be more favoured by the more qualified (Std 3 and higher), and the urban blacks. Afrikaans plays an important role among the lower qualified and the rural blacks, especially for contact with whites.

4. English is more popular as a medium of instruction at school and Afrikaans is more liked as a language subject at school.

In his conclusion he states that English is more prestigious, whereas Afrikaans has more of a pragmatic value for South African blacks between the ages of 15 and 54.

Young (1991) aims at establishing attitudes towards the status, role and function of English in the New South Africa; this could help language planners to formulate language policies in a post-apartheid South Africa. In his study, he attempts to bring to the attention of the authorities the need to formulate new language policies; these should not take the usual pattern of a top-down edict, as it may not reflect true public wishes, nor reflect the complex multilingual society of South Africa.

The research also aims to check whether English will become the national language or lingua franca, since most people interviewed believe that it could be the case. Young indicates that even if English is regarded as a

language that all South Africans need to know for communication, jobs, education, the economy etc, Afrikaans is also regarded as a language we cannot wish away.

1.4.4 Communication services in health care

The following studies conducted by other researchers in other health centres, highlight some of the communication problems which were also observed in Baragwanath Hospital.

Crawford (1995) conducted research in Cape Town hospitals, where the majority of patients were black Xhosa speakers and the majority of doctors white English speakers. The research involved interviewing doctors, nurses, (who often acted as interpreters), and patients in three township day hospitals and two inner-city academic hospitals.

Crawford (1995) discussed aspects of her research with her colleagues, which often gave rise to intense discussions about their own experiences. They share some of these in the following interview: (Crawford, 1995:9)

"Do you feel that the doctor wants to hear your account of the illness, how are you feeling and so on when you consult them?"

Sonia: With the hospital doctors there is never time to express myself or really talk, but my general practitioner lets me talk about how I am.

"If you ask doctors questions about the procedures or treatment how have you found their responses?"

Leila: Everytime I questioned something at the hospital I was seen as difficult. For example, a doctor gave my daughter an antibiotic which I know from previous experience makes her stomach burn. They seem to have no confidence in the mother's ability to know what medicine should be taken by the children.

"Do you feel you are treated with respect by your doctors or nurses?"

Sonia: Many out-patient clinics are structured in such a way that everyone can always hear everything. I once overhead a gynaecologist with an African woman - he was trying to establish how heavy her period was. She said three - and he was shouting at her, three pads or three packets of pads?

It was clearly a language problem but also one of race and gender. He got really aggressive with her for not answering his question the way he wanted.

In Crawford's research, one of the doctors indicated that if the patient does not speak English and the doctor does not speak Xhosa, the disaster is compounded. So at this point a third party is introduced to assist with communication; the interpreter, who is often a nurse, but may be a domestic worker or a family member. Further complexities and ambiguities creep in. The fact that serving as an interpreter is not compensated, produces a great deal of resentment among the nurses; they perceive, correctly, that they are forced into solving an enormous problem, for which the hospital has not taken responsibility. However, because the interpreting process itself, has

not been formally discussed, doctors get by in an *ad hoc* fashion; most doctors interviewed admitted that dealing with patients who spoke a different language was an enormous problem.

Crawford (1995) further observed that people generally go to doctors for reassurance, acceptance and understanding so that they can heal themselves; such a relationship could be termed therapeutic. It is now widely recognised that the way people perceive their illness has major implications in their subsequent healing. In other words, narrowly focusing on the disease only, rather than on the patient as a whole, may undermine the patient's ability to heal himself or herself. The patient's story is an indispensable guide to the doctor, yet medical discourse is carried out in such a way that it is difficult for a patient to be heard (Crawford, 1995:10).

However, intricate such communication usually is, it is nevertheless not as complex as at Baragwanath Hospital.

Bantlwana (1984) carried out a case study of relations and interactions between hospital staff and patients in Gaborone. He found that the staff failed to communicate with or guide patients in the out-patient department; health workers also showed no regard for patients waiting in the out-patients department. He observed that patients showed resentment and expressed displeasure about the way they were treated by health workers.

Owens and Kwadibe (1985), carried out a study conducted in Maun to assess the attitudes of women towards their hospital delivery; 62% of mothers who had had babies during 1983 had been delivered in hospitals, while 38% had been delivered at home. Many of the 38% preferred to have their babies at home, citing their inability to communicate with health personnel in hospitals as their reason for delivery at home. They stated that they feared and hated nurses and indicated that they received better care

and assistance from their mothers at home than they did from the health workers in hospitals.

Molefe and Kareng (1985) observed that in Masunga village in Botswana, the high attendance rate at the antenatal care clinic was not matched at the postnatal stage; during two observed periods in 1981, only 12% and 20% of the patients returned for postnatal care and family planning services.

They further observed that 60% of the delivered mothers stated that nurses did not stress the importance of postnatal care, making little effort to talk to them about postnatal care. None of the patients were visited at their homes during the postnatal period.

Mooka (1984), observed that women of childbearing age between 15 and 35 years, were not making full use of the maternal and child health services provided in their communities. Only 75% of the maternal and child health services were being fully utilised. Some 43% of the mothers stated that 'nurses had negative attitudes towards the patients'; 73,53% under-utilised maternal and child health services. It was further observed that many mothers did not attend postnatal care because they were neither properly informed about its availability, nor about its necessity. Nevertheless, these studies are different from the situation at Baragwanath in that the language mix is not as diverse as at Baragwanath Hospital.

A significant observation made during this study was the fact that a large number of mothers felt that the timing of postnatal care, which is six weeks after the date of delivery, conflicted with the traditional norms of the lying-in period; this stipulates that the mothers had to remain in their homes for at least three months after the delivery period (Mooka, 1984:22-27).

1.4.5 Other experiences at Baragwanath Hospital

Pantanowitz (1988) edited a collection of essays titled Modern Surgery in Africa: The Baragwanath Experience. It is a unique collection of essays written by doctors and scientists from Baragwanath Hospital.

Several noteworthy aspects of Soweto's disease patterns are examined by forty-five medical specialists. From this study it has emerged that diseases which occur with particular frequency are carcinoma of the oesophagus, non-biliary pancreatitis, etc.

Pantanowitz (1988) has made a significant contribution to medicine and medical decision-making in the Third World by sharing the findings in The Baragwanath Experience; these include the dramatic changes brought about by Westernisation and urbanisation. By recording the effect of these changes on health, and examining the trends of disease profiles, his work has signposted the road to the future.

Huddle and Dubb (1994) edited a collection of essays titled Baragwanath Hospital: 50 years A Medical Miscellany. The history is told by the current Chief Superintendent, Dr Chris van den Heever, in the opening chapter of this book. Huddle and Dubb present a composite picture of medicine as experienced in the changing society and have recorded some of the contributions made by Baragwanath staff members.

In many aspects, Huddle and Dubb (1994) regard Baragwanath Hospital as unique: its size (3000 beds); the variety and quantity of medical conditions seen; and in witnessing the transition of a population from a rural to an urban existence and moving from a simple to a more complex western way of life.

1.5 Deployment of Study

It is necessary to briefly describe the arrangement of the thesis. Chapter 2 deals with the theoretical background and the research methods used in this study. Many concepts relevant to this study are identified and defined in order to clarify issues as they apply to Baragwanath Hospital.

In Chapter 3, information about first language used by patients, doctors and nurses is presented. Three tables have been drawn up; the first indicating the languages spoken by patients; the second indicating the languages spoken by doctors and the third indicating the languages spoken by nurses. Scenarios that have occured in the hospital are also presented. The data was collected by means of interviews, questionnaires and informal observation by the researcher.

In Chapter 4 the general characterisation of language usage at Baragwanath Hospital is discussed. The functions of codeswitching, *tsotsitaal* and *iscamtho* are explained. The data which was obtained through recordings and personal observation are analysed by the researcher.

In Chapter 5, problems and attitudes towards language variations at Baragwanath Hospital are discussed and analysed. Full details from questionnaires, interviews and quotes are provided.

Chapter 6 is a summary of the findings of this study.

CHAPTER 2

2. Research Methodology and Definition of Concepts

2.1 Introduction

In this chapter the qualitative and the quantitative methods of investigation and data collection, as well as sociolinguistic concepts central to the issues to be investigated in the study are identified. These methods and concepts will be discussed and defined in order to obtain an understanding of these issues as they apply to the situation under investigation.

2.2 The choice of research methods

The term 'methodology' refers to the way in which we approach problems and seek answers. In the social sciences, the term applies to how one conducts research. Our assumptions, interests and purposes shape which methodology we choose (Taylor and Bogdan, 1984:1).

As already mentioned, the choice of one method of research over another depends mainly on the aims of the study, as well as the methodological preferences and research interests of the researcher. However, factors such as time, costs, and available manpower should be considered when choosing a particular method.

Miller and Crabtree (1992:6) distinguish three types of description: qualitative, quantitative and normative. Qualitative description, using qualitative methods, explores the meaning, variations and perceptual experiences of phenomena. Quantitative description, based on descriptive statistics, refers to the distribution, frequency, prevalence, incidence and size of one or more phenomena. Normative description seeks to establish the norms and values of phenomena. The choice of quantitative or qualitative methods depends on whether the norms of interest are numerical or textual.

Meulenberg-Buskens (1993) provides the following description of qualitative vs. quantitative research:

> To describe 'qualitative' in opposition to 'quantitative' briefly, one could say that in a qualitative approach the researcher tries to relate directly to the phenomena in reality, whereas in a quantitative approach the researcher tries to measure the degree in which certain aspects she /he assumes the phenomena consist of, are present in reality.

It was decided to use the qualitative research method for this study, based on five features of qualitative research as defined by Bogdan and Bilken (1982:29):

1. ***Qualitative research has the natural setting as direct source(s) of data and the researcher is the key instrument.***

Qualitative researchers feel that the only way to study human behaviour is through observation and face-to-face contact. Qualitative researchers believe that the setting has an effect on human behaviour and therefore, it is important for the researcher to be in that particular setting when conducting the research.

2. ***Qualitative research is descriptive.***

Qualitative researchers use questionnaires, interviews, a tape recorder and other methods to collect information. As they are searching for an understanding, qualitative researchers do not reduce the pages of information and other data to numerical symbols, but they analyse the data with all its richness and adhere closely to the form in which it was recorded.

3. ***Qualitative researchers are concerned with process rather than simply with outcomes or products.***

Qualitative researchers go in pursuit of an understanding of the way a speech community functions. They are, therefore, interested in attitudes and daily interactions.

4. ***Qualitative researchers tend to analyze their data inductively.***

Qualitative researchers connect small pieces of evidence to form a whole. That is, they construct a picture which takes shape as different parts are collected, examined and put together.

5. ***'Meaning' is of essential concern to the qualitative approach.***

Researchers who use this approach are interested in the way different people make sense out of their lives. In other words, qualitative researchers are concerned with what are called participant perspectives. Qualitative researchers focus on questions such as: What assumptions do people make about their lives? What do they take for granted? Such questions are essential to the style and content of the research conducted and the results yielded.

As the aim of this study is to identify language varieties and to describe the language situation at Baragwanath Hospital, both the qualitative and the quantitative approach seem relevant for the achievement of the goals of this study. Both methods allow for the opportunity to analyse the situation, as well as allowing the situation of the hospital to speak for itself. This is important especially because very little information is available on the language situation at Baragwanath Hospital. Both the qualitative and the quantitative methods can therefore be accepted as a basis from which this research can be done; this means that data would be collected by means of utilising interviews, personal observation, tapes and questionnaires as well as using statistical analysis.

Both methods were used in this study because of the following reasons:

1. Communication is hard to quantify. Therefore, the qualitative method was more suitable for describing certain aspects of the study.

2. Using interviews and questionnaires to find out language preference is easier because the interviewee is able to give reasons as to why she or he prefers to use a particular language.

3. Because of the personal nature of language, data and attitude problems at Baragwanath Hospital are not easy to quantify.

4. The quantitative method was found suitable for listing statistics at Baragwanath Hospital, (that is, giving the numbers of languages used in the hospital, the people using those languages and the distribution of doctors, nurses and patients in different departments).

2.3 Fieldwork

2.3.1 Introduction

Fieldwork has been conducted in this study. This 'involves an investigation, going to the place where the phenomenon occurs and typically studying it for an extended period of time' (Abrahamson, 1983:244). This makes it necessary to discuss the fieldwork experiences of other researchers, so that some of the issues, which pertain to the situation under investigation, are made clear.

According to Miller and Crabtree (1992:5), the style most suited to meeting the objectives of identification and qualitative description is the field research style. The field researcher is directly and personally engaged in an interpretive focus on the human sphere of activity; the goal is to generate holistic and realistic descriptions or explanations. The field is viewed through the qualitative filter used by the researcher. Field research is often called qualitative research. Field research has no prepackaged research designs. Instead, specific data collection methods, sampling procedures and analysis styles are used to create unique, question-specific designs that evolve throughout the research process.

One of the key strengths of field research is the comprehensiveness of perspective it gives the researcher. By going directly to the social phenomenon under study and observing it as completely as possible, you can develop a deeper and fuller understanding of it. The field researcher may recognise several nuances of attitude and behaviour that might escape researchers using other methods, and which can best be understood within their natural setting (Babbie, 1992:286). It was only through the use of field research that the attitudes and behaviour of the nurses at Baragwanath Hospital could be observed and identified.

Burgess (1984:31) contends that:

> Accounts by researchers have revealed that social research is not just a question of neat procedures, but a social process whereby interaction between researcher and researched will directly influence the

> course which a research programme takes (see the accounts in Hammond (1964), Shipman (1976), Bell and Newby (1977), Bell and Encil (1978), Shaffir, Stebbins and Turowetz (1980), Roberts (1981), and Burgess (1948a). Accordingly the project and the methodology are continually defined and redefined by the researcher and in some cases by those researched. In these terms, researchers constantly have to monitor the activities in which they are engaged.
>
> Nowhere is this more essential than in the conduct of field research, which is characterised by flexibility. Here, there are no set rules, rigid procedures and fixed roles. For field research predominantly involves the use of observation, participant observation, unstructured interviews and documentary evidence, all of which have to be applied to a specific social setting.

Burgess (1984:31) thus regards "the researcher, those who are researched and the setting in which the researcher works" as important for successful research.

2.3.2 The objectives of the fieldwork

In this study, the following goals have been set in order to describe the language situation at Baragwanath Hospital:

1. To identify all language varieties that occur at Baragwanath Hospital.
2. To describe each variety in different speech communities; that is, the variety used in conversations between:

i) doctors and doctors
ii) doctors and nurses
iii) doctors and patients
iv) nurses and nurses
v) nurses and patients
vi) nurses and visitors
vii) patients and visitors,

as well as the function of the particular language variety in every situation above.

3. To describe the attitudes towards each variety by the various speakers.

2.3.3 Selection procedure

The following selection procedure was used.
The out-patients department was chosen randomly by the researcher, who moved around different departments. Only patients who were not very sick, that is, those who were able to speak, were interviewed. The same procedure was followed when interviewing the in-patients.

In the case of doctors and nurses, all the doctors and nurses who were in their tea-rooms during the research period were given questionnaires to fill in. The information will be elaborated upon in section 2.4.

The total number of respondents was 1 298 consisting of 481 out-patients, 637 in-patients and 180 staff members. This is shown in Tables 2.1 and 2.2.

Selection table for patients

Table 2.1

DEPARTMENTS	NUMBER OF OUT-PATIENTS	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS	NUMBER OF IN-PATIENTS	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS
Surgical	7 989	160	2%	1 038	104	10%
Medical	5 989	180	3%	1 564	313	20%
Orthopaedic	1 303	130	10%	314	220	70%
ENT	10	6	60%			
Cardiology	20	5	25%			
TOTAL	15 311	481	100%	2 916	637	100%

As Baragwanath Hospital has a large number of in-patients, out-patients and staff members, it was not possible to interview every member in that hospital. Therefore, a representative sample was used.

Table 2.1 shows that of the 481 out-patients interviewed, 2% were from the Surgical Out-patient Department (SOPD); 3% were from the Medical Out-patient Department (MOPD); 60% from the Ear, Nose and Throat Department (ENT); 10% from the Orthopaedic Department and 25% from the Cardiac Clinic. As patients from different departments differ in numbers and in health conditions, it was not possible to interview equal percentages from each section of the hospital.

The 637 in-patients consist of: 20% from the Medical Department; 70% from the Orthopaedic Department and 10% from the Surgical Department.

Selection table for staff members

Table 2.2

STAFF MEMBERS	NUMBER OF RESPONDENTS	PERCENTAGE OF RESPONDENTS TOTAL
Doctors	80	44,4%
Nurses	100	55,6%
Total	180	100%

Table 2.2 indicates 180 staff members who answered the questionnaire, comprising 44,4% doctors and 55,6% nurses from

various departments. The percentage of nurses was higher than that of the doctors as the hospital has more nurses than doctors.

2.4 Data gathering techniques

In this study participant observation, questionnaires and interviews were used for collecting data. These techniques are crucial to the ultimate outcome.

Doctors and nurses were given questionnaires (see Appendix 1) to fill in; they could all read and write.

Both in-patients and out-patients as well as the visitors were interviewed; since many patients cannot read or write in English, they were interviewed in their home language rather than asked to fill in questionnaires. (See Appendix 2).

2.4.1 Interviews

Tuckman (1994 : 372) says that one direct way of finding out about a phenomenon is to interview people who are involved in it. Each person's answers will reflect his or her perceptions and interests. Because different people have different perspectives, a reasonably representative picture of the phenomenon's occurrence or of its absence, may emerge. This provides a basis for the interpretation of the phenomenon. The only possible way of finding out information from patients at Baragwanath Hospital regarding attitude and language problems in this hospital was through personal interviews.

Seliger and Shohamy (1989 : 166) say that:

> The purpose of the interview is to obtain information by actually talking to the subject. The interviewer asks questions and the subject responds either in a face-to-face situation or by telephone. Interviews are personalized and therefore permit a level of in-depth information-gathering, free response, and flexibility that cannot be obtained by other procedures. The interviewer can probe for information and obtain data that often have not been foreseen. Much of the information obtained during an open/unstructured interview is incidental and comes out as the interview proceeds.

The advantages of using unstructured interviews in this research can be summarised as follows:

* It allows the researcher the opportunity to let the interview develop in various situations, and to use relevant questions as the interview progresses. As the situation is new, it is difficult to predict specific questions that may be needed in order to elicit the necessary information.

* It does not limit the possibilities of the interviewee; as a response it may, in certain circumstances, pose the risk of wasting time on irrelevant information. However, there is a greater chance of satisfactory feedback.

* This provides the best way to evaluate the intentions and behaviour of others, since it allows face-to-face interaction and the potential for discussion (Schwartz and Jacobs, 1979 : 40).

The spontaneity of the interview situation is essential for the type of linguistic research conducted in this thesis. An interview (see Appendix 2) was found to be the most appropriate method for collecting information from patients and visitors in this setting. A great number of patients and visitors are unable to read or write, yet they can still answer questions in an oral interview.

It took eight months to conduct interviews: this consisted of five hours each day, six days a week, with a total number of 120 hours a month. The interviews covered a period of six months in 1995 and two months in 1996. The results from the years 1995 and 1996 were compared; this was done in order to find out if conditions were still the same in the former year. The average time taken for interviewing each patient was fifteen minutes.

2.4.1.1 Interview procedure

In order to cover the whole spectrum of language variation at Baragwanath Hospital, a sample of patients and visitors from each department in the hospital was interviewed. This was not an easy task, especially when dealing with people who were physically unwell. The exercise was further complicated by the transience of the Baragwanath population. For example, if there was a question about

a specific interview, the researcher could not always go back to the interviewee; either he or she had already left the hospital, or was too ill to talk to the researcher.

The first group of patients and visitors who were interviewed were out-patients from different casualty departments, the orthopaedic department, the surgical department, the medical department and the Paediatric Clinic.

The second group of patients interviewed were from the Admissions (in-patients). When interviewing them, the researcher moved from one ward to the next. In each ward the researcher interviewed patients, leaving out those who were critically ill and mentally sick, or those with mouth or throat injuries who could not speak.

In some cases the researcher would find patients sitting in groups and talking to each other. Then, the researcher would sit among the group and introduce herself, using Zulu.

Those who spoke Sotho (Northern Sotho, Southern Sotho and Tswana) normally answered in one of the Sotho languages and those speaking Nguni (Zulu and Xhosa) answered in Zulu.

The researcher interviewed the patients individually using the language of the patient (see Appendix 2 for a copy of the interview guidelines). They were asked questions such as: Where do you come from?; What is your home language?; Which other languages do you understand? and so on.

The patients were informed that the researcher wanted to know which language they felt comfortable with or which language they understood better when communicating with others. The question of encountering problems with communication was not mentioned, but was introduced by the patients themselves as the interview proceeded.

All in all, the interviewing of patients at Baragwanath Hospital proved to be very productive towards the overall objective. Patients were able to talk about their problems regarding communication; they had no one else they could tell or complain to, in order to change the situation.

2.4.2 Questionnaires

Abrahamson (1983:312) defines a questionnaire as 'a printed form that is handed out, or mailed to potential respondents. It is usually a self-contained form that provides respondents with all the information they will need in order to complete it.' At Baragwanath Hospital doctors and nurses had questionnaires delivered by the researcher, rather than mailed; as Babbie (1992:65) states that mailed questionnaires sometimes receive response rates as low as 10 percent, and 50 percent is considered 'adequate'.

Seliger and Shohamy (1989:172) state the following advantages regarding questionnaires:

a. They are self-administered and can be given to large groups of subjects at the same time. They are therefore less expensive to administer than other procedures such as interviews.

b. When anonymity is assured, subjects tend to share information of a sensitive nature more easily.

c. Since the same questionnaire is given to all subjects, the data is more uniform and standard.

d. Since questionnaires are usually given to all subjects of the research at exactly the same time, the data is more accurate.

In this study, doctors and nurses working at Baragwanath Hospital were given questionnaires to fill in while sitting in large groups during lunch time or tea time.

According to Cannel and Kahn (in Smith, 1975:171), the basic theme behind a good questionnaire or an interview schedule construction is based on the formulation of questions which give "maximum opportunity for complete and accurate communication of ideas between the researcher (or interviewer) and the respondent". Cannel and Kahn (1968) pointed out three components to this communication process: language, conceptual level of questions and frame of reference.

1. Language typically involves a compromise between formulating the content of information - getting a question or questions and searching for a shared researcher - respondent vocabulary with

which to express that question. Thus, the researcher must attempt to become aware of his or her subject's vocabulary, both its breadth and limitations.

2. Close to the problem of language is the problem of conceptual level of difficulty. That is, even if the respondent shares a certain common vocabulary with the researcher, he or she may not share the cognitive organisation necessary to answer the question.

3. Frame of reference refers to the fact that most words may be interpreted from different points of view or perspectives. Even a simple word like 'work' evokes different mental images in different persons.

All the questionnaires were in English. Even if the respondents' home language was not English, both doctors and nurses at Baragwanath Hospital are educated and could read and write English. No problems were encountered by the researcher; the procedure went smoothly, without doctors or nurses complaining about the terminology or of any possible ambiguity of questions. The researcher was also available to reply to any possible problem or confusion.

2.4.2.1 Questionnaire procedure

A sample of 80 doctors was chosen of whom 100% answered the questionnaires in their tea-room. This proceeded smoothly, as they were all willing to fill in the questionnaires.

The same procedure was followed with the nurses. Of 120 nurses approached, 40% answered the questionnaires in one group and 60% in another. Twenty nurses refused to answer the questionnaires, and did not give a reason.

2.5 Collecting information

Initially, a Sony dictaphone tape recorder was used to collect data from the interviews. The patients were informed beforehand that it might be difficult for the interviewer to remember all the information gathered, as there were many patients and they came from many different places. The individual response was generally positive towards the use of the tape recorder.

At first, the use of the tape recorder, had a negative effect on the patients' response since they responded in a more formal manner and the atmosphere changed. They seemed unable to communicate freely with the interviewer; their answers were brief and to the point.

After noting this effect, it was decided to use the tape recorder at a later stage in the interview rather than at the beginning. As a result, patients appeared to be more relaxed, and thus more information was forthcoming.

In order to increase the relaxed atmosphere, patients were asked only to answer the questions and not to give their names. The important facts were audio-taped later in the interview. In this way, it was not

necessary to take notes or to have to rely on memory to capture the data. This method enabled the researcher to record as much information as possible.

Another factor which made it impossible to record the whole conversation at one time was the background noise. This was particularly difficult in the Casualty Department, where children were crying and patients screaming with pain. Often research took place under very stressful circumstances.

2.6 Data analysis

The techniques used to analyse the data obtained during these interviews, proved crucial to the study's outcome. Data analysis refers to sifting, organising, summarising and synthesising the data so as to arrive at the results and conclusions of the researcher. Thus, the data analysis becomes the product of all the considerations involved in the design and planning of the research (Seliger and Shohamy, 1989 :201).

Seliger and Shohamy (1989:205) say that two main types of techniques may be identified in analysing qualitative data:

a) Deriving a set of categories for dealing with text segment from the text itself. This is an inductive procedure. Once the categories have been established, they are applied to the remainder of the data; this leads to the refinement of the categories and the discovery of new commonalities or patterns.

Thus, they serve as an ordering system for the data content. This type of research study is usually descriptive and exploratory in nature.

b) An ordering system of categories already exists at the beginning of the process and the research applies this system to the data. The system is derived either from the conceptual framework or from the specific research questions. These studies are more confirmatory and aim at some kind of explanation. The segments are selected and sorted according to the existing system. Then, in a second phase, the categories are investigated, for instance by cross-referencing, to see whether there are relationships that will assist in the understanding of the phenomenon under study.

In this thesis, data will be analysed in Chapters 3, 4 and 5. The kind of analysis used falls between the two mentioned above.

2.7 Definition of concepts

2.7.1 Introduction

As the primary aim of this study is to describe the language situation at Baragwanath Hospital, sociolinguistic concepts such as language contact, language variation, speech community and other aspects relevant to this study, will be discussed.

Van Wyk (1992:24) states that sociolinguistic concepts in general tend to be vague; that is, they are difficult to define conclusively and exhaustively. In fact, his opinion is that most sociolinguistic concepts have of necessity to be vague and imprecise, especially when compared with the rigorously defined concepts of theoretical linguistics. If we accept that sociolinguistics is the study of language in its social context, we are then faced with the fact that all social contexts in which languages function are the products of unique, and therefore, different sets of historical circumstances.

Consequently, no two languages can be expected to relate identically to their respective contexts. This implies that the spectrum of variation of sociolinguistic phenomena must be vast and that it must be difficult to define them precisely in each case. Although an attempt has been made to clarify the concepts discussed in the next section, Van Wyk's statement will remain true in this discussion.

2.7.2 Language varieties

Language varieties can simply be explained as different forms of a particular language or languages. Hudson (1980:24) says that the term 'variety of language' can be used to refer to different manifestations of that language, in just the same way as one might take 'music' as a general phenomenon and then distinguish different 'varieties of music'. One variety of language is different from the other because of the linguistic items that it includes. Because of this fact, Hudson (1980:24) defines a variety of language as 'a set of linguistic items with similar distribution'. A variety can therefore be

something greater than a single language. It could also be something less than a single language or even less than a speech form traditionally referred to as a dialect.

Ryan and Giles (1982:1) contend that "language variation within and between speech communities can involve different languages or only contrasting styles of one language. In every society the differential power of particular social groups is reflected in language variation and in attitude towards those variations."

Ferguson (1971) offers another definition of a language variety (in Wardhaugh 1986:22) which is, "any body of human speech patterns which is sufficiently homogeneous to be analysed by available techniques of synchronic description and which has a sufficiently large repertoire of elements and their arrangements of processes with broad enough semantic scope to function in all formal contexts of communication."

Ferguson further states that such definitions are comprehensive in that they allow us to call a whole language a variety and also any special set of linguistic usages that we associate with a particular region or social group. The term 'varieties of language' in relation to the hospital situation, refers to different languages spoken by patients, staff and visitors within the hospital itself. These language varieties will be discussed in detail in Chapter 3 of this thesis.

2.7.3 Language contact and variation

2.7.3.1 Introduction

In many situations in South Africa, one needs to know more than a single language in order to communicate. This is especially true in the black community in urban areas where several language groups may live and work together. The same situation applies at Baragwanath Hospital where a variety of languages is used. In order for communication to take place, staff members as well as patients, are forced to use languages other than their own.

Lehiste (1988:1) states that "in order for communication to take place, speakers must arrive at a certain degree of comprehension of the other language and must acquire a degree of facility in producing utterances that will be comprehensible". At times, some speakers will be able to alternate between languages; that is, they will have become bilingual. The same norms apply to multilingualism, the practice of using alternately two or more languages.

The discussion on language contact and variation includes the discussion of speech communities, since all speakers whether multilingual or bilingual belong to at least one speech community. This means a community whose members share at least a single speech variety and norms for its appropriate use.

2.7.3.2 Speech community

A description of the language variation at Baragwanath Hospital must take the Baragwanath community as its basic unit of analysis. The first concept we therefore need to define is 'speech community'.

Charles Hockett (1958, in Hudson, 1980:26) defines a speech community as "the whole set of people who communicate with each other, either directly or indirectly, via the common language".

In later research, Gumperz (1972a:16) explains:

> Members of the same speech community need not all speak the same language nor use the same linguistic forms on similar occasions. All that is required is that there be at least one language in common and that rules governing basic communicative strategies be shared so that speakers can decode the social meanings carried by alternative modes of communication.

Labov (in Hudson, 1980:27) states that "the speech community is not defined by any marked agreement in the use of language elements, so much as by participation in a set of shared norms". This view is supported by Gumperz (in Hudson, 1980:26) who defines a speech community as:

> Any human aggregate characterised by regular and frequent interaction by means of a shared body of verbal signs and set off from similar aggregates by significant differences in language use.

These definitions and the discussion directly preceding it imply that a speech community may feature more than one language and that a speech community cannot be defined as a group of people only sharing a common variety of language. Norms and values must inevitably be shared by the community as well.

Le Page (1968a, in Hudson, 1980:27) brings to the fore an approach which may avoid the term 'speech community' altogether, but refers to groups in society which have distinctive speech characteristics as well as other social characteristics.

> Each individual creates the systems for his verbal behaviour so that they shall resemble those of the group or groups with which from time to time he may wish to be identified, to the extent that:
>
> a. he can identify the groups,
> b. he has both opportunity and ability to observe and analyse their behavioural systems,
> c. his motivation is sufficiently strong to impel him to choose, and to adapt his behaviour accordingly,
> d. he is still able to adapt his behaviour.

Le Page's definition implies that individuals locate themselves in a multi-dimensional space; these dimensions are defined by the groups which they can identify in their society.

Bolinger (1975, in Hudson, 1980:28) supports this view in his dispute that:

> There is no limit to the ways in which human beings league themselves together for self identification, security, gain, amusement, worship, or any of the other purposes that are held in common, consequently there is no limit to the number and variety of speech communities that are to be found in society.

According to this view, any population may be expected to contain a great number of speech communities indeed, with overlapping membership and overlapping language systems (Bolinger (1975 in Hudson, 1980:28). It must be highlighted, though, that a speech community cannot be regarded as a fixed unit.

From the definitions given above, it is clear that there are several ways of describing a speech community. The data collected for this study indicate that various smaller groups (or speech communities) such as doctors, nurses and patients, who belong to different groups, can be defined within a larger speech community such as the Baragwanath Hospital speech community.

It would seem therefore, that Gumperz's (1968) definition of a speech community (in Hudson, 1980:26) as "any human aggregate characterised by a regular and frequent interaction by means of a shared body of verbal signs and set off from a similar aggregate by significant differences in language use" best describes the situation observed in the hospital studied in this thesis. This will be elaborated on in Chapters 3 and 4.

2.7.3.3 Bilingualism and Multilingualism

The concept of 'multilingualism' is central to the discussion of the language situation at Baragwanath Hospital. This hospital is characterised by the occurrence of various linguistic varieties. The high level of co-occurrence of language varieties within the hospital implies that there is contact between speakers of the various linguistic varieties. This contact situation may result in various language contact phenomena such as the use of a 'mixed language' to form a common medium of communication.

Van Wyk (1978:29) states that multilingualism is a reality which no South African can escape. Monolingualism is rare in South Africa and is confined mostly to underdeveloped areas with homogeneous communities. The impact of the linguistic situation on education, administration, official policy, politics, as well as on every aspect of day-to-day life is felt by everyone. Evidence of this diversity of language is found in the census data of 1991 (Schuring 1993:11) which clearly indicates that South Africa is indeed a multilingual society.

Schuring (1993:11) calculates the statistics for the total South African population. In 1991, the total population of South Africa could be divided according to their home languages thus: Afrikaans was 15,43%, and the combined African languages was of 73,98%. The other 1,33% of the population were speakers of European languages such as Portuguese, German, Spanish, Greek, Polish, Italian, Czech, Dutch, French, as well as Japanese, Asian languages such as Gujerati, Hindi, Tamil, Urdu, Telegu, Chinese; and other languages such as Hebrew, Arabic, Bemba, Chichewa, Herero, Shona, Wambo and !Kung.

Schuring's (1993:1) statistics on home languages spoken by different African communities reveal that in 1991, 22,49% of the total South African population spoke Zulu as a home language; 17,16% Xhosa; 2,61% Swati; 0,94% Southern Ndebele; 0,58% Northern Ndebele; 9,77% Northern Sotho; 6,84% Southern Sotho; 7,59% Tswana; 4,31% Tsonga and 1,69% Venda.

The Gauteng area features a conglomeration of various languages, providing a fertile breeding ground for language contact phenomena. The most complex situation according to Van Wyk (1978 : 36), occurs in Johannesburg, which is the largest city in South Africa and also the most industrialised, as well as being the centre of the mining industry. A unique pattern emerges here, where representatives of all the linguistic communities in the country are drawn together. This is perhaps the only place in South Africa where all the indigenous languages are spoken and where these come into contact with a variety of foreign and Asian languages. Therefore, for many of the people living in this area, multilingualism is a way of life.

Mackey (1968:555) defines bilingualism as "the alternative use of two or more languages or language varieties by the same individual". On the other hand, Weinreich (1963, in Bokamba 1988:24) characterised the ideal bilingual speaker as "a person who switches from one language to another according to appropriate changes in the speech situation (interlocutors, topic and so on); however, this would not include an unchanged speech situation, and certainly not within a single sentence." What Weinreich is referring to here is the general phenomenon of embedding within the same speech event, utterances, i.e., words, phrases and sentences, from two distinct grammatical systems or subsystems.

The concepts 'multilingualism' and 'bilingualism' are therefore relevant to this study. Baragwanath Hospital is situated in Johannesburg, serving a population with a great diversity of languages. Doctors come from all over the world to work in this hospital. They in turn come into contact with patients speaking a variety of languages; therefore a dynamic multilingual speech community exists.

2.8 Language use in a speech community

The very nature of the situation at Baragwanath Hospital where sick people are there to be cured, has demanded that the doctor and patient should understand one another. Without doctors being able to understand patients and without patients being able to understand doctors, the process of healing is often impeded. Scenarios are

discussed in Chapter 3 to give evidence that language plays a very important role in this hospital.

Ryan and Giles (1982:148) say that speech is clearly of paramount importance in medical, legal and occupational settings. Doctors attempting a diagnosis engage in a dialogue with patients as well as using a physical examination. Clients talk to lawyers to convey their problems. Prosecuting and defence attorneys examine and cross-examine witnesses through questions and answers. Speech features prominently in the presentation of evidence, in a judge's instruction to juries and in jury deliberations. In all these settings, the explicit premise for communication is objectivity and the pursuit of truth.

2.8.1 The effect of language contact

2.8.1.1 Introduction

Language contact phenomena such as codeswitching, lingua franca, *tsotsitaal, iscamtho* and the associated language attitudes have emanated due to the language contact situation at Baragwanath Hospital. Interactions on a day-to-day basis between people of different backgrounds, age and ethnic groups have initiated linguistic improvisation and adaptations to deal with the situation.

Codeswitching, *tsotsitaal* and *iscamtho* will be discussed in Chapter 4.

2.8.1.2 Lingua franca

As mentioned in 1.1.2, doctors, nurses, patients and visitors who come into contact with one another at Baragwanath Hospital, must arrive at a common medium of communication in order to facilitate an accurate diagnosis in order to help patients. It is, therefore, appropriate that a 'lingua franca' be chosen as a medium of communication in this hospital.

Samarin (1968:55) defines a lingua franca as "a language which is used habitually by people whose mother-tongues are different, in order to facilitate communication between them."

The term 'lingua franca' originated from the linguistic diversity (i.e. multilingualism) faced by the Crusaders when they descended upon the Muslims on the eastern shores of the Mediterranean. The Crusaders had come from many parts of Western Europe, and therefore spoke native languages (vernaculars) which were mutually unintelligible. Their need for a language which could be understood by all was found in the language of Provencal, spoken along the southern shores of Europe, between Marseilles and Genoa.

This language became the base of a language used by the Crusaders along the length of the Mediterranean. The 'French language' (literarily 'lingua franca', though it was probably only a particular dialect), thus came to be used among the Crusaders and with the non-French speaking peoples who had learned this language (Samarin, 1962:54).

Although the use of this particular form of French eventually died out, it left behind its own name as its heritage for languages which are used in a similar fashion. Languages which are commonly used by people whose native languages are different are therefore referred to as 'lingua francas' today.

Samarin (1962:56) mentions the following:

> Since a lingua franca is simply a language used to communicate across linguistic barriers, it can itself be any kind of a language; **natural, pidginised, creole,** or **artificial**. By natural language is meant any language acquired by the normal processes of enculteration. Natural languages are thus the **mother** or **native** languages of some people. When a natural language is acquired as the **second language** of different people, it becomes their lingua franca. In the process of becoming a lingua franca, a language often loses some of its vocabulary or is simplified in its phonology or grammar.

Doctors and black nurses at Baragwanath Hospital speak English when communicating with one another. Doctors also use English when communicating with patients who understand the language or when the nurse is acting as an interpreter.

Certain language varieties used by doctors when communicating with patients at Baragwanath Hospital function as lingua francas in various situations. For example, English is used as a lingua franca between English doctors and black nurses. During the absence of the nurses, this is even more true because the patients try to use some of the English words they know, to communicate with the doctors; doctors

in turn also try to use some of the African language terms or basic Zulu they know to communicate with patients.

2.8.1.3 Diglossia

Language contact situations may also lead to the situation of diglossia. When two languages or two varieties of the same language are used in a stable manner by all members of the same community for different functions, a diglossic relationship develops between them.

The term 'diglossia' was introduced by Ferguson (cf. Fishman, 1972:91). Initially it was used in connection with a society that recognises two (or more) languages or varieties for intra-societal communication. The use of several separate codes within a single society is dependent on each code serving functions distinct from those considered appropriate for the other codes. This separation was most often along the lines of a H(igh) language, on the one hand, used in conjunction with religion, education, and other aspects of high culture, and a L(ow) language, on the other hand, used in conjunction with everyday pursuits of health, home, and in the lower spheres of work. Ferguson spoke of H as 'Superposed' because it is normally learned later and in a more formal setting than L, and is thereby super-imposed on it.

Hudson (1980:54) says a diglossic situation is found in societies where there are two distinct varieties of the same language, and one is used only on formal and public occasions while the other is used by everybody under normal, everyday circumstances.

Ferguson (1959:245) proposes the following definition of diglossia:

> Diglossia is a relatively stable language situation in which, in addition to the primary dialects of the language (which may include a standard or regional standards), there is a very divergent, highly codified (often grammatically more complex) superposed variety, the vehicle of a large and respected body of written literature, either of an earlier period or in another speech community, which is learned largely by formal education and is used for most written and formal spoken purposes but is not used by any sector of the community for ordinary conversation.

Van Wyk (1978:47) has distinguished two current situations in South Africa which may be termed diglossic. One is the use, in an informal context, of a typical variety or dialect of Afrikaans by Coloured speakers in the Cape Province. The other situation is found "in black communities in bigger urban areas, where 'urban dialects' seem to be coming into existence. These differ appreciably from the Bantu languages used in traditional areas and also in formal situations in urban areas. Again, the uses of these dialects have not been investigated well enough to decide whether the situation represents a case of diglossia, of emerging dialects or of a widening of the stylistic spectra of the relevant languages" (Van Wyk, 1978:47).

It would seem therefore, that Hudson's (1980:54) definition of a diglossic situation as found in societies where there are two distinct varieties of the same language (one formal and the other 'everyday), best describes the situation observed at Baragwanath Hospital among the nurses, where two languages are being used. English (the H variety) is used for formal purposes by nurses when communicating

with doctors and a variety (the L) of African languages used by nurses when communicating with patients or friends.

2.8.1.4 Language Attitudes

The very nature of the situation at Baragwanath Hospital has demanded a discussion on language attitudes in this study. Scenarios such as where the difficulties occur between patient and doctor in the course of their communication, or when some nurses are unwilling to help with interpreting, will be given in Chapter 3 to give a clearer picture of the situation.

Language attitude as an explanatory concept for social stratification through language variation was first developed by social psychologists, as discussed by Ntshangase (1993:104). Initially, social psychologists were not necessarily concerned with language attitudes as much as with attitudes in general. Through the development of research into attitudes by social psychologists, other social scientists have studied language attitudes.

According to Ntshangase (1993:105), language attitudes exist in every society. There are varieties, even of the same language, across class, gender, region, etc. Secondly, any research on language attitudes must tell us not only about the nature of the language being studied, but also about the nature of the community using that particular language or variety.

There are two views on language attitude studies. The first one is the *mentalist view,* which views attitudes as a state of readiness; and an intervening variable between a stimulus affecting a person and that of a person's response. In this view, a person's attitude prepares him or her to react to a given stimulus in one way rather than in another. Thus, language is a stimulus and the person's attitude is a response (Fasold, 1984:147).

The other view is the *behaviourist view* where "attitudes are to be found simply in the responses people make to social situations" (Fasold, 1984:147). In this view, language attitudes are as a result of behavioural patterns determined by a social context. The difference between the *mentalist view* and the *behaviourist view* is that the former's concern is with the response of an individual and the latter is with the response of a collective.

The study under investigation looks at the mentalist view as well as the behaviourist view, as both apply to the situation at Baragwanath Hospital. An explanation of the mentalist view by Fasold (1984:147):

> a person's attitude prepares her to react to a given stimulus in one way rather than in another. Thus the language is a stimulus and a person's attitude is a response.

This best describes the situation at Baragwanath Hospital where language attitudes have .been observed in this hospital, especially among the nurses; in certain instances, a nurse may not be willing to help a patient because the patient speaks a different language from the nurse.

Fasold (1984:47) adds that language attitudes arise as a result of behavioural patterns determined by social contexts. Some of the nurses at Baragwanath Hospital may react in a negative way when communicating with doctors or patients because of the work pressure they experience. More information on language attitudes and the effect of language attitudes will be discussed in Chapter 5.

2.9 Summary

In this chapter, both the qualitative and the quantitative research methods have been discussed. Both were found to be suitable for this study. The selection procedure as well as data collection procedures through interview, questionnaires and a tape recorder were discussed and explained.

Sociolinguistic concepts such as language varieties, speech community, bilingualism and multilingualism, were defined and explained. It is necessary to have a common understanding of these terms because they apply to the situation under investigation.

Language contact phenomena, such as the use of a lingua franca by patients and staff members at Baragwanath Hospital, were also explained.

Therefore, having briefly explained the theoretical background of the study, it is now necessary to analyse the language situation at Baragwanath Hospital in greater detail.

CHAPTER 3

3. Home languages and knowledge of other languages

3.1 Introduction

This chapter presents a sociolinguistic perspective on the critical understanding of the language situation at Baragwanath Hospital. The data in this study have been collected by means of questionnaires and interviews as described in the previous chapter. Subjectivity in interpreting the data is unavoidable. Nevertheless, as far as possible it was avoided.

Six scenarios will be given in order to present more vividly the data collected at Baragwanath Hospital. These are written descriptions of what happens at this Hospital.

3.2 The language situation at Baragwanath Hospital

From questionnaires and interviews conducted at Baragwanath Hospital a list of languages has been compiled. This shows that the following languages are spoken: Zulu, Tswana, Southern Sotho, Venda, Northern Sotho, Tsonga, Ndebele, Xhosa, Afrikaans and English.

With the exception of English and Afrikaans, all these languages fall into the African languages groups. While their genetic affiliations are

very obvious, their degree of relationship varies considerably. Most fall into either the Sotho or Nguni groups; within these groups, there is a fair degree of mutual intelligibility. Notable exceptions are Tsonga and Venda, which are outside either group. Guthrie (1971) classifies the Sotho group as S.30, Nguni as S.40, Venda and Tsonga were distinct, being classified as S.20 and S.50 respectively.

Various reasons have been given for the multitude of languages which are spoken at the Hospital. The main cause for this phenomenon is that the hospital also serves patients, as already stated, from areas such as the Eastern Cape, Northern Cape, KwaZulu-Natal, Free State and North West, as well as countries such as Botswana, Lesotho, Mozambique and Zimbabwe.

Patients who are from KwaZulu-Natal, the Eastern Cape, Northern Cape, Lesotho, Mozambique and Zimbabwe now reside in squatter camps such as Phola-park, Orange-farm, Chicken-farm, Snake-park and Kliptown in Soweto. These people, from various ethnic backgrounds, moved to the Gauteng area in search of jobs.

Other patients from different areas come to Baragwanath Hospital as referrals from other hospitals and from private doctors.

There is another factor which complicates the language situation at Baragwanath Hospital. From the total of 80 doctors who answered the questionnaires, 35 doctors are foreigners from countries such as the Netherlands, Australia, Zimbabwe, Belgium, Zaire, Portugal,

Germany and India. Their home languages vary and among others are Dutch, Greek, Italian, Portuguese, German, Hindi, Gujerati; they use English for communication purposes in the hospital.

The nurses are mostly South African citizens, all of whom are black, and who speak different African languages including: Zulu, Xhosa, Southern Sotho, Northern Sotho, Tswana, Venda and Tsonga.

Three tables are given below, which should clearly show the variety of languages spoken at Baragwanath Hospital. Table 3.1 indicates the languages used during interviews by patients; it also shows the percentage of the patients who come from different areas. As more than 70% of the patients served by this hospital are South African citizens, their residential area is given.

Table 3.2 shows the languages spoken by doctors: that is, their home language, the language they use for communication and their citizenship. Table 3.3 indicates the languages spoken by nurses: that is, their home language, the language they use for communication and their citizenship.

3.2.1 Languages used by patients

The total number of people interviewed was 1 118. Of the total, 447 gave Zulu as their first language, 224 gave Southern Sotho, 212 gave Tswana, 134 gave Xhosa, 34 gave Tsonga, 22 gave Northern Sotho,

11 gave Afrikaans, 11 gave English, 11 gave *tsotsitaal*, 6 gave Venda and 6 gave Ndebele as their first languages. These numbers are converted into percentages of the total, 1 118.

The table reflects: in the first column the first language of the interviewees; the second column indicates the actual numbers; the third gives the percentage of the total number of respondents; the fourth column shows where the respondents reside.

PATIENTS - FIRST LANGUAGES AND RESIDENTIAL AREA

Table 3.1

LANGUAGE	ACTUAL NUMBERS	APPROXIMATE PERCENTAGE	RESIDENTIAL AREA OR COUNTRY
AFRIKAANS	11	1%	ELDORADOPARK KLIPTOWN WESTONARIA CORONATIONVILLE
ENGLISH	11	1%	LENASIA ELDORADOPARK Foreign countries, e.g. ZAIRE ZIMBABWE Mozambique
TSOTSITAAL	11	1%	SOWETO NATALSPRUIT

LANGUAGE	ACTUAL NUMBERS	APPROXIMATE PERCENTAGE	RESIDENTIAL AREA OR COUNTRY
XHOSA	134	12%	SOWETO LAWLEY KLIPTOWN THOKOZA PHOLA-PARK EASTERN CAPE
ZULU	447	40%	SOWETO SNAKE-PARK CHICKEN-FARM ORANGE-FARM NATALSPRUIT THOKOZA EVATON SPRINGS SEBOKENG DAVEYTON WESTONARIA ALEXANDRA STANDARTON KWAZULU-NATAL NQUTU
S.SOTHO	224	20%	ORANGE-FARM EVATON SEBOKENG SOWETO DE-DEUR PARYS KLIPTOWN POTCHEFSTROOM LESOTHO

LANGUAGE	ACTUAL NUMBERS	APPROXIMATE PERCENTAGE	RESIDENTIAL AREA OR COUNTRY
TSWANA	212	19%	BEKKERSDAL ORANGE-FARM SOWETO CARLTONVILLE KAGISO WOLMARANSSTAD RUSTENBURG POTCHEFSTROOM BOTSWANA
TSONGA	34	3%	SOWETO GIYANI
VENDA	6	0.5%	SOWETO VENDA
NDEBELE	6	0.5%	KWANDEBELE
N.SOTHO	22	2%	SOWETO LEBOWA BUSHBUCKRIDGE

Table 3.1 and figure 3.1 (in the form of a histogram), indicate that the majority of patients speak an Nguni language: Zulu (40%), Xhosa (12%) and Ndebele (0,5%). Following this in the Sotho group; Southern Sotho (20%), Tswana (19%) and North Sotho (2%). Afrikaans, which is spoken by Coloureds, (1%). English spoken by foreigners, Indians, Coloureds and Whites (1%). Tsonga (3%). Venda (0,5%) and *tsotsitaal* (1%).

Column three of the table indicates that Zulu-speaking patients come from areas in the Gauteng province and KwaZulu-Natal province. Xhosa-speaking patients come from areas in the Eastern Cape province, and some from the Gauteng province. Ndebele-speaking patients come from areas in Mpumalanga province. Southern Sotho-speaking patients come from areas in the Gauteng province, Free-State province and Lesotho. Tswana-speaking patients come from Gauteng province, North-west province and Botswana.

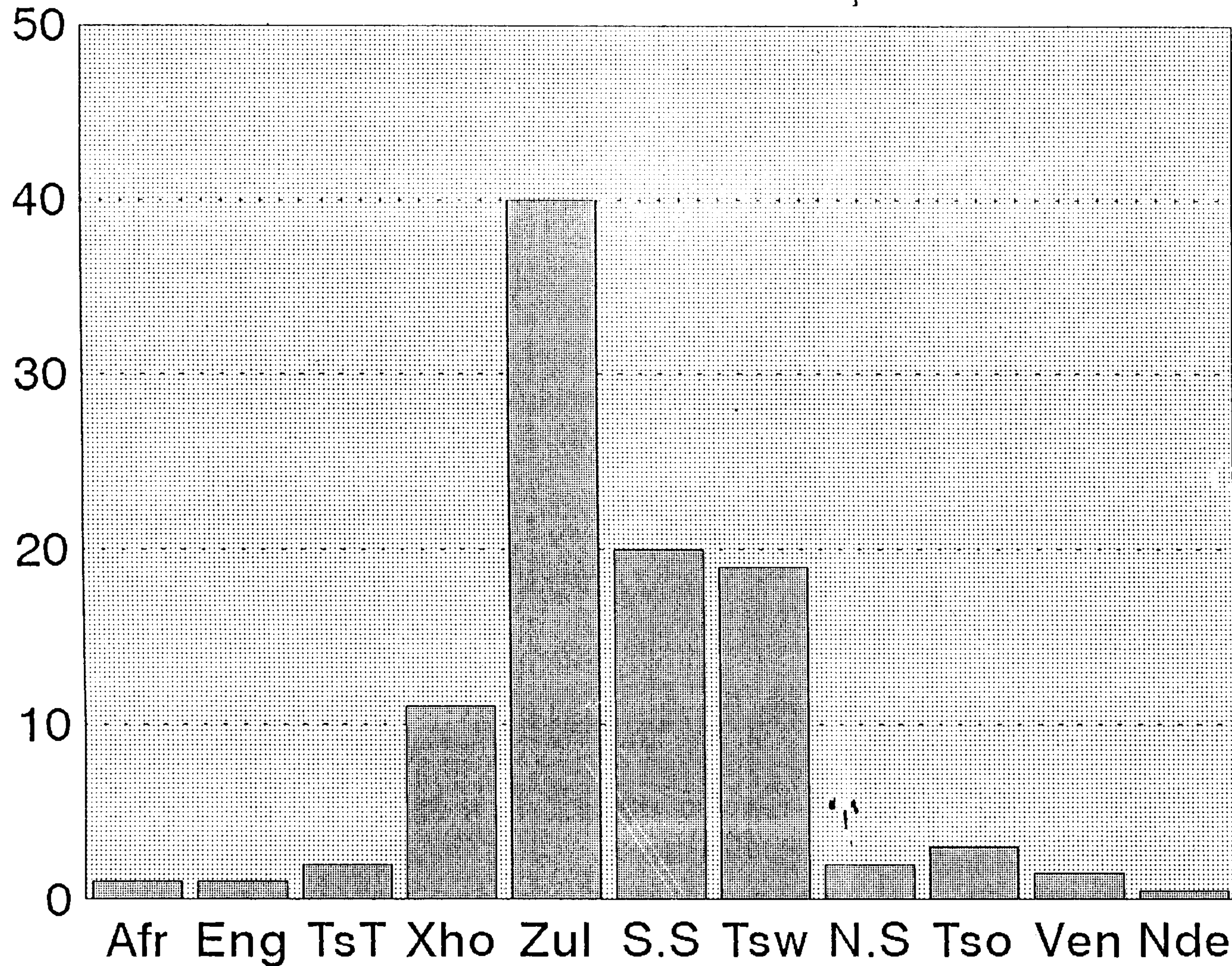
Northern Sotho-speaking patients, compared to Southern Sotho and Tswana, are a smaller group coming from areas in the Gauteng province, Northern province and Mpumalanga province. Tsonga and Venda-speaking patients come from Soweto and areas in the Northern province. Afrikaans-speaking patients are Coloureds from areas in the Gauteng province. English-speaking patients are Indians, Coloureds and Whites from areas in the Gauteng province, Zaire, Zimbabwe and Mozambique. Patients speaking *tsotsitaal* are from the Gauteng province.

The table above indicates that Gauteng is a multilingual society, with its residents coming from all over Southern Africa. From the analysis it is clear that patients at Baragwanath speak a variety of languages, including second and third languages. From the table, one can conclude that Nguni languages are widely spoken, followed by Sotho languages.

Another way of showing the same information is given in figure 3.1 which shows the percentage of speakers for each language.

Languages spoken by Patients
Baragwanath Hospital

FIGURE 3.1



3.2.2 Languages spoken by doctors

Table 3.2

Table 3.2 tabulates the languages spoken by the 80 doctors who completed the questionnaires at Baragwanath Hospital. Doctors who indicated that they spoke the same combination of languages are only represented once on the table. This was done in order to avoid duplication.

In the first column, the home language spoken by doctors is given. The second column reflects the actual numbers of the doctors speaking the same combination of languages and column three indicates the percentages. Column four gives an indication of languages used for communication by doctors and the fifth column gives an indication of their citizenship.

DOCTORS - FIRST LANGUAGES, LANGUAGES USED FOR COMMUNICATION, CITIZENSHIP

HOME LANGUAGE	ACTUAL NUMBERS	PERCENTAGE	LANGUAGE USED FOR COMMUNICATION	CITIZENSHIP
ENGLISH	1	1,25%	ENGLISH, MALAYALUM	INDIAN
GERMAN	6	7,5%	GERMAN ENGLISH	GERMAN
ENGLISH	2	2,5%	ENGLISH AFRIKAANS	SOUTH AFRICAN
GUJERATI	7	8,75%	ENGLISH AFRIKAANS GUJARATI	SOUTH AFRICAN

HOME LANGUAGE	ACTUAL NUMBERS	PERCENTAGE	LANGUAGE USED FOR COMMUNICATION	CITIZENSHIP
ENGLISH	5	6,25%	ENGLISH AFRIKAANS BASIC ZULU	SOUTH AFRICAN
GERMAN	3	3,75%	GERMAN ENGLISH FRENCH	GERMAN
HINDI	8	10%	HINDI ENGLISH	INDIAN
ITALIAN	5	6,25%	ENGLISH AFRIKAANS ITALIAN	SOUTH AFRICAN
ENGLISH	2	2,5%	ENGLISH FRENCH PORTUGUESE	PORTUGUESE
SWAHILI	4	5%	FRENCH ENGLISH SWAHILI	ZAIRAN
DUTCH	4	5%	DUTCH FRENCH GERMAN ENGLISH	BELGIAN
ENGLISH	3	3,75%	GERMAN ENGLISH AFRIKAANS	SOUTH AFRICAN
ENGLISH	2	2,5%	ENGLISH AFRIKAANS FRENCH	SOUTH AFRICAN
ENGLISH	3	3,75%	ENGLISH AFRIKAANS FRENCH BASIC ZULU	SOUTH AFRICAN
ENGLISH	1	1,25%	ENGLISH SHONA	ZIMBABWEAN

HOME LANGUAGE	ACTUAL NUMBERS	PERCENTAGE	LANGUAGE USED FOR COMMUNICATION	CITIZENSHIP
PORTUGUESE	3	3,75%	PORTUGUESE ENGLISH AFRIKAANS	SOUTH AFRICAN
ENGLISH	1	1,25%	ENGLISH BASIC ZULU	AUSTRALIAN
GREEK	4	5%	ENGLISH GREEK	SOUTH AFRICAN
HEBREW	6	7,5%	GERMAN ITALIAN ENGLISH HEBREW ROMANIAN	SOUTH AFRICAN
GREEK	2	2,5%	ENGLISH AFRIKAANS GREEK	SOUTH AFRICAN
DUTCH	5	6,25%	DUTCH GERMAN ENGLISH FRENCH AFRIKAANS	DUTCH
N.SOTHO	1	1,25%	ENGLISH AFRIKAANS N.SOTHO S.SOTHO TSWANA ZULU XHOSA TSONGA SWAZI	SOUTH AFRICAN
TSONGA	1	1,25%	ENGLISH AFRIKAANS TSONGA ZULU S.SOTHO XHOSA	SOUTH AFRICAN

HOME LANGUAGE	ACTUAL NUMBERS	PERCENTAGE	LANGUAGE USED FOR COMMUNICATION	CITIZENSHIP
N.SOTHO	1	1,25%	N.SOTHO TSWANA S.SOTHO ZULU ENGLISH AFRIKAANS	SOUTH AFRICAN

The table above shows that of the total of 80 doctors, 20 gave English as their home language, 9 German, 7 Gujerati, 6 Greek, 6 Hebrew, 9 Dutch, 2 N.Sotho, 1 Tsonga, 8 Hindi, 5 Italian, 4 Swahili and 3 Portuguese.

Column 4 of the table indicates that of the 20 doctors who gave English as their home language, only 8 could speak basic Zulu. Of the 9 German-speaking doctors, the 7 Gujerati-speaking doctors, the 6 Greek-speaking doctors, the 6 Hebrew-speaking doctors, the 9 Dutch-speaking doctors, the 8 Hindi-speaking doctors, the 5 Italian-speaking doctors, the 4 Swahili-speaking doctors and the 3 Portuguese-speaking doctors, none of them could speak any of the African languages spoken in South Africa. Of the 2 N.Sotho-speaking doctors; 2 could speak N.Sotho, S.Sotho, Tswana and Zulu. Only one could speak Tsonga and Swazi. The Tsonga-speaking doctor could speak Tsonga, Zulu, S.Sotho and Xhosa.

Column five of the table indicates that 45 doctors out of the total number of 80 doctors are South African citizens.

Most doctors speak more than one language. But only 11 doctors out of the total number of 80 could speak one of the African languages.

Doctors may 'know' smatterings of an African language, for example 'Basic Zulu', but this does not necessarily mean that they can question and diagnose patients about medical conditions in those languages. This statement is supported by the information gathered in the questionnaires answered by the doctors; they sometimes end up using body language, i.e the doctor may show what he/she wants from the patient by using the appropriate part of the body. The doctor may open his mouth if he/she wants the patient to do so, wave his/her hand(s) to greet the patient; wave goodbye and go, to indicate that the patient must go away. Facial expressions may be used to indicate pain (frown/sulk) in order to understand what the patient is saying.

It should also be noted from the table that a home language is not always the first language listed for communication purposes, but this is the preferential order of languages that the doctors gave in their questionnaires.

3.2.3 Languages spoken by nurses

TABLE 3.3

Table 3.3 indicates the languages spoken by the 100 nurses who filled in the questionnaires at Baragwanath Hospital. As with the table about the doctors, nurses speaking the same combination of languages are only represented once on the table in order to avoid duplication.

The first column of the table shows the home language spoken by the nurses. The second column reflects the actual numbers of the nurses speaking the same combination of languages; column three indicates the percentages of the total interviewed. Column four indicates languages used for communication. The fifth column shows their citizenship. As the total number pf nurses who answered the questionnaire is 100, the percentage and the number are therefore the same. In order to be consistant with other tables in this study, the researcher has therefore stated both.

Table for nurses

Table 3.3

HOME LANGUAGE	NUMBERS	PERCENTAGE	LANGUAGE USED FOR COMMUNICATION	CITIZENSHIP
ZULU	5	5%	ENGLISH VENDA ZULU TSWANA N.SOTHO	SOUTH AFRICAN
ZULU	7	7%	XHOSA ZULU S.SOTHO TSWANA ENGLISH AFRIKAANS	SOUTH AFRICAN
ZULU	12	12%	ZULU ENGLISH XHOSA	SOUTH AFRICAN

ZULU	3	3%	N.SOTHO S.SOTHO TSWANA ZULU XHOSA NDEBELE SWAZI ENGLISH AFRIKAANS	SOUTH AFRICAN
ZULU	6	6%	XHOSA ZULU TSWANA ENGLISH	SOUTH AFRICAN
ZULU	2	2%	ZULU ENGLISH TSWANA S.SOTHO N.SOTHO TSONGA	SOUTH AFRICAN
XHOSA	2	2%	ZULU XHOSA TSWANA TSONGA N.SOTHO ENGLISH AFRIKAANS	SOUTH AFRICAN
XHOSA	5	5%	XHOSA ZULU TSWANA S.SOTHO ENGLISH AFRIKAANS	SOUTH AFRICAN
XHOSA	4	4%	XHOSA ZULU SWAZI NDEBELE ENGLISH VENDA	SOUTH AFRICAN

TSWANA	6	6%	TSWANA ENGLISH AFRIKAANS ZULU N.SOTHO	SOUTH AFRICAN
TSWANA	3	3%	ENGLISH AFRIKAANS TSWANA	SOUTH AFRICAN
TSWANA	5	5%	S.SOTHO TSWANA ENGLISH ZULU	SOUTH AFRICAN
TSWANA	10	10%	ENGLISH AFRIKAANS TSWANA S.SOTHO ZULU XHOSA	SOUTH AFRICAN
TSWANA	4	4%	ZULU TSWANA ENGLISH AFRIKAANS S.SOTHO TSONGA VENDA	SOUTH AFRICAN
S.SOTHO	2	2%	S.SOTHO N.SOTHO TSWANA ENGLISH AFRIKAANS	SOUTH AFRICAN
S.SOTHO	3	3%	S.SOTHO VENDA TSWANA ENGLISH AFRIKAANS TSONGA	SOUTH AFRICAN
S.SOTHO	4	4%	TSWANA ENGLISH ZULU N.SOTHO S.SOTHO	SOUTH AFRICAN

S.SOTHO	4	4%	ENGLISH AFRIKAANS S.SOTHO ZULU XHOSA TSWANA N.SOTHO	SOUTH AFRICAN
N.SOTHO	3	3%	AFRIKAANS ENGLISH N.SOTHO S.SOTHO TSWANA ZULU	SOUTH AFRICAN
N.SOTHO	2	2%	S.SOTHO ZULU XHOSA ENGLISH AFRIKAANS N.SOTHO	SOUTH AFRICAN
TSONGA	2	2%	TSONGA ZULU S.SOTHO VENDA TSWANA N.SOTHO XHOSA SWAZI ENGLISH AFRIKAANS	SOUTH AFRICAN
TSONGA	3	3%	TSONGA ZULU TSWANA S.SOTHO ENGLISH	SOUTH AFRICAN

VENDA	2	2%	VENDA ZULU TSONGA N.SOTHO S.SOTHO XHOSA ENGLISH AFRIKAANS TSWANA	SOUTH AFRICAN
VENDA	2	2%	VENDA ENGLISH AFRIKAANS TSONGA N.SOTHO	SOUTH AFRICAN
SWAZI	1	1%	SWAZI S.SOTHO ZULU N.SOTHO TSWANA XHOSA ENGLISH AFRIKAANS	SOUTH AFRICAN

The table show the information as regards a total number of 100 nurses; 33 gave Zulu as their home language; 11 Xhosa; 28 Tswana; 13 S.Sotho; 5 N.Sotho; 5 Tsonga; 4 Venda; 1 Swazi. Column 4 of the table indicates that of the 33 nurses who gave Zulu as their home language only 2 could speak Tsonga, 5 Venda, and 12 could not speak any Sotho languages, i.e. N.Sotho, S.Sotho and Tswana. Of the 11 Xhosa-speaking nurses, only 4 could speak Venda and 2 Tsonga. Of the 28 Tswana-speaking nurses only 10 could speak Xhosa, 4 could speak Tsonga and Venda. Of the 13 S.Sotho-speaking nurses only 8 could speak Zulu, 4 Xhosa and 3 Tsonga. Of the 5 N.Sotho-speaking nurses only 2 could speak Xhosa, none of them could speak Tsonga

or Venda. Of the 5 Tsonga-speaking nurses only 2 could speak Xhosa. Of the 4 Venda-speaking nurses only 2 could speak Xhosa and Zulu.

Of the 100 nurses, only 5 who gave Zulu as their mother tongue, gave English as their first preference. Thirteen Tswana-speaking nurses gave English as their first preference. Four S.Sotho-speaking nurses gave both English and Afrikaans as their first preference. Three N.Sotho-speaking nurses gave both English and Afrikaans first preference as languages for communication. Only 25% prefer English or Afrikaans as their first language of communication; 75% of the nurses gave first preference to African languages, in the list of languages used for communication. This suggests that, though they have been trained in English, they prefer not to use English when communicating. This attitude possibly influences their reaction when they are called to interpret for doctors (see Scenario 6).

Column 5 indicates that all 100 nurses who answered the questionnaire are black South African citizens. They speak an African language, but they cannot understand all the nine African languages spoken by patients.

3.3. Implications for communication

3.3.1 Introduction

Many people tend to associate health care with medicinal cures or drug therapy. This obscures the powerful and complementary role that

verbal communication plays in medical procedures; for example, history-taking and establishing a diagnosis are part of the process. Therefore, good quality care can be compromised by the inexperienced use of language or by inadequate communication between patients and health-care professionals.

The use of real-life scenarios, which occurred at Baragwanath Hospital, will give an overview of the language issues. In presenting these scenarios, the researcher highlights the fact that in the area of health care, it is difficult to treat language issues as if they operate independently of the social organisation of the health system.

From all the research conducted at the hospital and from an analysis of the events which occurred at the hospital, what seemed to be a typical course of events is discussed in this section. The information presented in these scenarios was gathered over a period of six months by the researcher through observation and interviewing patients.

3.3.2 Scenario 1: Ward 20

Before a patient can be admitted to Baragwanath Hospital, he/she has to be seen by a doctor at the casualty department who, after examination may find it necessary to admit the patient to the hospital for further treatment. The patient will then be taken to ward 20, where the patient's history will be taken before he/she is referred to another ward for admission. Ward 20 seems to be the most important

ward because it is here that the doctor gets to know and understand the medical history of the patient in greater depth; and where the doctor makes his/her initial diagnosis.

The observation has been made that there are not more than 20 nurses who work in this ward; they are busy with other professional duties such as taking the patient's temperature, blood pressure etc. They are therefore not always in a position to help doctors with language interpretation. This is unfortunate, as their linguistic abilities may be very helpful in facilitating doctor-patient communication.

Some of the patients in this ward are accompanied by their relatives who have brought them to the hospital, while others are left alone by their relatives after they have been told that the patient has to remain in hospital.

From the total number of 1 118 patients interviewed, 838 (i.e 75%) of the patients at Baragwanath Hospital did not understand English. At the same time, most of the doctors use English to try and communicate with the patients (refer to Table 3.1, 3.2, and 5.1). For this reason problems arise when communication is not clear between the two.

When the doctor does not understand what the patient is saying, visitors in the same ward are asked to come and interpret for the doctor.

The information in this scenario is supported by the data collected from the questionnaires which were filled in by the doctors. More details and interpretation will be given later in chapter 3, in 3.3.8.

3.3.3 Scenario 2: Paediatric casualty

The paediatric casualty department is completely separated from the adult section. In this ward only children between the ages of 0-9 years are examined. These children are accompanied by their relatives. Most of the people accompanying these children do not understand English very well, while the majority of doctors in this department communicate with visitors in English. Because of the large number of sick children, two doctors usually use the same consulting room, with a nurse as an interpreter.

In one incident the doctor called the nurse to interpret what was being said by the patient's mother. The nurse, who was Zulu-speaking, interpreted in Zulu even though she realised that the patient's mother did not understand Zulu; the visitor was a Sotho-speaking person from Parys, a town in the Free State Province which is predominantly Sotho-speaking.

Because of being unable to understand, the visitor did not know what to do after she was given the child's file, so she went outside the ward and cried. Fortunately, the researcher who was busy interviewing other people saw her and asked what was bothering her. So she explained to the researcher what had happened.

The visitor was taken to the doctor who was asked what had to be done about the child and the file. The explanation was that the child had to report to the ward where she had previously been operated on, and had to be examined by the doctors who had operated on her. When everything was explained, the visitor, who had been very frustrated, was relieved because she now knew where to go and what to do next.

3.3.4 Scenario 3: Patient 1 and Patient 2

The doctor told patient 1, who was from Kwazulu-Natal and therefore Zulu-speaking, that he could only operate on her after the Easter holidays, and asked her if she wanted to go home and come back after the holidays. The patient did not understand what was being said and agreed. So the doctor then wrote a letter of discharge. Fortunately, patient 2 who was sleeping in a bed parallel to patient 1 could understand English, and was listening to the doctor when he was talking to patient 1.

After the doctor had left, patient 2 asked patient 1 how she was going to get home. Patient 1 replied, saying that she was not going home because she had come by ambulance and did not have any money for transport. When patient 1 was told that she had unwittingly agreed with the doctor's proposal to go home, she started crying.

Patient 2 looked for the doctor, who was, fortunately, still there checking on other patients. The doctor was given an explanation of

patient 1's circumstances and was told of the misunderstanding. The doctor then cancelled the letter of discharge because it was not what the patient had wanted in the first place.

3.3.5 Scenario 4: Incorrect medicine

A Sotho-speaking patient asked the nurse to report to the doctor that the medicine which the doctor had given her caused her to vomit and have stomach cramps. The patient asked the nurse to tell the doctor because she herself could not communicate in English and was feeling very ill. The nurse did not answer the patient. Later on, the same nurse came back with the same medicine for the patient to drink, but the patient refused to drink it.

The nurse shouted at the patient for refusing to drink the medicine. When the doctor arrived, the nurse told the doctor that the patient had refused to drink the medicine; she did not explain what the patient had said about that medicine.

The doctor was very angry. He told the patient to drink the medicine, and left her alone. The patient was depressed because she was unable to relate her problem to the doctor, as she did not know how to communicate in English. In addition, she had experienced a dictatorial attitude at the hands of both the nurse and the doctor.

3.3.6 Scenario 5: A patient from Messina

A Tsonga-speaking patient from Messina went to visit her English-speaking doctor at Messina. The doctor treated her and told her to come back after two days. When she went to see the doctor after two days, she was taken to Baragwanath Hospital by ambulance, together with other patients.

The patient did not know that she was being taken to Baragwanath Hospital because the nurse at Messina who had interpreted from Tsonga for her, had not informed her that the doctor was transferring her to Baragwanath Hospital. She was told that she was going to a hospital nearby where she was not even going to sleep over. When she found herself at a distance of 550 kilometres from home, she was shocked.

When conducting the interviews at Baragwanath Hospital, the researcher came across this patient who was very depressed and who told her that she wanted to go home because her children were alone at home. Had she known that she was coming to Baragwanath Hospital, she would have refused to get into the ambulance.

3.3.7. Scenario 6: Too busy to help

A Venda-speaking patient at Baragwanath Hospital had a communication problem with his doctor who was communicating in English. The doctor called the nurse, who was too busy giving other patients medicine, to come and help him interpret.

The nurse, who looked very annoyed when called by the doctor, only interpreted one sentence and continued with her duties. The doctor, who failed to get help from the nurse, used body language to communicate with his patient. The patient was discharged from the hospital.

The same patient was re-admitted after three days as he had become worse and had developed a skin problem. He was then under the supervision of another doctor with whom he could communicate, with the help of a nurse who could speak both Venda and English. The patient then recovered from his illness.

3.3.8 Analysis of Scenarios

Scenario 1 presents two problems with interpreting: the doctor had to ask the visitor to help him or her with interpreting during the process of admitting the patient; also, nurses were too busy to help doctors with interpreting. Nurses have indicated that they do not get extra remuneration for interpreting. Other problems arise when doctors may have a problem in getting a visitor who understands the medical terminology.

Scenario 2 presents a problem of a nearly complete lack of understanding on both sides: the doctor does not understand the language spoken by the patient's mother and the patient's mother does not understand the doctor and the nurse.

This raises the question of how many patients do not follow the doctor's instructions, because of a lack of a common language. The doctor made an assumption that the nurse and the patient's mother understood each other because they were both speaking an African language; unfortunately these were two different languages. The nurse spoke Zulu and the patient's mother spoke Sotho. This problem could have been solved if the nurse had asked the patient's mother what language she understood, and then had got someone who could communicate with the mother.

Calteaux (1994:120) comments, "people who are angry about something or in a hurry, and do not take the time to use mixed language, but simply speak their straight language (their own first language), are regarded as reacting in a negative way." This statement by Calteaux may hold some truth about the situation nurses find themselves in at Baragwanath Hospital. Maybe the nurse in Scenario 2 used Zulu because she was resentful about having to act as an interpreter, or for some other reason.

Scenario 3 presents a further problem as regards a lack of understanding on both sides. Patients may unwittingly agree with the doctor when in reality they do not understand what the doctor has said.

If the nurse had been there when the doctor spoke to the patient about going home, the chances of the patient misunderstanding the doctor might have been minimised. Both nurses and doctors have a role to

play in situations such as this. Nurses should be around when doctors do their ward visits, in order to help both the patient and the doctor.

Patients, too, need to be educated; they should not agree to instructions they do not understand. They must insist on asking for help from people who can understand the language spoken by the doctor. In this case, a nurse could have facilitated this communication. Ultimately, patients need to realise that their health and their lives depend on efficient communication.

In Scenario 4, communication is complicated by the nurse's attitude towards the language used by the patient. The nurse did not listen to the patient's complaint; nor did she report this complaint to the doctor. Added to this, the doctor and the patient did not understand each other.

In this case there might have been a possibility that the nurse did not understand the language spoken by the patient; nevertheless she should have tried another means of understanding the patient. It was important that the doctor should know why the patient would not take the medication. This kind of behaviour is unacceptable in the medical field; nurses should not disregard the patient's information.

Again, the doctor simply got angry without asking for the reason for the patient's reluctance to take the medication. The doctor in this instance did not have enough information because he did not understand the language spoken by the patient. The nurse either did not understand the language spoken by the patient or simply

disregarded important information. They did not make any attempt to understand and help the patient; yet, this is their duty.

Marston (1978:139) discusses the role that nurses play in encouraging patient's compliance. She states:

> Nurses by virtue of their numbers and amount of patient contact, have the greatest potential of any group of health professions for exerting an impact on patient health behaviour. Until recently, nurses have not taken advantage of the opportunities available to them.

Scenario 5 presents a problem, initially caused by interpreting, but complicated by the nurse's attitude towards the patient. The patient was referred to Baragwanath Hospital without her knowledge because the nurse did not interpret the doctor's full message.

Had the patient been told beforehand that she was to be taken to Baragwanath Hospital, she could have arranged that her children be properly cared for. Because she was not well informed, she became worried and confused. Her depressed condition would not have helped her as she was already sick. This sort of behaviour is unacceptable in medical institutions, as it may help to worsen the patient's condition instead of helping the patient to get better.

Scenario 6 again presents a combination of two problems: i.e a lack of understanding because doctors and patients do not use the same language; added to this, nurses have a heavy workload and do not wish to co-operate.

The doctor, who was unable to understand the patient, asked the nurse to help him with interpreting. The nurse interpreted only one sentence because she had other duties to perform. As the doctor was unable to get help from the nurse, he used body language to try and communicate. (Examples of body language: the doctor may have opened his/her mouth if he/she had wanted the patient to do so. He/she may have waved his/her hand to greet the patient; he/she may have pointed to specific parts of the body to ask the patient the location of pain; he/she may have waved goodbye to indicate that the patient should leave. Facial expressions may have also been used to indicate pain (frown/sulk)).

Body language, though, is not specific enough to use for communication, especially in medical institutions; the doctor may only get a rough idea of what bothers the patient. He/she may end up giving the patient the incorrect medication because he/she does not know enough about the patient's condition.

This scenario also illustrates that nurses often inadvertently jeopardise the health and the lives of patients by not giving all the information patients tell them, and by not helping doctors with interpreting.

3.3.9 Questions raised as a result of the analysis

These scenarios clearly reflect some of the problems regarding the language situation at Baragwanath Hospital. The following questions and some possible answers regarding these scenarios are raised:

* Should interpreting be a duty carried out by health care workers or should special posts be created for interpreters at Baragwanath Hospital for this purpose?

  It is the task of the hospital management to decide whether new posts for interpreters be created or not.

* If special posts are created, should they be created throughout the system or only where it is impossible for nursing staff to carry out both functions?

  An argument for involving nursing personnel in the interpreting would be that they are already knowledgeable about medical procedures. A counter-argument would be based on indications that nursing staff who carry out both tasks experience work overload.

* From analysing the scenarios, it becomes clearer that interpreting has an important function at Baragwanath Hospital; often it is the only way that communication takes place between a doctor who uses English as a medium of communication, and a patient who cannot understand English.

  Another consideration to take into account is that tension builds up, since patients remain helpless and unable to express themselves or to get the correct message across to the doctors. Tension also builds up between patients and nurses when the patient does not understand the language used by the nurse.

All these elements have a strong influence on the essential hospital staff-patient relationship.

3.3.10 Conclusion

The conclusion drawn from these scenarios is that interpreting needs someone with the right personality; their attitude, honesty and clarity of language play a very important role in communication.

At Baragwanath Hospital, the anxiety levels of the patients inevitably rise because they feel that what they say is not being understood or acted upon.

A number of written descriptions of what happens at Baragwanath Hospital have been presented; this has been done in an attempt to dynamically and vividly illustrate the situation at this vast hospital. These examples, and many more which could have been presented, set the scene for the following chapter.

CHAPTER 4

4. General characteristic of language use

4.1 Introduction

In this milieu of multilingualism, the language contact situation has elicited an exciting dynamic situation whereby the participants involved in all the communicative events were of necessity bound to use a number of strategies to enhance their communicative competence. These strategies include codeswitching, *tsotsitaal* and *iscamtho*. Therefore, in this chapter the definitions of codeswitching, *tsotsitaal* and *iscamtho* will be given in order to clarify these issues as they apply to the situation under investigation. Codeswitching is one of the communication strategies used by people as they mix in the multilingual setting of Baragwanath Hospital.

4.2 Codeswitching

According to Scotton and Ury (1977:6) a speaker switches codes for the following two reasons:

(1) to redefine the interaction as appropriate to a different social arena, or to avoid, through continual codeswitching, defining the interaction in terms of any specific social arena.

(2) codeswitching back and forth reflects the speaker's uncertainty concerning which social arena is the best ground on which to carry out the interaction with a view to the speaker's long term or short term goals.

Researchers such as Blom et al (Romero 1982:5) have observed the following:

> In the course of an ordinary conversation the speech events that make up the body of the linguistic exchange will be determined by (a) the participants, (b) the setting, and (c) the topic of the exchange. The manner in which the speech events take place when the above factors have been taken into account generally follows an established social convention. Such a convention is what the term Code implies. A change in participants, setting or topic will call for a change in the Code.

The definition and description of codeswitching given by Scotton and Ury, may easily apply to the situation under investigation. Codeswitching is used by staff members and patients at Baragwanath Hospital in order to enhance their communicative competence. Given the fact that most have scant doctors' knowledge of any African language, and that in turn the patients themselves have little communicative skill in English, one is faced with a gap which needs to be filled. In such an event the interlocutors need to resort to some means of communication in order to get their message across. Nevertheless, there is also the danger, as described in chapter 2,

that English is viewed as the H variety and therefore is perceived, especially by some nurses, as an excellent means of reinforcing their status within the hospital. Codeswitching is specially important in bridging the gap in situations where there is a communication breakdown between a doctor and a patient trying to understand each other.

There are different opinions regarding the switching that occurs in the speech of bilinguals. Espinoza (Lehiste, 1988:23) describes switching as a random intermingling of words from two languages. Gumperz and Hernandez (Lehiste, 1988:23) see a direct functional similarity between codeswitching on the one hand, and style switching within a single language, on the other hand.

Romero (1982:8) says that:

> ...when a speaker has access to two or more languages and in his conversation makes use of the two languages, he is engaging in what is ordinarily called Bilingual Codeswitching.

This codeswitching differs from the other types of codeswitching already mentioned in that "...it makes use of two different linguistic systems. Bilingual codeswitching borrows alternatively from two different linguistic systems while it strives to maintain the degree of grammatical correctness necessary to make the message intelligible" (Romero, 1982:8).

A second characteristic of bilingual codeswitching is that "...in making use of two languages it also draws from the stylistic resources of each of the two languages individually, so that there may be cases of intra-language style switches within the larger confine of a bilingual codeswitch" (Romero, 1982:8).

Lance (in Lehiste, 1988:23), demonstrates that codeswitching is not entirely random. He claims that language does not occur simply because the speaker does not know a particular word in one language or the other; rather, the word or phrase that is most readily available at that moment is the one that comes out. The reasons why a particular word or phrase is more readily available is important in a sociolinguistic study.

Myers-Scotton (1979:71) presents an explanation of this phenomenon which is to some extent representative of other explanations and in fact may be viewed as an overview of all other explanations. She reasons that codeswitching "...often takes place because the switcher recognizes that the use of either two languages has its value in terms of the rewards and costs which accrue to the user. The switcher chooses a 'middle road' in terms of possible rewards and decides to use both languages in a single conversation." For instance, use of one variety may distinguish the speaker as a 'common' person without pretences, whereas use of another may establish the person's identity as educated and/or economically successful. The speaker may therefore codeswitch between the two varieties in an attempt to maintain his or her image as both unpretentious and educated.

The speaker uses a switch in code as a tool to negotiate the rights and obligations which she/he wishes to take effect for the exchange. The addressee uses the switch as an index of the negotiations in which the speaker is engaged (Scotton 1982:433).

Studies on the codeswitching process in South Africa (Calteaux 1994:120) have shown that it may be used as a means of accommodation rather than of confrontation. Codeswitching therefore, is not considered to be used by those who have difficulty in expressing themselves in a certain language rather than another, but rather that the speaker should be equally proficient in two (or more languages) so that they can switch appropriately. In the situation at Baragwanath Hospital it must be emphasised that 96% of the patients, nurses, doctors and visitors in this hospital are bilingual as indicated in Table 3.2 and Table 3.3. They resort to whatever language they know in order to make communication possible. The conversation quoted in 4.3.1 also illustrates this point.

4.3 Users of codeswitching

In this section, examples of discourses in different speech communities will be presented in order to identify the factors determining codeswitching.

4.3.1 Conversation between Patient and Patient

At Baragwanath Hospital, patients intermingle daily, some sleep in the same wards for days, weeks and even months, and therefore it is impossible not to communicate with one another.

The following dialogue is an example of a conversation between two patients who are sleeping in the same ward. The one (Patient 2) is Zulu-speaking and lives in Meadowlands in Soweto; the other (Patient 1) is Northern Sotho-speaking, from Chiawelo in Soweto.

Example 1:

(Zulu words are written in bold. Northern Sotho words are italicised.)

Patient 1: *Kganthe go bohloko bjana go lwala le go robala sepetlela nako e telele.*
(I never thought it is so painful to be sick and to sleep in the hospital for a long time.)

Patient 2: **Kanti wena wafika nini lapha esibhedlela ngoba ngathi kudala wagula.**
(When did you arrive in this hospital, it seems as if you have long been sick?)

Patient 1: *Ke na le dikgwedi tše pedi ke robetše mo, fela ga ba bolele le gore ba tla ntokolla neng ka ya gae.*
(I have been sleeping here for two months, they don't even indicate that I will be discharged.)

Patient 2: **Mina ngibona sengathi usazohlala isikhathi eside ngoba nawe uyazibona ukuthi awukakaphili kahle.**
(I think you are still going to stay here for some time, you can see for yourself, you are still not well.)

Patient 1: *Nna ke kwa ke le kaone kudu, ge ke fihla mo sepetlela ke be ke sa kgone go ja le go nwa, e bile ke nagana gore ke leke dingaka tša sesotho.*
(I feel much better than before; when I arrived here at the hospital, I could not eat or drink. I was even thinking of trying traditional doctors.)

Patient 2: **Mina ngibona ukuthi kungcono ukuzama khona lapha esibhedlela kuqala. Uma ngibona ukuthi bayahluleka ngizokuya esangomeni.**
(I thought it was better to try the hospital first; If I see that they have failed, then I will go and see the traditional doctor.)

Patient 1: *Nna ke kwele bare bolwetši bjo bo ntshwerego ga bo fole, ke tla nna ke boa boa mo sepetlela.*
(I was told that my sickness does not heal completely, I will still have to come for a checkup regularly.)

Patient 2: **Nginethemba lokuphila ngoba ngiqala nje ukugula ngaphuthuma esibhedlela.**
(I have faith that I will be healed, because I rushed to the hospital when I started feeling sick.)

Patient 1: *Nna ke bone batho ba bantši ba hlokofala ge ke dutše ke le mo sepetlela, ga ke sa tshepa gore ke tla fola.* Nurse *šoo o etla ka dihlare le dipilisi.*

(I have seen so many people dying, whilst sleeping in this hospital. I don't have any hope of recovering. There comes the nurse with pills and medicine.)

The dialogue shows that communication is often facilitated through the use of two or more different languages when two speakers are engaged in conversation with each other. Each patient completed a turn speaking his/her own language; yet they are able to understand each other, even though they may not have sufficient competence to speak the standard version of each other's language.

The dialogue raises the following questions:

* How did these patients understand each other even though they were speaking different African languages?

* Was this because they were both from Soweto, which is a multilingual society, or was it because the languages are related?

* The answer to these questions is that patients at Baragwanath Hospital are by and large bilingual. They understand more than one language. As informants mentioned during interviews, Zulu is spoken by most patients. Even those who are not Zulu-speaking are forced to learn Zulu in order to communicate with Zulu speakers.

The statement above is supported by the research conducted by Finlayson and Slabbert (1996:10), where one of the interviewees said that "...some people are not interested in learning other languages. They make no effort at all, they are selfish, they are not interested in knowing any other language than their own. Particularly the Zulus, I'm sorry to say but they are very stubborn."

4.3.2 Conversation between nurse and nurse

The conversation below occurred between two Zulu-speaking nursing sisters. Sister 1 was working night duty and Sister 2 was resuming day duty. It should be noticed that in the conversation below English words are written in Roman text, Afrikaans words in italics, Zulu in bold.

Example 2:

Sister 2: **Hawazi wena ukuthi beku**-busy **kanjani, sisebenze kwaze kwa sa! Sinama**-gunshots **awu-6 futhi a**-under guard. Three MVA's hit and runs. Two of them **banama**-fractures on both legs. This third one slightly injured and no fracture. **Sibuye sa**-admita five men with stabs, this other one with a stabbed neck and two stab chest, **lona omunye unama**-multiple stabs. Look at this one, **umfazi umthele nge**-boiling water as you can see he has 35 degree burns, as it is, he will be transferred to burns unit.

(You don't know how busy it was, we worked until this morning. We have 6 people with gunshots who are under guard. Three MVAs [Motor vehicle accidents] hit and runs. Two of them have fractures on both legs. This third one is slightly injured and no fracture.

We also admitted five men with stabs, this other one with a stabbed neck and two with stabbed chests, this other one has multiple stabs. Look at this one, his wife poured boiling water over him, as you can see he has 35 degree burns, as it is, he will be transferred to burns unit.)

Sister 1: Whoo! **hi sono** *man*! **kodwa uzophola, asiqali uku**-admita such a case. **Uyakhumbula** we had that one with 65 degree burns?

(Whoo! It's pathetic, but he will be healed. It is not the first time that such a case has been admitted. Do you still remember we had that one with 65 degree burns?).

Sister 2: **Ngiyakhumbula! Waphelela kuphi?**

(I remember! What happened to him?)

Sister 1: **Uhlele e**-burns for three months but he survived, **kusele nje ama**-scars. **Uyazi ukuthi ama**-scars **akhona awasuki.**

(He stayed at the burns unit for three months but he survived, he only has scars. You know that those scars will always remain.)

Sister 2: **Mzala, manje** these ones?

(Cousin! now what about these ones?)

Sister 1: Okay! *amper* **ngakhohlwa, lo mama lo ungambona, oshaywe yindoda yakhe.**

(Okay! I nearly forgot. This woman, this one has been assaulted by her husband.)

Sister 2: **Hawu! bekwenzenjani aze amoshaye kanje?**

(Good gracious! What actually happened, that made her husband hit her like this?)

Sister 1: **Athi ebeye ku**-doctor **emini,** u-doctor **umtshele ukuthi u**-pregnant.

(She said that, she went to see the doctor during the day, who told her that she was pregnant.)

Sister 2: **Manje angamshayela lokho nje?**

(Then, can he really hit her for that?)

Sister 1: **Uthi indoda yakhe ifuna ukubona ukuthi uzohlala kuphi naloyo mntwana, ngoba yena akafuni umntwana. Base beya**-argua and he ended up beating her **azabenje.**

(She said that her husband told her that she must find a place where she can stay with that child, because he does not want any child in his house. Then they started arguing and he ended up beating her until she was like this.)

Sister 2: Anyway **sizothini? Hamba muntu wabantu,** you must be tired.

(Anyway, there is nothing we can say, just go, you must be tired.)

Both nurses are Zulu-speaking, but they codeswitch when communicating with each another. They use a mixture of Zulu and English. Words occurring most frequently in their conversation are: 'fracture', 'stab chest', 'stab neck' and 'admit' which are all English terms.

From the conversation above the following question is raised:

* Why is codeswitching or what has been called (Calteaux, 1994) 'mixed language' spoken so often at Baragwanath Hospital?

The answer to the above question could be that nurses at Baragwanath Hospital spend most of their time in hospital communicating with doctors who are English-speaking; also because of their training, they have become accustomed to English medical terms [Example 2].

Another aspect of this particular use of English is that the user shows his/her higher level of education. That is, there is a certain amount of prestige involved in being able to speak English.

4.3.3 Conversation between doctor and patient

The data collected from the questionnaires indicate that the doctors at Baragwanath Hospital speak English either as their first, second or third language, according to their responses to the questionnaires (in Table 3.2). The language they use in the contact situation with nurses and patients is English, though some may have a basic knowledge of Zulu. On the other hand, the majority of patients speak an African language and are not educated and therefore unable to understand English fully (see Table 5.1).

In the medical context, in order to arrive at an accurate diagnosis, it would be an optimum situation that doctor and patient are able to communicate and understand each other. As witnessed from the data obtained during interviews, communication often does not take place

between doctor and patient. In some instances they communicate using body language; if a nurse is available, she is used as an interpreter. However, nurses are not always available or co-operative.

Because of the large number of patients at Baragwanath Hospital, doctors are sometimes forced to communicate with patients without the help of nurses. Patients and doctors very often codeswitch in order to accommodate one another. Patients usually switch from an African language to English most of which they do not understand, as will be demonstrated in the next example.

A conversation between a doctor and a Venda-speaking patient is presented below:

Example 3:
(Zulu words are written bold. Venda words are italicised.)

Doctor: **Sawubona! Kunjani?**
(Hi! How are you?)

Patient: *Ee! dokotela ndi a lwala.*
(Hi! Doctor, I am sick.)

Doctor: What is wrong?

Patient: *Ndi a neta nda fhelelwa nga maanda musi ndo lala na mufakadzi nda* bleed*a nga dziningo.*

(I get tired, and when I sleep with a woman, I bleed through my nose.)

Doctor: It seems like you have high blood pressure.

Patient: *Ndi kale ndina* high blood pressure
fhedzi u bleed*a ndi zwithu zwiswa.*
(I have long had this high blood pressure, but nose bleeding is a new thing.)

Doctor: Do not worry, I will give you some medicine to stop the bleeding.

Patient: *Vha khou pfa zwine nda kho u amba?*
(Do you understand what I am saying?)

Doctor: Try and get enough rest, then you will be fine.

From the conversation above it is clear that the doctor and the patient have a communication problem. There is an indication that the patient cannot communicate in English but can understand some of the English words (for instance, when he talks of his high blood pressure). From the fact that he is able to ask the doctor whether he understands him or not, it is clear that the patient realises that the doctor does not understand him. The doctor's reply also confirms that he does not understand the patient because after the patient has asked a question the doctor does not answer his query.

At first the doctor greets the patient in Zulu and then switches to English. The reason could be that the doctor only knows greetings in Zulu, and not medical terms or questions; or that the doctor switches to English because the patient answers in Venda and not in Zulu. Because the doctor does not understand the Venda-speaking patient, he uses body language (see the analysis of scenario 6) to communicate with the patient.

From the conversation above, the following questions may be raised:

* Did the patient understand the doctor?

* Did the doctor understand exactly what the patient's problem was or was he only using his own discretion?

* Lastly, what type of treatment did the patient receive?

The answer to the above questions could be that body language may sometimes help in asking and conveying information. But it is not the best method, as it is not accurate enough in conveying specific health conditions. When body language is used, correct treatment cannot be guaranteed. It appears that the patient, who suffered from high blood pressure, experienced further complications when performing the sexual act. The doctor was apparently unaware of this fact; he was only aware of what was physically demonstrable at the time, that is, nose bleeding.

4.3.4 Conversation between nurse and patient

Nurses at Baragwanath Hospital speak several different African languages, but not all of them understand all the African languages spoken by patients (Refer to Table 3.3). The same applies to the patients. They may speak several African languages but do not understand all of the African languages spoken at the hospital.

The data obtained through interviews indicate that most of the Nguni-speaking patients do not entirely understand the Sotho languages: that is Southern Sotho, Northern Sotho and Tswana, especially those varieties spoken by patients from rural areas. Sotho-speaking patients do not easily understand Xhosa and Zulu. Very few patients are fluent in speaking and understanding both the Nguni and Sotho languages.

Table 3.3 indicates that most of the nurses can speak at least one language from each of the two groups. Two nurses indicated that they can only speak African languages from one group. Both patients and nurses make use of codeswitching to facilitate communication. The nurses usually use a mixture of African languages and English when communicating with patients, while the patients try to use the language which is spoken by the nurse [Example 4 below].

Example 4:
(Zulu words are written in bold; Tswana words are in italics.)

Patient: *Ijoo* ..... *Ijoo* ..... nurse!
(Ooh .... Ooh .... nurse!)

Nurse : **Hini! Kwenzenjani?**
(What is wrong?)

Patient: *Ke ya opelwa, ke kopa dipilisi tsa dipeini.*
(I'm having pains, could I have pain killers.)

Nurse : **Anginazo, udokotela uzokunikeza makafike.**
(I don't have pills, the doctor will give them to you when he comes.)

Patient: Nurse! *ke kopa meetse.*
(Nurse! can you please give me some water.)

Nurse: I am still busy.

Patient: *Ijoo* .... nurse! **ngicela amanzi**
(Oh .... nurse! can you please give me some water to drink.)

Nurse : Ok! I am coming just now.

The nurse and the patient in this conversation communicate in two different African languages. The nurse uses Zulu and English and the patient uses Tswana. From the answers given, it is evident that they understand one another because the patient requests pills from the nurse using Tswana and the nurse answers the patient's question correctly using Zulu; she states that she does not have pills.

The patient switches from speaking Tswana to Zulu after the nurse says that she does not have the pills she requested.

The following questions are raised:

* Why did the nurse reply in Zulu even when she realised that the patient was a Tswana speaker?

* Did she give the patient water to drink because the patient used Zulu when asking for water, or out of compassion?

* Does language attitude influence nurses' attitude towards the patients?

From the interviews it has been stated that most of the Zulu-speaking nurses can only answer or help a patient if the patient speaks Zulu. In some cases, if a patient speaks another language, the nurse may pretend not to understand him/her until he/she switches to Zulu. This is not the case in the conversation above; perhaps the nurse, in this situation, simply is not fluent in Tswana although she understands it.

It could be concluded that sometimes language attitude does affect the nurses' actions; this could then complicate the communication necessary between nurse and patient, and nurse and doctor.

4.3.5 Conversation between doctor, nurse and patient

The idea of nurses being interpreters does not seem to be very effective. Both the doctors and the patients complain about this arrangement. Nurses use codeswitching when interpreting, to enable the doctor and patient to communicate with one another. For example, a nurse may use English when talking to the doctor whereas she uses an African language or a mixture of African languages when talking to a patient.

In some cases, there may be a Sotho-speaking patient attended by a nurse who, being Zulu-speaking, may not be fluent in Sotho, and nevertheless falls into the role of interpreter.

The nurse, therefore, switches from one language to the other in order to get the message across to the patient. Sometimes the nurse uses a mixture of African languages interspersed with English or medical terms. [See example 5 below]

A conversation between a Northern Sotho-speaking patient, a Zulu-speaking nurse and an English-speaking doctor is presented below:

Example 5:
(Zulu words are written in bold; Northern Sotho words are italicised.)

Doctor : How are you?

Patient : *Ke a babja ngaka*
(I am sick doctor.)

Nurse to Doctor : He says he is sick.

Doctor : What is wrong?

Nurse to patient : **Yini inkinga?**
(What is the problem?)

Patient : *Ke sehlare seo ngaka a mphilego sona maabane, se ntshepediša mala. Ga ka lala ke robetše bošego bjo ka moka ke ya ntlwaneng.*
(Since I drank the medicine the doctor gave me yesterday, I did not sleep the whole night, I had a runny stomach.)

Nurse to Doctor : He says he does not like the medicine you gave him.

Doctor : He must drink the medicine so that he can get better.

Nurse to patient : **Udokotela uthi uphuze lowo muthi, ukuze uphole.**
(The doctor says you have to drink the medicine so that you can get better.)

Patient	:	*Ga ke sa nyaka sehlare seo se ntshepedišа mala.* (I no longer want to drink that medicine because it causes me to have a runny stomach.)
Nurse to Doctor	:	He says he is not going to drink that medicine.
Doctor	:	It's up to you whether you want to get better or not.
Nurse to patient	:	**Udokotela uthi kuphuma kuwe noma** you drink the medicine or not.(The doctor says it is up to you whether you want to drink the medicine or not.)

This discourse was recorded during interviews with patients when the nurse and the doctor were doing ward rounds; they had interrupted an interview between the researcher, who is a Northern Sotho-speaking person, and the patient, also a Northern Sotho-speaker.

The nurse, who was with the doctor did not tell the doctor everything the patient had said. The doctor was not told **why** the patient refused to drink the medicine; he was angry with the patient and insisted that the patient should drink the medicine.

The patient, who did not know how to communicate with his doctor in English to explain his problem, was left depressed.

The conversation above raises the following questions:

* Did the nurse not tell the doctor everything because she did not understand Northern Sotho very well? Was it because she resented doing both nursing and interpreting.

* If the nurse did not understand the language very well, why did she not ask another nurse, who knew the language better, to act as an interpreter?

The answer to the above questions could be that the nurse did not have a good understanding of Northern Sotho. The reason for not asking another nurse to help her interpret could be that she (the nurse) did not regard interpreting as part of her job. She may also have thought it would reflect unfavourably on her if she asked for help.

Five conversations, in different speech communities, have been presented; in all, codeswitching is used in most communication situations at Baragwanath Hospital. This necessitates a discussion on the importance of codeswitching.

4.4 The importance of codeswitching

According to Scotton (1982a : 436) the use of both English and an African language identifies the participants in an expected or unmarked

way: the use of an African language affirms their identity as ethnic brethren; the use of English affirms their acquired status as educated persons.

This could explain the use of both English and an African language by the nurses at Baragwanath Hospital. Perhaps they mix English with African languages when communicating with patients to demonstrate their knowledge of English on the one hand, and to show solidarity with their ethnic group on the other. In addition using codeswitching may be an important form of accommodation.

Scotton (1982a:437) mentions that an African language speaker who continually switches to English "wants to show he is different from others in the group by his switching or he switches because he cannot think of the right word in the first language." At Baragwanath Hospital for example, sometimes the medical terms are not known in an African language and therefore nurses are forced to codeswitch even if they are communicating with patients in an African language.

The fact that patients are not equally educated and do not understand all the African languages, or the English spoken in that hospital, causes the patients to resort to whatever they know in order to make communication possible. Codeswitching therefore, depends on the proficiency of the participants in the conversation; it also depends on the sense of urgency to communicate with others.

As far as the doctors are concerned, it depends either on their own proficiency in the patient's language or on their reliance on the nurses to interpret, whether the latter are willing or unwilling.

Codeswitching is a means of making communication possible and depends on the willingness of people to accommodate others and to compromise their language in order to enhance communication.

4.5 Conclusion

Codeswitching, or what may be termed a 'mixed language', is a means of making communication possible. If it were not for this mixed language and the fact that it facilitates communication at Baragwanath Hospital, there would have been a great deal more confusion and possibly increased conflict as a result of the inability to communicate. "As an accommodating strategy, codeswitching has both sociolinguistic and psycholinguistic aspects. The social motivation for switching for the speaker is to be seen as a co-operative person, someone who can recognise everyone does not have the same background. The psycholinguistic motivation is to improve comprehension" (Finlayson et.al, 1996).

4.6 *Tsotsitaal* and *Iscamtho*

Tsotsitaal and *iscamtho* are discussed in this study, as 1% of the (see Table 3.1) patients who are admitted to the casualty department as out-patients use *tsotsitaal* or *iscamtho* to communicate with others. Most of these patients (see Table 1.1) are in the lower income bracket. These patients use English as well as *tsotsitaal*, depending on the

situation. *Iscamtho* or *tsotsitaal* are used mostly when communicating with friends, fellow patients and nurses; English is used when communicating with doctors. It is necessary therefore to present some definitions of *tsotsitaal* and *iscamtho*.

4.6.1 Various definitions of *Tsotsitaal* and *Iscamtho*

According to Slabbert (notes), researchers such as Schuring (1983) and Ntshangase (1995) have traced the origins of *tsotsitaal* or *iscamtho* back to the activities of the Amalaita and Funani criminal gangs which were active in the Witwatersrand during the late nineteeth century and early 1900s. These gangs later split into the 'number gangs', '27', '28' and the 'Big Five'; these are still associated with the use of *tsotsitaal* and *iscamtho*. Under the apartheid regime, many offences were not regarded as criminal acts by the African population; thus, returning criminals were not considered as criminals and therefore their way of speaking was not stigmatised. On the contrary they were valued. These returning criminals popularised *tsotsitaal* in the townships.

Another theory on the origin of *tsotsitaal* is that it also developed as a lingua franca for male social interaction in the old mixed areas of Pretoria (Schuring 1983; 1985) and Johannesburg, such as Attridgeville and Sophiatown (Slabbert 1994, Ntshangase 1995). Ntshangase (1995) ascribes the use of Afrikaans as a base to the fact that many Africans who came to the cities came from white farms where they used Afrikaans.

Respondents in Slabbert's study have mentioned that Afrikaans was not stigmatised in the early 1900s and that it was a natural choice as a lingua franca. When the residents of the mixed areas were removed to the townships, the language spread through the black urban community and was passed down to the next generation.

According to Ntshangase (1993:79) the destruction of the Western Areas and the relocation of those communities to what is now known as Soweto, meant that both speakers of *iscamtho* and *tsotsitaal* had to share the same space. This resulted in both language varieties being spoken in Soweto. *Tsotsitaal* was spoken largely in Meadowlands, Diepkloof, Dube and Rockville; while *iscamtho* was spoken in all other townships particularly Orlando and Pimville.

According to Msimang (1987 : 82), *tsotsitaal* is:

> ...a contact medium which developed when blacks of various ethnic groups were thrown together in the South African cities, especially on the Rand. It was created mainly by the first and second generation in the cities who - unlike their forebears - wanted to transcend ethnic differences and regard one another as members of a common urban community. These youths were also motivated by participation and interaction in common activities, particularly crime.

Msimang (1987:85) translates '*isiqamtho*' as '*tsotsitaal*'. In other words, he sees *tsotsitaal* with an Afrikaans base (i.e. the variety which he is describing in the article) as being identical to *iscamtho*.

Msimang (1987:85) says the following:

> Isiqamtho comes from the verb -qamutha or -qamunda (talk volubly or maintain a constant flow of language). Of course the tsotsis never refer to themselves as tsotsis (but as Matjithas or other similar expressions). Similarly they never refer to their medium as tsotsitaal although they are not offended by these words if used against them by members of the out-group. Among themselves, their medium is isiqamtho (or isicamtho), which implies that they really have a gift of the tongue. There is a possibility that this word is derived from Xhosa, a sister language of Zulu, where to speak volubly is to qamtha.

Ntshangase (1993) has put a strong argument that these varieties are in fact two distinct varieties. His analysis is based on a comparison of Nguni-based *iscamtho* as spoken in Soweto, and Afrikaans-based *tsotsitaal*. *Iscamtho* on the other hand developed from the argot known as Shalambombo which was first spoken by the Amalaita gangs in the 1920s. It spread with the dominance of Amalaita activities and became used by the non-Amalaita criminal gangs in the 1930s. It became a language of prison gangs from the 1920s; it was

transformed in the 1940s and 1950s; it became an urban youth language and changed its name in the 1960s when it became known as *iscamtho*. This language was generally first spoken by young males who were generally members of criminal gangs in Orlando, Pimville and later the Moroka Emergency Camp. (Ntshangase 1993 : 44).

A possible explanation for the confusion regarding the terms *tsotsitaal* and *iscamtho* can be found in Coplan (Mfusi, 1990:8) who states:

> Borrowing heavily from American slang, Johannesburg tsotsitaal was eventually spoken by most urban workers and became the language of the African working-class culture. As conditions worsened, tsotsis turned to robbery, mugging and other violent crimes. Meanwhile the label broadened to include all urban criminals except for the gangs of migrants such as the MaRashia and Amalaita.

The fact that the use of the label 'tsotsi', was "broadened to include all urban criminals", could account for the use of the term *tsotsitaal* as an umbrella term to refer to all linguistic varieties used by "tsotsis".

It is important to note that not all people who speak *tsotsitaal* and *iscamtho* are criminals. There are those who through contact with the speakers of these languages, also learn to speak it. Patients who speak *tsotsitaal* are mainly from Soweto in areas such as Rockville and Meadowlands, areas which were the first destinations of the removals from Sophiatown; during 1955-1958, *tsotsitaal* flourished in Sophiatown.

4.7 Users of *Tsotsitaal* and *Iscamtho*

From the researcher's observation at Baragwanath Hospital, *tsotsitaal* is used most frequently by elderly patients and *iscamtho* by younger patients in communication with other patients, nurses, doctors and visitors. Discourse by different speech communities is presented in this section.

4.7.1 Conversation between doctor and patient

A conversation between a patient and a doctor in a surgical pit ward is presented:

Example 6:

(Zulu words are written in bold and *iscamtho* in bold and italics.)

Doctor: **Yebo baba!** What can I do fo you?
(Hello dad! What can I do for you?)

Patient: **Yebo** doctor **ngilimele**
(Hello doctor I am injured)

Doctor: What happened?

Patient: Doctor, **gusho ukuthi besihlele *namagents*, kwase kusuka lama *authi* angilimaza ngize ngibe nje. Angali bengishayile kodwa hhayi kangaka ukuthi ngingaze ngilimale kangaka.**
(I was sitting with other gentlemen, then came other boys

who assaulted me until I was like this. I don't deny the fact that I was drunk, but not too much.)

Doctor: Sister please come and help me here,
I cannot understand what the patient is trying to say.

Sister: Doctor I am coming; I am still helping here.

Doctor: Please, this patient is bleeding, and I do not understand what this patient is trying to say.

Sister: Okay! doctor I won't be long.

(Because the sister was still busy with another patient, the doctor decided to move to patient 2, leaving patient 1 bleeding.)

Doctor: Hallo **baba**, what is wrong?
(Hallo dad, what is wrong?)

Patient 2: Hallo! doctor. I injured my hand, while I was trying to put new glass in my window. I fell on top of the pane of glass.

Doctor: Oh! terrible! Did you fall on your hand?

Patient 2: Yes, doctor, as you can see.

Doctor: Okay, I will have to order an X-ray to see if you have a fracture or not.

(Writing an X-ray form, referring the patient 2 to X-ray.)

Doctor: Sister! are you ready now?

Sister: Not yet doctor, I am still busy with this patient and this doctor. Can you please ask somebody else to help you.

Doctor: Where will I find that somebody, dammit! This patient is in a terrible state now.

Sister: Nurse!! (calling another nurse) Can you please help the doctor? He needs somebody to help him.

Doctor: Nurse, can you please prepare this patient for theatre it looks like his bleeding has got worse and he looks very pale. I will have to order blood immediately.

From the conversation above it is clear that the doctor did not understand the language used by patient 1. He had to wait for the nurse who was busy helping another doctor to come and interpret.

Because of the large number of patients in the surgical pit of the casualty ward, the nurse asked another nurse to help the doctor who was very angry because the patient was losing a lot of blood while waiting for the nurse to interpret. By the time the nurse arrived, the patient had already lost a lot of blood.

From the discourse above, the following questions are raised:

* How many people die because of a shortage of interpreters or because of communication breakdowns?

In the conversation above, the doctor asked the nurse to interpret what was being said by the patient, but she could not help the doctor as she was helping in another situation.

The bleeding of the patient got worse while waiting for the interpreter. This scenario gives us the impression that patients could die, due to lack of immediate medical attention; this could be due to communication problems or because the doctor was indifferent. In fact he was very frustrated because of the lack of support staff.

4.7.2 Conversation between patient and patient

Patients also use *tsotsitaal* between themselves.

A discourse between two patients, who were sleeping in the same ward at the hospital is given:

Example 7:
(Zulu words written in bold and *tsotsitaal* in italics.)

Patient 1 : *Heita! Bra* ....
(Hi! brother.....)

Patient 2 : *Heita! Hoez it?*
(Hi! How are you?)

Patient 1 : **Kusase ntswembu** *maar* **la bo**doctor **sebangi**discharg**ile.**
(I am still in pain but the doctors have discharged me.)

Patient 2 : Hawu? **Unje, ngoba u phefumula** *seer* **kanje?**
(Goodness! Being like this, still breathing with difficulty like this?)

Patient 1 : **Angazi** *bra* **wami.** *Mara* **mhlambe uma ngingabona uma***grizza* **ngizoba** *grand.*

(I don't know my brother, maybe if I can see my mother, I will feel much better.)

Patient 2 : *Mara laehosi* **kunjani? Banga** discharg**a umuntu asase** weak **kanje.** Anyway **uzophola** *Bra* **wam. Uzi***nese* **uze ube** *grand.*
(But how is this hospital? Can they really discharge a person, being so weak. Anyway, you will get well my friend. Look after yourself until you are healed.)

From the conversation above, it is clear that both patients were using *tsotsitaal* as a communication medium and could understand each other without difficulty.

Patient 2 begins by using *tsotsitaal* and patient 1 responds indicating that they understand each other's language.

Tsotsitaal is a combination of English, Afrikaans and Zulu words. For example, '*umagrizza*' from 'grizzled' (English), '*seer*' (Afrikaans) and '*unje*' (Zulu). In the conversation above, patient 2 tells patient 1 that he has been discharged and patient 1 is surprised because patient 2 still breathes with difficulty.

The following question is raised:

* Were the two patients using *tsotsitaal* to identify themselves as belonging to the same group or as a secret language.

  According to the various definitions previously mentioned, the reason could be:

* To identify themselves as belonging to the same group.

4.7.3 Conversation between a visitor and a nurse

Sometimes *tsotsitaal* and *iscamtho* are spoken between patients or visitors and nurses. The following discourse took place at the casualty department, where a visitor asked a nurse to help him, by attending to his friend who had been stabbed.

Example 8:

(Zulu words in bold, tsotsitaal in italics.)

Visitor: Sister! **awungenzele** ifavour, I *bra* **yam iya*donsa*,**
bheka ukuthi ubleeda **kanjani?**
(Sister! do me a favour, my brother is dying,
look how much he is bleeding.)

Nurse: **Kwenzenjani?**
(What happened?)

Visitor: **Bebafuna ukumbamba inkunzi abanye abo***bhari,*
so hulle het hom gesteek.
(Some fools wanted to rob him,
so they stabbed him.)

Nurse : **Use laeneni, ayikho into engingayenza abo**doctor
bafanele bambheke kuqala.
(He is standing in a queue, the doctors
must first examine him, there is nothing I can do.)

Visitor: *Ei! die dokters* **nabo** *hulle is te stadig,*
Bra **yam** *ezocisha.*
(Oh! these doctors are too slow,
my friend is going to die.)

In the conversation the visitor used *tsotsitaal* to communicate with a Zulu-speaking nurse who answered in Zulu. Both the patient and the nurse understood each other even though they were not speaking the same language.

The following question is raised:

* Are all the nurses at Baragwanath Hospital able to understand these languages? If not, what happens to patients speaking *tsotsitaal* and *iscamtho*, when the nurse and the doctor do not understand them?

The answer to the question is probably a problem in communication between the patient speaking *tsotsitaal* and the nurse or doctor; this may in turn delay the process of giving the patient immediate medical attention. But communication is not the only criterion at play here; the patient's condition would have been clearly visible. It may also be possible that the patient's friend was unduly panicky. Again, another factor could be that there are too few nurses and doctors attending to the patients in the casualty ward at certain times.

4.8 The function of *tsotsitaal* and *iscamtho* at Baragwanath Hospital

Iscamtho and *tsotsitaal*, like any other language or language variety, also has social character. Both are associated with being urban, i.e. it becomes one of the most important social markers and defines an urbanite. It is also associated with being modern, whereas standard Zulu is associated with being conservative, parochial and backward (Ntshangase 1993:81). At Baragwanath Hospital patients as well as criminals speak *iscamtho* and *tsotsitaal.* Some people who are not criminals use this variety to indicate that they are modern or 'with it'.

Calteaux (1994) refers to the function of *tsotsitaal* as a secret language of prison gangs. As most of their activities are illegal, they do not want other people to hear what they are saying. Patients, who are criminals, do come to Baragwanath Hospital after being shot by the police (or by rivals/rival gangs?) in the process of committing a crime. This may cause some confusion when they are relating the circumstances of their injury to the nurse or the doctor.

These languages are mainly spoken by males who have either been stabbed or shot; they are mainly found in the casualty department. The researcher has not come across any female patients who speak either of these language varieties.

4.9 Summary

A form of codeswitching is often used at Baragwanath Hospital by staff members, patients and their visitors due to the varieties of languages spoken in this hospital. In order that patients, doctors and nurses understand one another, they sometimes need to codeswitch. Another reason which forces nurses to codeswitch regularly could be that most of the time they have to use English when communicating with the doctors or when using medical terms. On the other hand they have to speak an African language when communicating with patients.

The fact that the patients at Baragwanath Hospital are not equally educated and do not understand all the African languages or English,

causes the patients to resort to whatever language or language variety they know. They codeswitch in order to enhance the possibility of getting their message across.

Another factor which adds to the confusion at Baragwanath Hospital is the use of *tsotsitaal* and *iscamtho* by many patients. The majority of the doctors do not understand these varieties; therefore the patients speaking them are unable to receive immediate medical attention due to the delay caused by interpreters or doctors not understanding them.

This multilingual situation which prevails at Baragwanath Hospital and which operates at a number of levels, adds to the complex and yet dynamic interaction at the hospital. The complexity is compounded by the language attitudes of the nurse; this will be discussed in greater detail in the following chapter.

CHAPTER 5

5. Problems and attitudes towards language variation at Baragwanath Hospital

This chapter deals with problems caused by language varieties at Baragwanath Hospital as well as the associated attitudes towards language varieties.

There are a number of complex levels of communication at this hospital, most of which have been discussed in the previous chapters. Evidence of this is included in Tables 3.1, 3.2 and 2.3. Two tables are provided in this chapter (Table 5.1 and Table 5.2) to indicate languages used by doctors and nurses when communicating with patients, in order to give a clearer picture of the situation. The analyses of interviews and questionnaires is also discussed in more detail.

5.1 African languages

Table 5.1 Analysis of different languages used by different groups of people at Baragwanath Hospital

In Table 5.1, column 1 indicates the home languages spoken by patients. Column 2 gives the total number of patients speaking the languages listed in column 1. Column 3 gives an indication of the total number of nurses who could speak each of the languages listed

in column 1. Column 4 indicates the total number of doctors who could speak each of the languages listed in column 1.

Languages spoken by patients	Total number of patients speaking home-language	Total number of nurses who can speak each language	Total number of doctors who can speak each language
Zulu/Basic Zulu	447	90	12
Xhosa	134	58	2
S.Sotho	224	57	3
N.Sotho	22	40	2
Tswana	212	81	2
Venda	6	10	-
Tsonga	34	18	2
English	11	100	80
Afrikaans	11	61	13
Ndebele	6	7	-

Table 5.1 indicates that Zulu is spoken by 447 (40%) patients, 90% nurses and 12 (15%) doctors; Xhosa is spoken by 134 (12%) patients, 58% nurses and 2 (2.5%) doctors; S.Sotho is spoken by 224 (20%) patients, 57% nurses and 3 (3.75%) doctors; N.Sotho is spoken by 22 (2%) patients, 40% nurses and 2 (2,5%) doctors; Tswana is spoken by 212 (19%) patients, 81% nurses and 2 (2.5%) doctors; Venda is spoken by 6 (0.5%) patients, 10% nurses and (0%) of the doctors; Afrikaans is spoken by 11 (1%) patients, 61% nurses and 13 (16.25%) doctors, Ndebele is spoken by 6 (0.5%) patients, 7% nurses and (0%) of the doctors. English is spoken by 11 (1%) patients, 100% nurses and 80 (100%) doctors.

(Please note: only percentages are used in indicating the nurses' numbers, as there are only 100 nurses who answered the questionnaires.)

Although Zulu is spoken by 40% patients, 60% patients (out of the total number of 1 118 interviewed) and 88.75% doctors (out of a total number of 80 doctors who answered the questionnaire), do not understand this language. With these figures to hand, as well as the diversity indicated by the rest of the table, it can be concluded that none of the African languages spoken by patients at Baragwanath Hospital would naturally become the dominant language of communication here.

5.2 Afrikaans

Of the total number of 1 118 patients interviewed, only 11 use Afrikaans as a medium of communication. These patients are predominantly from Westonaria, Eldorado Park, Kliptown and Coronationville in Johannesburg. Thirteen doctors of the total of 80 doctors (who are all South African citizens) could speak Afrikaans; 61 nurses out of the total number of 100 nurses could speak Afrikaans as indicated in the questionnaires. Possibly, nurses who know Afrikaans refuse to acknowledge this as they have an attitude problem towards the language. The patients encounter problems as doctors from foreign countries cannot communicate using Afrikaans. Another factor compounding the problem, is that most of the nurses, especially those speaking Zulu and Xhosa, have a problem in communicating and understanding Afrikaans. The reason for those nurses not speaking

Afrikaans could be that the areas from which the majority of these people come have traditionally been English-speaking areas; that is, KwaZulu-Natal and the Eastern Cape.

Although there is a communication problem with those patients who speak Afrikaans, they are in the minority in this hospital. So it may be said that Afrikaans serves as a medium for a minority of doctors and patients at the hospital.

5.3 English

The data obtained from the questionnaires and interviews indicate clearly that English plays an important role at Baragwanath Hospital. All the doctors, including those who are from foreign countries, understand English (Table 3.2); they use this language when communicating with nurses (consider example 5 in Chapter 4), patients (Table 5.2), and among themselves.

The nurses also use English when communicating with doctors; some nurses use a mixture of an African language and English when communicating with patients (see example 4 in Chapter 4).

However, 838 (75%) patients out of the total number of 1 118 who were interviewed do not understand English; this is especially more so among the elderly people. Because English is not spoken or understood by 75% of the patients at the hospital, it is not possible that English could become the official language of communication at the hospital.

5.4 Conclusion

Even if Zulu is spoken by 40% of the people at Baragwanath Hospital it cannot function as the only medium of communication, as the majority of the patients, as well as the doctors, do not understand or speak this language. The same applies to the Sotho languages, Afrikaans as well as English.

The people involved can only communicate with each other if they are willing to accept one another and compromise their language to the extent that they can understand one another. At least, there should be an acceptance of the situation and that each person is prepared to go halfway towards understanding the other person's language or the problem that the person may have in communicating.

5.5 Interview analysis

In this section the information obtained from the patients through interviews and from the nurses who filled in the questionnaires is discussed and analysed.

5.5.1 Language situation at Baragwanath Hospital

The data obtained from the interviews indicates that English is the language which is spoken most frequently by nurses and doctors at Baragwanath Hospital. In the case of the African languages, Zulu can

be understood by Xhosa and Ndebele speakers as well as most of the patients who are from the urban areas. Even though some of the patients cannot speak Zulu very well, they often try to understand and reply in Zulu when addressed by another Zulu-speaking patient.

In Baragwanath Hospital most of the Sotho-speaking patients indicated during interviews, that Zulu-speaking patients made no effort to speak any language other than their own. Therefore, in order to communicate with them, they are forced to use Zulu.

Another factor which forces patients to use Zulu, even if Zulu is not their home-language, is that some of the doctors greet patients in Zulu, because many of the doctors have been taught basic concepts in Zulu while doing their medical training.

In the case of the Sotho languages, there is little difference between Southern Sotho, Tswana and Northern Sotho. The patients speaking these languages can understand one another. However, some nurses have indicated in their questionnaires that they only understand one African language from one group (Refer to Table 3.2).

The information obtained from the interviews, indicates that the majority of Sotho-speaking patients are from the rural areas and neighbouring countries such as Botswana and Lesotho (see Tables 3.1 and 5.1). These patients have a problem understanding any of the Nguni languages, while Nguni-speaking patients from rural areas also have a problem understanding any of the Sotho languages spoken at the hospital.

Venda and Tsonga-speaking patients face a serious problem; nurses, doctors and other patients who understand these languages are a distinct minority (refer to Table 5.1). Most of these patients are from rural areas and cannot communicate in any language except their own. They also experience problems in finding people who can act as interpreters.

An added complication to the multilingualism at Baragwanath Hospital, is the influx of people into the Gauteng area from countries such as Mozambique, Zimbabwe and Zaire. These people generally speak French, Portuguese, Shona and English, and usually cannot understand any of the African languages spoken at the hospital. These non-South African patients often keep to themselves and use their own language or English when speaking to nurses or doctors.

The data regarding the languages used for communication obtained from the interviews, have been synthesised in the next Table and indicate that most of the patients who are from rural areas and countries outside South Africa, are usually referrals by private doctors and other hospitals. This is illustrated in Table 5.2 below:

Referrals

Table 5.2

Column 1 of this table indicating referrals shows the place that patients originated from. Column 2 indicates which institution or

individual referred patients to Baragwanath Hospital. Column 3 shows where patients resided at the time of the interviews. Column 4 indicates their home language. Column 5 indicates their level of comprehension of English, while Column 6 indicates the languages that doctors use for communicating with patients.

PLACE OF ORIGIN	REFERRAL	PRESENT RESIDENCE	HOME LANGUAGE	LEVEL OF ENGLISH	LANGUAGE OF COMMUNICATION USED BY DOCTOR
Sebokeng	Edenvale hospital	Sebokeng	South Sotho	Weak	English
Sebokeng	Natalspruit Hospital	Thokoza	Zulu	Poor	English
Lesotho	Sasol Hospital	Lesotho	South Sotho	Good	South Sotho
Vokrosh	Private doctors	Vokrosh	Zulu	Poor	English
Potchefstroom	Private doctor	Parys	South Sotho	Poor	Afrikaans
Botswana	Princess Marina Hospital	Botswana	Tswana	Weak	English
Bushbuckridge	Private doctor	Bushbuckridge	Northern Sotho	Weak	English
Standerton	Private doctor	Standerton	Zulu	Poor	English

PLACE OF ORIGIN	REFERRAL	PRESENT RESIDENCE	HOME LANGUAGE	LEVEL OF ENGLISH	LANGUAGE OF COMMUNICATION USED BY DOCTOR
Zimbabwe	Koos Beukes Clinic	Kliptown	Shona	Good	English
Venda	Private doctor	Venda	Venda	Poor	English
Nquthu	Private doctor	Nquthu	Zulu	Poor	English
Ermelo	Private doctor	Ermelo	Shangaan	Poor	English
KwaNdebele	Private doctor	KwaNdebele	Ndebele	Good	Zulu
Pampierstad	Private doctor	Pampierstad	Tswana	Poor	English
KwaZulu-Natal	Private doctor	Springs	Zulu	Poor	Zulu
Westenoria	Private doctor	Westornaria	Afrikaans	Poor	Afrikaans
Rustenburg	Private doctor	Rustenburg	Tswana	Weak	English
Lenasia	General hospital	Lenasia	Hindi	Good	English
Westdene	Coronation Hospital	Westdene	Afrikaans	Poor	English

PLACE OF ORIGIN	REFERRAL	PRESENT RESIDENCE	HOME LANGUAGE	LEVEL OF ENGLISH	LANGUAGE OF COMMUNICATION USED BY DOCTOR
Parys	Private doctor	Parys	South Sotho	Poor	English
Heidelberg	R.G Visser Hospital	Ruthanda	Zulu	Good	Zulu
Mafikeng	Randfontein Clinic	Bekkersdal	Tswana	Poor	English
Vokrosh	Amajuba Hospital	Vokrosh	Northern Sotho	Poor	English
Giyane	Private doctor	Giyane	Tsonga	Poor	English
Mozambique	South Rand Hospital	Mozambique	Shangaan	Good	English
Wolmaransstad	Tshepong Hospital	Wolmaransstad	Tswana	Poor	English
Western Cape	Private doctor	Western Cape	Xhosa	Good	English
Free State	Private doctor	Free State	South Sotho	Weak	Afrikaans
North-West	Private doctor	North-West	Tswana	Weak	English
Eastern Cape	Private doctor	Lawley	Xhosa	Poor	English

Column 1 indicates that referrals are from: Gauteng Province, KwaZulu-Natal Province, North-West Province, Free State Province, Northern Province, Eastern Cape Province and Countries such as: Lesotho, Botswana, Mozambique and Zimbabwe.

Column 2 shows that of the 30 referrals: 60% patients were referred to Baragwanath Hospital by private doctors; 33% patients by other hospitals and 6,7% patients by clinics.

In Column 4 the 30 referrals were 20% Zulu-speaking patients, 6,7% Xhosa, 16,7% S.Sotho, 20% Tswana, 6,7% N.Sotho, 10% Shangaan/Tsonga, 3,3% Venda, 3,3% Shona, 6,7% Afrikaans, 3,3% Ndebele and 3,3% Hindi-speaking patient.

In Column 5, out of the 30 referrals interviewed, 23,3% patients could communicate very well in English and had no problem understanding the doctors; 20% patients could not understand adequately; while 56,7% were unable to speak English at all with their doctors.

Column 6 indicates the language the doctor chose to use when communicating with patients. Eighty percent doctors used English when communicating with patients; 10% spoke Zulu; 6,7% spoke Afrikaans and 3,3% spoke S.Sotho.

5.6 Attitudes towards language variation

The data obtained through interviews indicate that the patients are very unhappy about some of the nurses who interpret.

One of the reasons is that nurses do not convey their messages accurately to the doctors; another reason is that nurses do not inform the doctors what happened to the patients during the doctors' absence. For instance, in one case, patient 1 collapsed during the absence of the doctor. Then the doctor, who was not informed by the nurse about what had happened to patient 1 during his absence, came to discharge patient 1. Patient 2, who was sleeping in the bed parallel to patient 1 was listening to the doctor talking to patient 1 about discharging him. Patient 2, who knew how to communicate in English, told the doctor that patient 1 had collapsed during his absence. Then patient 1, instead of being discharged, was kept for a longer time in the hospital under observation.

Yet another reason for patients disliking nurses was that they were scared of explaining all their problems to the doctors or having lengthy discussions with doctors because some nurses have told them to be brief when talking to doctors. This may be because they the nurses have 'more important' duties to perform than acting as interpreters.

There is also an indication that some of the nurses show a negative attitude towards patients speaking an African language other than their own. They do not want to switch to the patient's language, despite

the fact that the patient may not understand them. About 400 patients indicated this in their interviews.

As a result, many of the patients prefer to ask nearby patients, who may understand English even if it is limited, in order to help them with interpreting, rather than relying on the nurses for help. Another problem in this situation is that, those patients who understand English may have problems understanding the medical terminology used by doctors.

5.7 Analysis of questionnaires

In the questionnaires, 50 doctors out of the total number of 80 doctors have pointed out that they use body language (see 3.2.2) and make use of other patients nearby, to help them with interpretation. This clearly indicates that more than 50% of the doctors have a problem asking nurses to help them with interpreting. It has also been observed that, most of the time, doctors are not accompanied by nurses when checking their patients or consulting with them. The reason for this may be that doctors have realised that nurses are not willing to help them with interpreting.

This conversation took place between two doctors in the tearoom. It illustrates the kind of problems doctors encounter in the hospital because of language varieties and the unwillingness of nurses to interpret.

Doctor 1 : Most of the time when you get one of the nurses to translate for you, obviously it's a very rushed thing, and like a quick little conversation and the nurse does not even know you. You don't have the time to introduce the patient. They don't know who the patient is, and then it's all over. I think it's a very inadequate way of getting information.

Doctor 2 : Well, at times the nursing staff that can translate are not even available and we have to start calling the cleaners. If there are no cleaners around who can speak the lingo, you start calling other patients.

Some of the doctors also indicated in the questionnaire that there are cases in which they hear a patient talking for a long time obviously giving details; the nurse who is meant to interpret then gives only a short sentence as translation. The doctors wonder what the patient was actually saying. Other Nguni-speaking nurses indicated in their questionnaire that they can only speak and understand Nguni languages. The same situation applies to some of the Sotho-speaking nurses about the Sotho languages.

This information raises the following question:

Are those nurses, who indicated that they can speak one language or languages from one group only, telling the truth? or do they merely have a negative attitude towards other languages or languages in the other language group?

Indeed, if it is true that some nurses have a negative attitude towards other languages, it is a sad reflection on them; they have possibly chosen the wrong career, as their behaviour is unacceptable in the context of the medical profession and medical institutions. Being a care-giver in the caring profession implies that the patient's health and well-being takes priority over any other criteria.

5.8 Summary

The information derived from an analysis of the patient interviews and from the questionnaires collected from doctors and nurses, clearly indicates that there is a communication problem at Baragwanath Hospital owing to the number of languages involved. Other communication problems are caused by some of the nurses' attitudes. Where a multiplicity of languages is spoken, one can assume that these problems are typical of public hospitals in Gauteng.

As communication lies at the very heart of positive medical interaction and often forms part of the healing process itself, the political will to address such communication barriers will have to be found, so that the health system may become effective.

An added complication to the language situation at Baragwanath Hospital is that the nurses are not willing to ask their colleagues to help them when they encounter problems with other African languages; this could possibly be rooted in fear of having their image tarnished in the eyes of their colleagues. Or do they simply not care?

The nurses sometimes give doctors the impression that they understand all the African languages, when in fact they don't. Whichever way, it is always the patient who is on the receiving end.

Suggestions are made in Chapter 6; these may help solve such problems as have already been described.

CHAPTER 6

6. General conclusion

6.1 Introduction

In this Chapter a summary of the thesis is presented. Proposals are suggested that may be constructive in easing the situation; suggestions are also made for further research. As Baragwanath Hospital is the largest hospital in South Africa, and has a very high population density as well as a high patient/nurse/doctor ratio, it appeared to the researcher that it was an important setting in which to conduct research. The interactions of various speech communities as well as the lack of any common variety, seemed to create an enormous problem, where doctors, nurses and patients fail to understand one another in a situation of crucial importance.

During the course of the study, it has been observed that nurses make use of codeswitching on a regular basis. They communicate with doctors in English; they use a variety of languages when speaking to patients. Doctors on the other hand, encounter many problems when trying to communicate with their patients even on a basic level; many patients speak several varieties of languages (other than English), including *tsotsitaal* and *iscamtho*.

Attitudes towards language varieties also play an important role in communication. During this study, problems often arose because of

the attitude of some nurses towards certain African languages. It was apparent that some problems arose because nurses were not willing to ask their colleagues to help them when they encountered problems with African languages spoken by patients and which they did not know. Their unwillingness to help each other worsened the situation in helping the patients' illnesses. Scenarios presented in chapter 3 reflect nurses' attitudes, and clearly illustrate the sort of problems which arise as a result of this. In scenario 2, for example, the doctor called the nurse to interpret the patient's account of her illness. The nurse who was Zulu-speaking, interpreted in Zulu even though she realised that the patient's mother did not understand Zulu, since she was a Sotho-speaking person from Parys, in the Free State. The patient's mother did not know what to do next because she had not understood the nurse; the researcher who happened to be present at that particular time was able to help her.

The nurses, who claim to have a heavy workload, appear to be largely unwilling to help interpret and translate; this fact may contribute to their attitudes towards the problem in communication. The complex situation became evident during the progress of the study; each participants' view had to be considered. Suggestions for solving such problematic situations are discussed later in this chapter.

6.2 Communication problems reflected in this study

The most important problems which occur at Baragwanath Hospital, owing to language variation, have been highlighted in the preceding chapters. These include:

1. The communication problems between patients and doctors, which is caused by the use of different language varieties; there is little understanding between the two parties, which could lead to incorrect diagnoses. In scenario 6, for example, the doctor, who failed to get help from the nurse, used body language to communicate with his patient. The patient was discharged from the hospital. The same patient was re-admitted after three days, his condition having worsened.

2. The communication problems between patients and nurses is caused by an attitude towards certain languages. Evidence is presented in scenario 4. For example a Sotho-speaking patient, who could not communicate in English, asked a Zulu nurse to report to the doctor that the medicine the doctor had given her, gave her stomach cramps and made her vomit. Later on, the same nurse came back and administered the same medicine to the patient, but the patient refused to take it. The nurse then reported to the doctor that the patient had refused to drink the medicine. She did this without explaining to the doctor what the patient had originally said about the medicine.

3. Doctors, who do not understand any of the African languages, are faced with problems when communicating with their patients at Baragwanath Hospital. This is partly due to the fact that some nurses are unwilling to help them with interpreting and translation. On the other hand, doctors are unable to communicate in other African languages; although they may

know the basics of another language, they are not able to use the unfamiliar language for making decisions on medical problems.

From the analysis of questionnaires (refer to Table 3.3) the following conclusions have been drawn with regard to the nurses:

1. The findings reveal that of the 100 (100%) nurses who filled in the questionnaires 92 (92%) cannot speak all the African languages. Therefore, not all of them can be expected to interpret all the African languages spoken by patients at Baragwanath Hospital. Nurses could speak one or more of the African languages and not all nine languages as indicated (in Table 3.3).

2. The findings show that of the 100 (100%) nurses who answered the questionnaires 40 (40%) were not willing to help doctors with interpreting. This could have adverse effects on the patients. Look at scenario 6, for example.

3. Of the 1 118 (100%) of the patients who were interviewed 391 (35%) indicated that nurses did not want to speak African languages other than their own. For example: A Tswana-speaking patient asked the nurse to give her water to drink. The nurse told the patient to wait. The patient later asked the same nurse to give her water to drink, using Zulu. The nurse who was Zulu-speaking, did not hesitate this time.

Given these observations, the researcher suggests certain proposals in the following paragraphs.

6.3 Proposals

6.3.1 Language training for doctors

The most logical proposal would be to have doctors learn an African language spoken by the majority of patients. However, another proposal would be to teach doctors key questions, phrases and responses in African languages such as; Zulu, S.Sotho and Tsonga. Showing the willingness to speak the patients' language (however badly) gives the patient more confidence. Certain phrases would cover most situations; some examples are:

* I want to help you
* Speak slowly (or)
* Show me
* Where does it hurt?
* Are you feeling better?
* Is it still bad?

1. Most of the doctors have indicated in the questionnaires that they are willing to learn at least one or even two of the African languages spoken by the majority of patients; therefore a training session could be organised at Baragwanath Hospital to teach them key questions and responses. Ideally, a full course could be specially designed for them.

2. In all instances key questions should be taught with appropriate responses. Each question and response would be practised first in one language, and then in another. A written English phrase would be followed by alternative responses. The process would start with the learning of the most common forms; but later learners would be exposed to other forms that mean the same as the first form, which they are likely to hear. The learning process would involve more alternatives as it progresses.

Example 1:

Stage 1: Teacher presents the question in English but says the African language version twice. Students don't see the writing of an African language version until they are familiar with the pronunciation. For example: Where does it hurt? (English)
Kubuhlungu kuphi? (Zulu) x 2

Stage 2: Teacher presents the written form in an African language and repeats this twice or three times, students repeat to practice pronunciation. Students then see the written words and pronounce them (using visual and listening skills together). For example: The teacher shows a flashcard written in Zulu: Kubuhlungu kuphi; she pastes it on the board and they read it.

Stage 3: Some possible responses to this question are practised with the same procedure as stages one and two. As the teacher gives the response,

students touch the appropriate parts of the body and pronounce the phrases. This will help them remember the appropriate vocabulary for parts of the body. For example: "Kubuhlungu idolo" "The knee is painful" i.e (following stages 1 and 2).

Stage 4: Teacher divides the class into two groups. One group asks the questions, the other gives the responses. This would be followed by working in pairs. Role play would also reinforce the vocabulary.

Stage 5: Teacher asks learners to name the common parts of the body about which patients normally complain. He/she writes these on the board in Zulu, South Sotho and Tsonga. Students then practise the question/response routine using these different parts of the body. For example:

Head	(English)
ikhanda	(Zulu)
hloho	(S.Sotho)
nhloko	(Tsonga)

The vocabulary involving parts of the body, forms the foundation for communicating or eliciting information about pain and where it is located. Related questions involving time could be taught next. For example:

Example 2:

Question	:	When did the pain start?	(English)
Answer	:	Yesterday/Long ago/in the morning	(English)
Question	:	Buqale nini ubuhlungu?	(Zulu)
Answer	:	Izolo/Kudala/Ekuseni	(Zulu)
Question	:	Bo qadile neng bohloko?	(S.Sotho)
Answer	:	Maobane/Khale/Hoseng	(S.Sotho)
Question	:	Ku vava loku ku sungurile rini?	(Tsonga)
Answer	:	Tolo/Khale/Ni mpundzu/Mixo	(Tsonga)

(At this stage phrases and responses are taught)

Example 3:

Question	:	Is it painful when I do this?	(English)
Answer	:	Yes/No	(English)
Question	:	Ho bohloko ha ke etsa jwana?	(S.Sotho)
Answer	:	Ee/Tjhee	(S.Sotho)
Question	:	Kubuhlungu uma ngenza nje?	(Zulu)
Answer	:	Yebo/Cha	(Zulu)
Question	:	Ka vava loko ndzi endla leswi?	(Tsonga)
Answer	:	Ina/Ee	(Tsonga)

Doctors could meet early in the morning for a brief lesson and then use the material in practise, for the day. Doctors should explain that they are learning and that they request patients to help them. Also this will improve the relationship between the doctor and the patient.

These phrases can be written out on flashcards and pasted on the walls of the consultation rooms to reinforce the learning. Doctors could carry these flashcards around with them. Cassettes may also be made available to the learners so that they become familiar with the pronunciation of the phrases and words.

Using this method of teaching key questions, responses and phrases could help reduce the problems encountered in communication between doctor and patients.

In addition to language training for doctors who do not know any African languages, there is an urgent need to increase the number of doctors who know and speak an African language at Baragwanath Hospital.

6.3.2 Additional suggestions: nurses' training

In addition, there are further suggestions that could help improve the situation.

1. Special posts need to be created for interpreters at Baragwanath Hospital. Nurses who have worked for a long time and are familiar with the situation, could be thoroughly trained by the hospital to become interpreters. The advantage of using such nurses is that they have some knowledge of medical terminology and processes.

2. Nurses have to mediate between two different linguistic and conceptual systems within the rigidly hierarchical structure; nurses form an important link between doctors (at the top) and patients (at the bottom). Consequently, nurses should receive recognition, financial reward and additional training for such complex and demanding tasks.

3. If interpreters are hired, they should know at least four languages, that is, one of the Nguni languages, preferably Zulu, in addition to English; one of the Sotho languages, and Tsonga or Venda. The reasons why these would be the best choices is that according to Table 3.1, 40% of the respondents spoke Zulu, followed by South Sotho, spoken by 20% of the respondents. Tsonga (3%), compared to Venda (1%), is spoken by a large number of patients, especially in the maternity department. (Refer to Tables 1.4, 3.1 and 3.2).

   In addition to this competency, interpreters should have a basic knowledge of medical terms.

4. One of the prerequisites of working at Baragwanath Hospital is that interpreters should be dedicated to their work. Honesty and accuracy in interpretation should be their main priority, purely because lives are at risk. This dedication and accuracy is supported by Searle (1981:65) who states:

   > ...a critical element in nursing care is the act of communication. It requires greater skill than any of the highly involved technological procedures

> nurses are required to carry out... Is there any constant and consistent strengthening of such skills throughout the training period? In a multilingual community with a wide diversity of language groups, true nursing collapses without this bridge building skill and deteriorates into a technical service.

(The researcher is aware that the source is 16 years old; however, the observations made are applicable to the situation.)

5. As a result of the changes occurring in the health care system, nursing is experiencing pressure from many sources (Ruano, 1971:417). Despite the fact that this source is 25 years old, nevertheless it still applies to Baragwanath Hospital.

> If nursing responds tropistically to all these pressures, the profession could grow in so many directions that the outcome might easily be diversity to such an extent that coordination would be impossible and chaos would be inevitable. If innovation is the response, certain characteristics of individual practitioners must be developed if they are to be equipped to act as innovators, and certain supportive functions must be carried out by the profession to facilitate their acting as change agents.

Ruano also points out that: "...nurse educators structure the students' learning experiences to the extent that the student

could be an innovator in the student setting; however, once they have achieved their qualifications they appear to shrug off this important responsibility."

6. Part of the solution would be to restructure the initial training that nurses undergo. This should incorporate training in medical ethics; trainee nurses should be aware that the patients they treat belong to a community, and that this community is aware of their conduct as nurses. Therefore nurses must take responsibility for their role in the patients' treatment.

7. Once nurses are fully trained, a series of financial incentives would facilitate the growth of a more responsible attitude. Another incentive would be to promote nurses on the basis of responsible conduct and the interest they show in their work. This would mean that both the community and doctors are thoroughly involved, and nurses are aware of this. Promotion, therefore, would not be based entirely on the acquisition of further qualifications, merely a collection of pieces of paper.

   Nurses would in effect be able to take ownership of their important role in assisting patients, and in the healing process. They would do this as much for the patients' good as for their own good.

6.4 Conclusion

The language situation at Baragwanath Hospital is a complicated one. The picture given in this thesis is a limited representation of what actually happens. However, the data is self-explanatory; such an approach is in line with the qualitative nature of the study. Furthermore, a conscious attempt has been made not to impose the researcher's own ideas on the data by attempting to fit it into predetermined categories. The description of the complexity of the problem is described in chapters 3, 4 and 5.

It has been shown in this thesis that none of the languages identified in chapters 3 and 5 can be used as the only language of communication. That is, there is no one language which doctors and patients can use for mutual understanding. This is despite the fact that Zulu may appear to be the most spoken language, spoken by 40% of respondents (Table 3.1). Patients and doctors are facing a real crisis in communication due to the variety of languages used in this hospital, the unwillingness of some nurses to help in interpreting, as well as the negative attitudes of some nurses towards patients.

Most of the nurses performing the task of interpreting, do not care whether a patient and a doctor understand each other or not. Since they are not paid for doing the task, they think interpreting is not part of their duty.

Nurses working at Baragwanath Hospital should ideally be able to speak at least Nguni and one Sotho language in order to minimise problems when communicating with patients. It should be remembered that in fact patients, doctors, visitors and nurses come from a large variety of ethnic backgrounds at Baragwanath Hospital; even the minimum requirement for nurses of having one Nguni language and one Sotho language, as well as English may not cover all situations.

What remains to be done is to find a way for these people to communicate with one another. This can only happen if people are willing to accommodate others; the rationale of 'own language' should not be the issue. The main issue is communication, and the understanding that flows from this.

6.5 Suggestions for further research

This study has investigated the different language varieties occurring at Baragwanath Hospital. Many of the problems that occur in this hospital were shown to be rooted in problems with communication. It was also demonstrated in a number of scenarios that these problems have led to an almost complete breakdown in communication in some situations; in other situations the problems were made worse by unwilling or uncooperative interpreters, or the lack of anybody to interpret at all. Sometimes the situation was hampered by nurses who had negative attitudes towards other languages.

This thesis paves the way for further studies on language varieties and language attitudes at other hospitals. Such investigations in medical situations, especially on these two aspects, would possibly lead to an improvement in the efficiency and function of hospitals in this country; it would therefore benefit society as a whole.

It is also important to investigate the question of why nurses are so unwilling to help with interpreting. As WHO (1974/1:8) states:

> There is a widespread belief that better Management of health services is essential if higher standards of health and health care are to be achieved. Without effective management, attempts to improve the organisation, structure and functioning of services will meet with little success.

(As mentioned earlier, despite the reference being 23 years old, the researcher feels that it still has relevance to the situation under study.)

There is also a need for further research to be done on how a system of interpreters would be implemented; how they would be selected and trained in medical situations, and how they in turn could train experienced nurses in their own situations.

Marks (1994:196) quotes an anonymous matron at the time of a strike in 1992 at the Baragwanath Hospital:

> Nurses are intimidated from all sides, from the strikers who see us as scabs, from our bosses who threaten to fire us, from our own disciplinary body, the South African Nursing Council (SANC) which [now] tells us that we have the right to strike, but which also tells us that if we leave our patients to spend even an hour on the picket-line we will be struck off the roll.
>
> In all of this, the failures of the health services and the intolerable strains in the hospital have often been blamed by the public, on the black nurses who are the most visible scape-goat for a multitude of ills.

The Sunday Times dated September 10, 1995 also had the following pertinent report:

> When nurses at Baragwanath Hospital opened their pay packets in August 1995, they did so with more enthusiasm than usual - their annual increase, backdated from July had come into effect. But the pay rise for most, with tax and other deductions, came to little more than R80 a month. Over tea and in the corridors, they spoke of little else. On Tuesday, August 29, two days after payday - The Baragwanath nurses, led by Sister Belinda Kgogo, called a meeting where they drew up demands including a 25% wage increase. A letter was faxed to the Gauteng government asking for a response by the end of the week.

> A letter on Friday from the Gauteng Premier, Tokyo Sexwale, promised to look into their problems "in due course". When no proper response was received, 1 700 Baragwanath nurses stopped working. The strike spread immediately to Soweto clinics, whose nurseshad been at Baragwanath that day to find out what the government's response would be.
>
> By the end of the week the strike had spread to the Hillbrow and Garankuwa hospitals and 15 Gauteng clinics.
>
> Doctors supported the nurses' pay demands, but many were angry about the way they had walked out. An Eastern European doctor at Baragwanath was so exhausted after 22 hours on duty that he stuck a needle into his finger.
>
> The hospital, located at the entrance to sprawling Soweto, handles more than 44 000 operations a year. It serves 15 000 meals, washes 50 tons of laundry a day and has a staff of 10 000. The casualty and out-patients section handled more than four million people in 1995. Like other Gauteng teaching hospitals, Baragwanath's budget in 1996 was cut by 20%, R600 million, as central government redirected the health budget towards primary care, in an attempt to get a better return from spending.

The information quoted from the Sunday Times could be the same as some of those reasons behind why nurses are not willing to help

doctors with interpreting. The nurses' negative attitude towards patients in general could be due to their unhappiness at work. In order to solve such problems the government and the hospital management should first look into the problems regarding staff salaries, especially at big hospitals such as Baragwanath Hospital. Perhaps, while achieving staff satisfaction, more efficient services will become part of the improvement; this can only help patients too.

Because Baragwanath Hospital is located in an area such as Soweto in Gauteng, where almost all the languages spoken in Southern Africa are used, there should be some provision made towards the problems and stumbling blocks of living in a multilingual society. Doctors and nurses serving the community need to acquire the tools for working effectively in such a situation. The provision of health care remains a basic need and should be regularly reassessed and improved.

BIBLIOGRAPHY

Abrahamson, M. 1983. : Social Research Methods England Cliffs: NJ: Prentice-Hall, Inc.

Babbie, E.R. 1992. : The Practice of Social Research. California: Wadsworth Publishing Company Inc.

Baker, T.L. 1988. : Doing Social Research. Singapore: McGraw-hill Book Co.

Bantlwana, K. 1984. : Case-study on Relations and Interaction between Hospital Staff and Patients: "An observation study of nurse patient communication in an out-patient department and a medical ward - Princess Marina Hospital". Gaberone: Unpublished discussion paper. pp 1-7.

Baragwanath Hospital Year book. 1994/1995. : "Statistics for the year 1994/1995". Johannesburg: Fox Publishing (Pty) Ltd.

Baragwanath Hospital Year book. 1995/1996. : "A Proud History of Baragwanath Hospital". Johannesburg: Fox Publishing (Pty) Ltd.

Bogdan, R.C. and Bilken, S.K. 1982. : Qualitative Research for Education An Introduction to Theory and Methods. Boston Mass : Allyn and Bacon, Inc.

Bokamba, E.G. 1988. : Code Mixing, language variation and linguistic theory: "Evidence from Bantu Languages". Unpublished Paper presented at the 16th Annual Conference on African Linguistics. Yale University, Connecticut.

Burgess, R.G. 1984. : In the Field. An introduction to field research. London: George Allen and Unwin (Publishers)Ltd.

Calteaux, K. 1994. : A sociolinguistic analysis of Multiligual community. Unpublished thesis for the degree DLitt et Phil. Johannesburg: Rand Afrikaans University.

Coplan, D.B. 1985. : In Township Tonight! South Africa's Black City Music Theatre. Johannesburg: Ravan Press (Pty) Ltd.

Crawford, A. 1995 : "At the heart of the healing. Traces the web of power in health care" in Bua. Vol. 9 Number 4.

Downes, W. 1984. : Language and Society. The Chaucer Press London.

Dube, M R. 1992 : Language Attitude in Soweto - The place of the indigenous languages. Unpublished dissertation for the degree of M.A. Pretoria: Vista University.

Eastman, C.M. 1992. : "Codeswitching as an Urban Language Contact Phenomenon", in Journal of Multilingual and Multicultural Development. Vol 13 Numbers 1 and 2.

Fasold, R. 1984. : The Sociolinguistics of Society. Oxford: Basil Blackwell.

Ferguson, C.A. 1959. : 'Diglossia'. Word, 15:325-340 Reprinted in Giglioli (ed): Language and Social Context. pp. 232-251.

Ferguson, C.A. 1971 : Language Structure and Language Use: Essays USA. Stanford University Press.

Finlayson, R., Myers-Scotton, C and Calteaux, K 1996. : "Orderly mixing: Codeswitching in the South African Township" Unpublished Paper.

Finlayson, R and Slabbert, S 1996. : "Language and Identity: A Comparison between Nguni and Sotho". Paper presented at the Annual Conference on African Linguistics, UCLA.

Fishman, J.A. 1972. : "Domains and the relationship between micro-and macrosocioliguistics". In Gumperz & Hymes (eds): Directions in Sociolinguistics. Holt, Reinart, Massachusetts.

Gumperz, W.A. 1968 : Directions in Sociolinguistics. Cambridge University Press.

Gumperz, W.A. 1972. : "Introduction". In Gumperz and Hymes (ed): Directions in Sociolinguistics. pp.1-25.

Gumperz, W.A. 1972b. : "The Speech Community". In Giglioli (ed.) Language and Social Context. pp.219-231.

Guthrie, M. 1971. : Comparative Bantu, Volumes I-IV. Farnborough: Gregg International Publishers.

Hauptfleisch, T.(ed) 1978. : Literacy in South Africa. Pretoria, HSRC.

Hauptfleisch, T. 1977. : "Language Loyalty in South Africa?" Vol. 1 in Bilingual Policy in South Africa - Opinions of White Adults in Urban Areas. Pretoria: HSRC.

Hellman, E. 1967. : Soweto: Johannesburg's African City, South African Institute of Race Relations.

Huddle, K and Dubb, A. 1994 : Baragwanath Hospital 50 Years. A Medical Miscellany South Africa: Ultra Litho (Pty) Ltd.

Hudson, R.A. 1980. : Sociolinguistics. Cambridge: Cambridge University Press.

Hudson, R.A. 1983. : Sociolinguistics. Cambridge. Cambridge University Press.

Influx Control Act, No. 68. 1986. : Act of Parliament, Government Notices and Proclamation. Abolition of Influx Control Acts. R.S.A.

Lebelo, M.S. 1990. : Apartheid's chosen few: "Urban African Middle classes from the slums of Sophiatown to the Northern suburbs of Johannesburg, 1935-1985"; Paper

presented at the History Workshop Conference, University of the Witwatersrand.

Lehiste, I. 1988. : Lectures on Language Contact. London: MIT Press.

Lieberson, S. 1981. : Language Diversity and Language Contact. Stanford University Press. California.

Li Wang, V. 1977. : "Social Goals, Health Policy and dynamics of Development as bases for Health Education". In International Journal of Health Education 20. pp4.

Mackey, W.F. 1968. : "The Description of Bilingualism". In Fishman (ed) Readings in the Sociology of Language. pp 554-584.

Marks, S. 1994. : Divided Sisterhood Race, Class and Gender in the South African Nursing Profession. South Africa: Witwatersrand University Press.

Marston, M V. 1978. : "Nursing Management of Compliance with Medication Regiments: Changing philosophy of nursing profession with respect to 'Managing patient health

behaviour'". Quoted in Medication Compliance: A behavioural Management Approach. Thorafare, New Jersey: C.B. Slack Inc.

Meulenberg-Buskens, I. 1993.: "Qualitative Research in South Africa". Unpublished paper. Human Sciences Research Council, Pretoria.

Mfenyana, B. 1977. : IsiKhumsha nesitsotsi: The sociolinguistics of school and town sintu in South Africa (1945-1975). Unpublished thesis for the degree of M.A. Boston. Boston University.

Mfusi, M 1990. : Soweto Zulu Slang: A Sociolinguistic study of an Urban Vernacular in Soweto. Unpublished Mini-dissertation for the degree BA Honours. Pretoria University of South Africa.

Miller, W.L. and Crabtree, B.F. 1992. : "Primary Care Research: A Multimethod Typology and Qualitative Road Map". In Crabtree & Miller (eds): Doing Qualitative Research. pp.3-28.

Molefe, M J. and Kereng, K 1985 : "Attitude toward Post Natal Care". Gaborone. Botswana National Health Bulletin, Vo. 2, No. 2, pp.16-22.

Mooka, D. 1984 : "The extent to which mothers utilise maternal and health services:" Research paper submitted in partial fulfilment for the B.Ed Nursing requirements. University of Botswana. pp22-27.

Msimang, C.T. 1987. : "Impact of Zulu on Tsotsitaal". In South African Journal of African languages, 7(3): 82-86.

Myers-Scotton, C. 1979. : "Codeswitching as a 'Safe Choice' in choosing a Lingua Franca". In McCormack & Wurm (eds) Language and Society. pp 71-87.

Ngwenya, A. 1992. : "The static and dynamic elements of Tsotsi language with special reference to Zulu- A sociolinguistic study". South African Journal for African languages 12, Supplement 1:97-103.

Ntshangase, K.D. 1993. : The Social History of Iscamtho. M.A. Dissertation, Johannesburg: The University of the Witwatersrand.

Ntshangase, K.D. 1995. : "Indaba yami i-straight: Language and language practices in Soweto". In language and Social History. Studies in South African sociolinguistics, Raj Meshrie (eds), 291-297. Johannesburg: David & Philip.

Owens, F and Kwadibe, K 1985. : "Attitudes of Women in Maun towards hospital delivery and home delivery". Botswana National Health Bulletin, Vol. 1, No. 2. pp215-227.

Pantanowitz, D. 1988. : Modern Surgery in Africa. The Baragwanath Experience. Johannesburg: Southern Book Publisher (Pty) Ltd.

Parnell, S.M. 1990. : "The ideology of African home-ownership: The establishment of Dube, Soweto, 1946-1955". Paper presented at the History Workshop Conference, The University of the Witwatersrand, Johannesburg.

Pettifor, J. 1996. : Baragwanath Hospital Year Book 1995/1996. Johannesburg: Fox Publishing (Pty) Ltd.

RSA : Constitution of the Republic of South Africa: Act 200 Of 1993 as adopted by the Constitutional Assembly May 1996.

Romero, O. 1982. : Aspects of Code-switching in Bilingual children. Ann Arbor University Microfilms International.

Ruano, B. 1971. : "This I believe about Nursing". Nursing Outlook 19 (June 1971). pp416-419.

Ryan, E.B. and Giles, H. 1982. : Attitude towards language variations. London: Edward Arnold Publishers.

Samarin, W.J. 1962. : "Lingua francas of the world". In Fishman (ed.): Readings in the Sociology of language. pp. 660-672.

Samarin, W.J. 1968. : "Lingua Francas, with special reference to Africa". In Rice (ed.): Study of the Role of Second Languages in Asia, Africa and Latin America. pp. 54-64.

Saville-Troike, M. 1982. : Language and Society. The Ethnography of Communication. An introduction. England: Basil Blackwell Publisher Ltd.

Schuring, G.K. 1979 : A Multilingual Society: English and Afrikaans amongst Blacks in the RSA. HSRC, Pretoria.

Schuring, G.K. 1983. : "Flaaitaal", In Classen and Van Rensburg (eds): Taalverskeidenheid 116-133. Pretoria: Academica.

Schuring, G.K. 1985. : Kosmopolitiese omgangstale: Die aard, oorsprong en funksies van Pretoria - Sotho en ander Koine-tale. Pretoria: Raad vir Geesteswetenskaplike Navorsing.

Schuring, G.K. 1993. : "Sensusdata oor die tale van Suid-Afrika in 1991". Unpublished Working Document. Pretoria: Human Science Research Council.

Schwartz, H. and Jacobs, J 1979. : Qualitative Sociology. A Method of Madness. New York: The Free Press.

Scotton, C.M. and Ury, W. 1977. : "Bilingual strategies: Social Functions of Code-switching". International Journal of the Sociology of language. Vol. 13: 5-20 Nairobi: Oxford University Press.

Scotton, C.M. 1982. : "The possibility of code-switching: Motivation for Maintaining Multilingualism". Anthropological Linguistics. Vol. 24: 432-444. Michigan State University.

Scotton, C.M. 1988. : "Code-switching as indexical of Social Negotiations". Code-switching: Anthropological and Sociolinguistics Perspectives. Berlin: M de Gruyter Publishers.

Searle, C. 1981. : Some Aspects of Nursing Education. Pretoria: South African Nurses Association. pp65-75.

Seliger, H.W. and Shohamy, E 1989. : Second Language Research Methods. Oxford University Press.

Slabbert, S. 1994. : "A re-evaluation of the Sociology of Tsotsitaal". South African Journal of Linguistics, 12(1):31-41.

Slabbert, S. and Myers-Scotton 1995. : "The structure of Tsotsitaal and Iscamtho codeswitching and ingroup identity in South African Townships". Unpublished paper. The University of the Witwatersrand, Johannesburg.

Smith, H.W. 1975. : Strategies of Social Research: The Methodological Imaginations. New Jersey: Prentice - Hall, Inc.

Taylor, S.J. and Bogdan, R. 1984. : Introduction to Qualitative Research Methods: The Research for Meanings. New York: John Wiley & Sons.

The Sunday Times 1995. : "The hospital crisis: Are nurses paid too little?". Times Media Limited. September 10, 1995 p5.

Thomson & Coetzee 1987. : Urbanization and urban growth in the SATBVC States. Research Report No.7, Development Bank of Southern Africa, Halfway House.

Tuckman, B.W. 1994. : Conducting Education Research Fourth Edition. USA: Harcourt Brace & Company.

Van Den Heever 1991. : Baragwanath yearbook 1991/1992. Johannesburg: Fox Publishing (Pty) Ltd.

Van Wyk, E.B. 1978. : "Language contact and Bilingualism". In Lanham & Prinsloo (eds): Language and Communication Studies in South Africa. pp.29-52

Van Wyk, E.B. 1991. : "Sociolinguistics and Standard Languages". Unpublished Paper. Rand Afrikaans University.

Van Wyk, E.B. 1992. : "The Concept Standard Language". South African Journal of African Languages, 12 (supplement 1): 23-24.

Wardhaugh, R. 1986. : An Introduction to Sociolinguistics. Oxford: Basil Blackwell.

Weinreich, G. 1953 : Language in Contact. New York.

WHO 1974. : "Modern Management Methods and the organisation of health services". Public Health papers (1974/1) No. 55, Geneva.

Young, D. 1991. : "Attitudes Towards English in Education in a changing South Africa": A Western Cape Perspective Paper.

APPENDIX 1

QUESTIONNAIRE:

1. Are you a South African citizen ? yes .... no ....
   If no, state your country ....

2. What is your home language?...

3. State your rank at work. (e.g doctor, medical student, staff nurse, etc)
   ....
   ....

4. How long have you been working in this particular hospital ?
   ....
   ....

5. How many languages can you speak? ....
   ....

6. Which language do you prefer speaking? ....
   ....

7. Which African language is spoken by the majority of patients in this hospital ?...
   ....

A	ZULU	
B	SOUTHERN SOTHO	
C	TSWANA	
D	VENDA	
E	NORTHERN SOTHO	
F	XHOSA	
G	TSONGA	
H	OTHER	

8. Which language do you regularly speak at work ?

....

....

A	XHOSA	
B	AFRIKAANS	
C	ENGLISH	
D	ZULU	
E	SOUTHERN SOTHO	
F	NORTHERN SOTHO	
G	TSWANA	
H	VENDA	
I	TSONGA	
J	OTHER	

9. Which language do you normally use in contact situations at work?

....

....

10. Do you sometimes find yourself in a situation where different languages are actually used ? yes........ no............
If yes, which ones ? ....
....

11. Do you always understand your patients when consulting ? yes.... no.... If no,what do you normally do?
....
....

12. Give an estimation of the ratio of the patients understanding English in this hospital ? (e.g 1:3, 1 representing those who understand English.) ....
....

13. Would you like to be taught one of the African languages spoken by the majority of your patients ? ....
....

14. What results does language contact have for the languages involved?
....

15. Does the influence of one language on the other have a detrimental effect or does it develop the particular language ?
....
....

16. In your own opinion, how do people with different language backgrounds communicate

....

....

17. It is important for me as a Doctor:

		Not important	Fairly important	Very important
(a)	To be responsive to patients' needs and problems.	1	2	3
(b)	To be honest and tell the truth when making a diagnosis.	1	2	3
(c)	To make patients feel safe and at ease.	1	2	3
(d)	To take all patient complaints seriously.	1	2	3

18. Have you any comment on language variation in this hospital?

....

....

APPENDIX 2

INTERVIEW QUESTIONS:

1. Are you a South African citizen ? yes... no... If no state your country.

   ....

   ....

2. What is your home language ?

A	XHOSA	
B	AFRIKAANS	
	ENGLISH	
D	ZULU	
E	SOUTHERN SOTHO	
F	NORTHERN SOTHO	
G	TSWANA	
H	VENDA	
I	TSONGA	
J	OTHER	

3. If other specify? ....

   ....

4. Where do you live at the moment? ....

   ....

5. What is the highest standard passed at school? ....

   ....

A	NO SCHOOLING	
B	GRADE 1 & 2	
C	STANDARD 1-3	
D	STANDARD 4	
E	STANDARD 5	
F	STANDARD 6	
G	STANDARD 7	
H	STANDARD 8	
I	STANDARD 9	
J	STANDARD 10	
K	OTHER	

7. Do you work ? yes... no... If yes what type of job are you doing ?

   ....

8. How much do you earn per month?

   ....

A	±R500 - R1500	
B	R2000 - R3500	
C	R4000 - R5500	
D	R6000 - R7500	
E	R8000 - R9500	
F	R1000 - R12000+	

9. How many languages can you speak ? ....

   ....

10. Which language do you prefer ? ....

    ....

11. Which language did you use when talking to the doctor? ....
....

12. In which language were you answered by the doctor ? ....
....

13. Did you understand the language used by the doctor? during consultation?..
....

14. Do you sometimes find yourself in a situation where different languages are actually used simultaneously? yes....... no..........
If yes, which ones ? ....
....

15. Was there any nurse in the consulting room when talking to the doctor?..
....

16. Have you ever found yourself in a situation where you did not understand the doctor ? yes... no... If yes what did you do ?
....
....

17. Have you ever found yourself in a situation where the nurse was acting as an interpreter ? yes... no..If yes, which language was the nurse using when talking to you and which when talking to the doctor? ....

18. Which language do you prefer to hear in this hospital? ....
....

19. How many Africa languages can you speak ? Name them
....
....

20. How do you normally respond if you find yourself in a situation where more than two languages are used ? ....
....

21. Which language do you normally choose in contact situations: your mother-tongue, English or another language and why?
....
....

22. If you had to describe how well you understand English would you say:
....
....

1 = Perfect
2 = Very well
3 = Moderately well
4 = Not so good
5 = Hardly at all
....

APPENDIX 3

LENGTHY CONVERSATIONS

3.1 MEDICAL WARD

(Zulu words are underlined)

A conversation between two sisters in a Medical Ward. Sister 2 has just arrived for her night Shift.

Sister 2: Good evening sister.

Sister 1: Good evening.

Sister 2: How is the ward today ?

Sister 1: We had a very hectic day. We admitted 26 patients, eight of them very ill indeed. Anyway we had 15 discharges from our previous patients and two deaths. So we are left with 45. Come let's see them.

Sister 1: This is a very ill asthmatic which we admitted.
She is on a nebulizer three hourly. This one is a known diabetic but has defaulted thus she has been admitted. The doctor is still waiting for her blood results.

Sister 2: Manje lo ?
(what about this one.)

Sister 1: Lona, is mentally disturbed but has had her treatment already. Bheka lo mama, Udoctor uthesingamuphi ukudla as she is to go to theatre tomorrow (This one, is mentally disturbed but has had her treatment already. Look at this woman, the doctor said we must not give her any food, as she has to go to theatre tomorrow).

Sister 1: Laba abanye uyabazi, except that the treatment has changed on this one. This other patient will be transferred to intensive care unit as he has just resuscitated about 45 minutes ago, ICU said will phone us when the bed is ready as they were still preparing. (These ones you know, except that the treatment has changed on this one. This other patient will be transferred to intensive care unit as he has just been resuscitated about 45 minutes ago, ICU said they will phone us when the bed is ready as they were still preparing.)

Sister 2: This last one is a chronic renal failure. We are just waiting for the porter, to be transferred to the dialysis ward.

3.2 MEDICAL ADMISSION WARD

Conversation between two doctors, a registrar and an intern.

An intern: May I present my case ?

Registrar: Yes.

An intern: She is a lady of 68 years and she is suffering from hypertension.

Registrar: What treatment are you giving her?

An intern: Because she has swollen legs as well, I gave Lasix to drain and I will start with hypertension treatment after that.

Registrar: Please put her on oxygen because it looks like she is short breath as well, and she might have CVA (stroke) if the treatment is delayed. I also suggest that you must be careful that she does not become dehydrated, because of Lasix.

An intern: Yes doctor I will definitely do that. (Moving to the next patient).

An intern: This is an asthmatic, as we all know that when the weather is like this the asthmatics are suffering, she is short of breath as you can see that I have ordered a nebulizer, but the sister said it is out of stock but she will make means of getting it.

Registrar: This patient looks very ill, please I want a nebulizer urgently and hourly blood gases, I want to see the P.H.

An intern: Yes doctor
(Sister was just passing).

An intern: Sister, did you manage to get the nebulizer?

Sister: Yes doctor, here it is.

3.3 SURGICAL WARD

A conversation between two sisters. Sister 1 was working night duty and Sister 2 is resuming duty.
(Zulu words are underlined)

Sister 2 : Whoo! Iward ya ze yagcwala.
(Whoo! this ward is so full).

Sister 1 : Awazi wena ukuthi bekubusy ka njani, Sisebensze kwaze kwa sa! Sinama gunshots awu-six futhi a under guard. Three MVAs (Motor Vehicle Accidents) hit and runs. Two of them banama fracture's on both legs. This third one slightly injured and no fracture. Sibuye sa-admita five men with stabs, this other one with stab neck and two stab chest, lona omunye unama-multiple stabs. Look at this one, Umfazi umthele ngeboiling water as you can see he has 35% burns, as it is, he will be transferred to burns unit.
(You don't know how busy it was, we worked until

this morning. We have six gunshots who are under guard. Three MVAs hit and runs. Two of them have fractures on both legs.

This third one slightly injured and no fracture. We also admitted five men with stabs, this other one with stabbed neck, this other one has multiple stabs. Look at this one, his wife poured boiling water over him as you can see he has 35 degree burns, as it is, he will be transferred to the burn's unit).

Sister 2: Whoo! hi sono man! kodwa uzophola asiqale uku-admita such case. Uyakhumbula we had that one with 65 degree burns?
(Whoo! Its pathetic, but he will he healed, it is not the first time admitting such a case. Do you still remember we had that one with 65 degree burns)

Sister 1: Ngiyakhumbula! Waphelela kuphi?
(I remember! what happened to him?)

Sister 2: U hlele e-burns for three months but he survived, ku sele nje amascars. Uyazi ukuthi amascars akhona awasuki.
(He stayed at burn's department for three months but he survived, he has only scars. You know that those scars will always remain there.)

Sister 1: Kuze busuke kwenzenjani uma umuntu athela omunye ngamanzi?
(What could have happened if a person pours (throws) water on another person?)

Sister 2: Mzala, Manje these ones?
(Cousin! Now what about these ones?)

Sister 1: Okay! *Amper* ngakhohlwa, lomamalo ungambona oshaywe yindoda yakhe.
(Okay! I nearly forgot this woman, this one has been assaulted by her husband.)

Sister 2: How! bekwenzenjani aze amoshaye kanje?
(How! What actually happened, that made her husband to assault her like this?)

Sister 1: Athi ebeye kudoctor emini, U doctor umtshele ukuthi uPregnant.
(She said that, she went to see the doctor during the day who told her that she was pregnant.)

Sister 2: Manje angamshayela lokho nje.
(Then, can he really assault her for that?)

Sister 1: Uthi indoda yakhe ifuna ukubona ukuthi uzohlala kuphi naloyo umtwana, ngoba yena akafuni umtwana. Base beya-argue and he ended up beating her aze abe nje.
(She said that her husband told her that she must find a place where she can stay with that child, because he does not want any child in his house. Then they started arguing and he ended up beating her until she was like this.)

Sister 2: Anyway sizothini? Hamba muntu wabantu you must be tired.
(Anyway what shall we say? Just go, you must be tired.)

Sister 1: Thank you, have a nice day.

3.4 SURGICAL PIT WARD

Conversation between a patient and a doctor.
(Zulu words underlined, Tsotsitaal in Italics)

Doctor: Yebo baba! What can I do for you?
(Hello dad! what can I do for you?)

Patient: Yebo doctor ngilimele.
(Hello doctor I am injured)

Doctor: What happened?

Patient:	Doctor Gusho ukuthi besihlele *namagents*, kwase kusuka lama *authi* angilimaza ngize ngibe nje? Angali bengishayile kodwa hhayi kangaka ukuthi ngingaze ngilimale kangaka. (I was sitting with other gentlemen, then came other boys who assaulted me until I was like this. I don't deny the fact that I was drunk but not too much.)
Doctor:	Sister please come and help me here, I cannot hear what the patient is trying to say.
Sister:	Doctor I am coming I am still helping here.
Doctor:	Please this patient is bleeding and I do not understand what this patient is trying to say.
Sister:	Okay! doctor I won't be long. (Because the sister was still busy with another patient, the doctor decided to move to the next patient, leaving the bleeding patient alone.)
Doctor:	Hallo baba, what is wrong?
Patient:	Hallo! doctor. I injured my hand, while I was trying to put new glass in my window. I fell on top of the glass panes.
Doctor:	Oh! terrible did you fall on your hand?

Patient: Yes doctor as you can see.

Doctor: Okay I will have to order an X-ray to see if you have a fracture or not.
(Writing an X-ray form. Referring the patient to X-ray).

Doctor: Sister! are you ready now?

Sister: Not yet doctor, I am still busy with this patient and this doctor. Can you please ask somebody to help you.

Doctor: Where will I find that somebody dammit! This patient is in terrible state now.

Sister: Nurse!! (calling another nurse) Can you please help the doctor, he needs somebody to help him.

Doctor: Nurse, can you please prepare this patient for theatre it looks like his bleeding got worse and he looks very pale. I will have to order blood immediately.

3.5 ORTHOPAEDIC WARD

A conversation between a nurse and a nurse in the orthopaedic ward. (Zulu words underlined)

Nurse 1: Uphume nini emsebenzini mntwana?
(At what time are you leaving?)

Nurse 2: Ngisebenza seven to seven.
(I am working seven to seven.)

Nurse 1: Mina ngiyoze ngisebenze kusasa ngoba bengi weekend off.
(I was weekend off, therefore, I will be working seven to seven tomorrow.)

Nurse 2: Uyazi isikhathi sokuphuma kuleliward asisihle phela ngina three weeks ngisebenza ngingaphumuli.
(You know that this ward has problems regarding offs. I have been working for three weeks without a single weekend off.)

Nurse 1: Job hi! job mntwana, ayikho nje into engingayenza.
(Work is work my friend, there is nothing I can do.)

Nurse 2: Asibonane ngeteatime sizokwazi ukuqedela those assignments ngoba bekumele si submitte last week.
(Let us meet at teatime, so that we can complete our assignments because we were suppose to have submitted them last week.)

Nurse 1: Oh! ngiyabona ukungikhumbuza, besengikhohlwa.
(Oh! thank you for reminding me, I have forgotten completely.)

Nurse 2: Ok! Mzala, see you at tea time.
(Ok! My friend, see you at tea time.)

3.6 SURGICAL WARD

A conversation between a doctor who was accompanied by other doctors and a nurse.

Doctor: Nurse, can you please help us, we are doing the ward rounds.

Nurse: Okay doctor!

Doctor: I ordered blood for this patient and I also want to see the X-ray film.

Nurse: Yes doctor, I have sent somebody for the blood and the X-ray films.

[Moving to the next patient]

Doctor: This drip must come down and please remove his bandages and clean this wound and apply betedine on the open wound and just continue with the treatment.

Nurse: Yes doctor, I will do so.

Doctor: Nurse! This patient was supposed to have been discharged yesterday, what happened?

Nurse: Doctor, I had to refer him to the social workers because he did not have money for the transport and I also had to arrange some clothes for him as well, I think he will go today.

Doctor: This one is also for discharge too. Okay sister, I will see you after lunch, I am wanted in theatre urgently.

3.7 CASUALTY DEPARTMENT

A conversation between a doctor and a patient who was using tsotsitaal to communicate with the doctor.
(Zulu words underlined and Afrikaans word italicised)

Doctor: Sawubona baba! What's your name?
(Hello gentleman! What's your name?)

Patient: Mina nguMandla doctor.
(I am Mandla doctor.)

Doctor: What happened to you Mandla?

Patient:	Kanti *hoe's jy? Jy kan sien mos* ukuthi *wat gaan aan, maar jy vra my.* (How is this man? You can see that I am bleeding, but you are asking me.)
Doctor:	*Kan jy Afrikaans praat? Wat het gebeur, ek wil weet.* (Can you speak Afrikaans? I want to know what happened to you.)
Patient:	Doctor, *ek voel moes pyn. Ek was met die outies, toe kom die ander outie* and *toe* clash *ons.* (Doctor, it is painful. I was with my friends, then came another friend of ours. We then started quarrelling with one another.)
Doctor:	You'll have to go to X-ray and from there, I think you'll need I.C. drain and I'll have to order blood for you.
Patient:	*Ek voel* pain, and *ek soek moes pille* and *ek sal* X-ray *toe gaan.* (It is painful, I want pills, then I can go to X-ray.)
Doctor:	I can't give you pills now before the X-rays. (Calling the porter to wheel the patient to the X-rays.)