Lwati: A Journal of Contemporary Research, Vol. 2, 2005, pp.71 - 83

Linguistic Barriers at a Malawian Referral Hospital

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Introduction

There is a growing realisation that language is one of the critical components of any health service, whether it is the provision of therapy and curative drugs on one hand; or the provision of health education, on the other hand (see, for example, Candlin & Candlin, 2003; Crawford, 1999; Drennan 1998; Fitzpatrick et al. 1992; Youdelman & Perkins, 2002). Whenever there is a communication breakdown between a client and a health service provider due to the use of unintelligible speech forms, or when poor translation or interpretation is used, the quality of a health service may be compromised. This, for example, can lead a physician into making poor diagnosis and inappropriate prescriptions. In some unfortunate cases, loss of life can be the final result. Ong et al. sum up the critical role of language in health services as follows: "While sophisticated techniques may be used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and patient exchange information" (Ong et al. 1995: 903). Cameron and Williams also articulate the same view:

> Although we may think that the primary tools of medicine are technological, the most fundamental tool, upon which all use of technology depends, is that of language. Language allows patients and care-providers to make their intentions known, a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy. Thus if problems in linguistic encoding interfere with this process, there may be important consequences (Cameron & Williams 1997: 419).

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Health service institutions that cater for linguistically heterogeneous groups of clients pose some linguistic challenges to their staff. To this end, institutional language policies and practices become important tools for ensuring that communication problems are minimised, if not eradicated entirely. In this regard, research whose goal is to determine the extent to which language policies and language practices facilitate the delivery of health services becomes necessary and relevant. It is important to stress at this stage that "virtually every organisation, from the multinational corporation to the local mom- and-pop corner convenience store, engages in some form of language policy formulation" (Kaplan & Baldauf 1997: 12). No institution operates without a language policy. The absence of a written language policy does not imply that there is no policy at work. The language policy of an institution can appear in either overt or covert form. Thus, a *de jure* language policy refers to an explicitly outlined policy whereas a *de facto* language policy tends to be implicit.

In this paper, I present and discuss a small portion of the findings of a sociolinguistic study that I conducted at the Mzuzu Central Hospital (hereafter, MCH), a major referral hospital in Northern Malawi. The hospital lies in the predominantly Chitumbuka-speaking region. The general objective of my study was to identify language and communication problems that occur at this referral hospital.

The Research Problem

Linguistic barriers to effective communication in service-providing institutions become very pronounced in multilingual settings. It has been widely acknowledged that Africa is generally linguistically heterogeneous. African referral hospitals in urban settings follow the same trend given that they attract clients from a wide diversity of linguistic and cultural backgrounds. A regional referral hospital situated in the linguistically heterogeneous city of Mzuzu in Northern Malawi offered me the right conditions to study communication problems that are induced by the presence of several languages. Another relevant point to make here is that members of staff at the hospital come from a diversity of linguistic backgrounds. The majority of the doctors at the hospital are expatriates who come from countries such as the Republic of China (Taiwan), Egypt, Palestine and the United Kingdom. The hospital's staff, therefore, represents all the three circles of English that were proposed by Kachru (2001).

Kachru's first circle, which is called the inner circle, consists of varieties that constitute English in the minds of its native speakers. The inner circle includes Australia, Canada, New Zealand, Britain and the United States of America. The second circle of English, called the outer circle, is made up of all the non-indigenous varieties of English that have been modified by local conditions. The outer circle mainly comprises the former colonies of Britain and the Unites States of America. Malawi's ESL position lies within the outer circle. The third circle is what is called the expanding circle. This consists of countries where English has an EFL status as is the case in Taiwan, Japan, Finland,

Egypt etc. The extent to which doctors from such a diversity of sociolinguistic backgrounds are able to use English effectively as a lingua franca in the hospital environment was part of my investigation.

The Medical Council of Malawi stipulates that one of the conditions for granting a work permit to a foreign medical practitioner is his/her ability to speak English fluently. This policy stipulation mistakenly presupposes that English is the main language of doctor-patient communication in Malawi given that Malawi is linguistically classified as an English-speaking country or a member of the Anglophone group of countries. The label Anglophone country, which Malawi carries, masks the fact that only a negligible minority of the population has competence in the language (see Mazrui & Mazrui, 1998; Schmied, 1991; for a critique of the Anglophone designation). Local languages, therefore, remain the principle media through which much of the service provider-client communication takes place.

The overall purpose of the study was to identify language policy and communication problems that existed at the MCH. The study addressed three specific objectives. The first objective was to identify patterns of language use and choice at the hospital. The second objective was to identify linguistic and non-linguistic barriers to communication. Thirdly, the study audited the hospital's language facilitation services. As mentioned earlier, this paper is only concerned with the second objective of the study, i.e. the linguistic barriers to communication existing at the hospital.

The study was conducted at the 300-bed Chinese-built Mzuzu Central Hospital. The hospital's catchment area is the entire Northern Region. Going by Malawi's 1998 population census (National Statistical Office, 1998) and other sources, the Northern Region is the most linguistically heterogeneous region in Malawi. While Chitumbuka is the regional lingua franca, other prominent languages exist in Northern Malawi, e.g. Chitonga, Chinkhonde, Chilambya, Chinyakyusa and Kiswahili. Given the linguistic heterogeneity of the hospital's catchment area, it was decided that the study should determine the extent to which such a linguistic profile created communication problems between the hospital's service providers and their clients.

I employed the case study as my research strategy. A case study is not a method but simply a research strategy. It involves a detailed study of one situation (see Hartley, 1994). The most outstanding strength of the case study lies in the fact that I was able to make an in-depth examination of the language situation at the MCH. The aim of my study was not to generalise the findings across all Malawian referral hospitals, but to document in a detailed manner the linguistic situation and the communication problems existing at one referral hospital. Malawi's other referral hospitals (also known as central hospitals) are located in linguistic environments that are different from the MCH. For example, the Lilongwe Central Hospital is located in an area that is predominantly Chichewa-speaking. Zomba and Queen Elizabeth Central Hospitals are located in the Southern Region where Chichewa is, again, the lingua franca. It is, therefore, understandable why the findings from the MCH cannot be generalised.

The data presented and discussed in this study were collected through a combination of qualitative and quantitative research methods. The current paper is mainly based on qualitative data drawn from interviews with key informants, questionnaire responses, observations, and document surveys. In the paper, key informants are referred to through pseudonyms whilst numbers are used when referring to health service providers who had responded to a questionnaire.

The barriers to communication that were identified at the MCH are categorised and discussed in the following order: multiplicity of languages, the use of English, service providers' inability to speak patients' language(s), and the language policy at the national level.

Multiplicity of Languages as a Communication Barrier

The existence of numerous languages at a health care institution like the MCH can be a problem. Apart from serving clients from the Northern Region, the MCH also serves patients who come from the other regions of Malawi. This further complicates the linguistic picture. The workforce is made up of local and expatriate staff. The expatriate staff comes from a diversity of linguistic backgrounds. The local workforce consists of people who come from all the regions and districts of Malawi, thereby making the hospital a linguistically diverse institution.

Despite having a multilingual workforce and a multilingual clientele, the MCH does not face communication problems of the magnitude recorded in South Africa by Drennan (1998), Crawford (1999) and Saohatse (1997, 1998, 2000). Unlike South Africa, Malawi has, since the colonial days, had Chichewa (Chinyanja) as the national lingua franca. This lingua franca has permeated into what were initially non-Chichewa-speaking areas; and in some cases, the result has been an acute language shift in favour of Chichewa. Given this scenario, it is not surprising that at the MCH, the second mostly widely used language is Chichewa. The most widely used language at the MCH is Chitumbuka. One can, therefore, say that the MCH has two main local lingua francas, Chichewa and Chitumbuka, whose knowledge greatly reduces linguistic barriers to communication. Knowledge of at least one of the two languages or both ensures that one survives well at the MCH.

The situation in South Africa, on the other hand, is more complex. Due to its previous apartheid system, South Africa did not produce a national lingua franca. During the apartheid era, each African ethnic group was encouraged to live in its own homeland. Furthermore, residents of the ethnically based homelands were encouraged to promote their own ethnic languages. The acquisition of other ethnic groups' languages was discouraged, and so was free movement across the homelands. The separate development scheme was part of the divide-and-rule tactic. After the demise of apartheid, the new South Africa, unlike Malawi, finds itself without a language that is spoken very widely across the whole country either as a mother tongue or a non-native tongue. In Malawi,

on the other hand, nearly 70% of the population use Chichewa as their language of household communication (see National Statistical Office, 1998). The existence of this widely spoken language reduces communication problems in Malawi, and this is also the case at the MCH.

What happens at the MCH is that the institution uses the available multiple linguistic competencies that the multilingual workforce possesses to solve the prevailing linguistic barriers. Whenever there is a patient whose language a service provider does not understand, efforts are made to locate a member of staff within the hospital that has competence in that language. The competent language speaker comes in to offer interpretation. The practice works well and my study did not find evidence of hostility or reluctance towards offering interpretation services. This is in contrast to South Africa where nurses and other service providers consider interpretation as an extra burden for which they are not financially rewarded (see Crawford, 1999; Saohatse, 1997). As a result, they either refuse to offer interpretation, or they offer it grudgingly, leading to a sub-standard type of interpretation. Crawford observes that at one South African hospital:

> On busy days, chaos rules. There is an atmosphere of continual crisis management, which raises the stress levels considerably between doctors and nurses. Doctors become agitated because they need someone to interpret quickly, and nurses may be unable to drop their own work and respond immediately. Since they are not rewarded for this largely unnamed though highly skilled work, there is much friction and resentment. (Crawford 1999: 30)

In contrast to the situation prevailing in South African hospitals, the general tendency at the MCH was to use the multilingual workforce and clientele to act as linguistic bridges whenever the situation demands. There were no institutional interpreters at the MCH. Interpretation was therefore done on an ad hoc basis. This then means that staff, patients and guardians are asked to assist with interpretation whenever necessary. I illustrate this situation with some selected extracts from clients' questionnaires. For example, service provider 48 (a patient attendant) noted that "there is no problem on language because in this hospital, there are so many people who speak different languages. So I can talk to someone to interpret."

The presence of multilingual health service providers is an asset, according to service provider 25 (a nurse): "The fact that staff that's working at this hospital is fluent in many languages that the patients who come here speak, communication is not bad. Patients are helped and their concerns addressed." The same view was expressed in a slightly different way by service provider 31 (a nurse) who observed that: "At our hospital, since we're many and from different areas of the country and it is a big hospital, if there is a barrier on communication, we just ask anyone who knows that language to interpret." The fact that the workforce represented all the Malawian languages simplified the communication problem, to some extent.

The fact that multilingual service providers at the MCH assist each other with interpretation to reduce the linguistic barriers to communication supports Langtag Report's (1996) view that in a multilingual society, knowledge of more than one language is an asset. Service providers who possess multilingual competencies are assets to the MCH. They stand in for full time interpreters.

The Use of English: Bridge or Barrier?

The role of English in the delivery of health services in Malawi and at the MCH in particular has to be discussed in connection with the status of English in the Malawian language policy. In Malawi, English is the official language. It is the language of government administration, education, the mass media etc (see Kamwendo, 2003). English holds an ESL (English as a Second Language) status in Malawi. This refers to a situation where English performs important functions in official domains. This contrasts with the EFL (English as a Foreign Language) situation where English is not the commonly used language in official domains. The existence of the three circles of English has implications on intercomprehensibility. The fact that there are several varieties of English or the new 'Englishes' as Kachru (2001) calls them, means that there are differences among the various users of these varieties in terms of pronunciation, grammar, the lexicon, collocations, idioms and discoursal and stylistic strategies. These differences do cause cross-cultural incomprehension or misunderstandings. This situation prevailed at the MCH as the forthcoming sections of the paper will show.

It is important to mention at the very beginning that English can act, either as a bridge, or a barrier to communication at the MCH. As a linguistic bridge, English enables local staff and expatriate staff to communicate, thereby rendering useless the fact that the interlocutors have different mother tongues. Sometimes, even local staff use English to communicate among themselves. All service providers, as members of one community of professional practice, are able to discuss medical issues through a common language of medicine, which is English (see Maher, 1986, for a discussion on English as the international language of medicine). On the other hand, for those clients who have partial or no competence in English, the language tends to be a barrier to communication.

Only one expatriate service provider, Dr Matata, had competence in a local language. All expatriates used English in order to communicate with their clients. Whenever the client did not speak English, an interpreter had to be called. This trend will continue as long as there is no official policy that demands that foreign health service providers working in Malawi must acquire at least one dominant local language. That the majority of the expatriate doctors do not speak local languages has also been documented in other countries such as Zambia (Chanda, 2003), South Africa (Crawford, 1999; Drennan, 1998; Saohatse, 1997, 1998, 2000) and elsewhere.

Local service providers at the MCH expressed concern over communication problems that arose due to some of the varieties of English that expatriate staff use. A case in point

was a nurse (service provider 28) from the MCH who indicated in her questionnaire that "we have other doctors i.e. from China who do not even know English." My understanding of this statement is not that such doctors were completely without any knowledge of English. Rather, the point is that their knowledge of English was too low for them to work effectively in the new environment in which English was a lingua franca. It has also to be mentioned that there is concern that Malawians' standards of English are going down (see Kamwendo, 2003). As a result, schools and even university colleges are producing students who are unable to communicate fluently via English.

As it has been mentioned earlier, the MCH is a Chinese-funded referral hospital. A Chinese Medical Mission, which is based at the hospital, comprises doctors and other specialists. All the Chinese expatriate staff at the MCH speak English as a Foreign Language (see Chia et al.1998). My study found that the variety of English spoken by the Chinese causes problems in comprehension. The inevitable mother tongue (Chinese) interference into English and the fact that English is not the official language in Taiwan gave the variety of English the Chinese (Taiwanese) speak distinct lexical and phonological features.

The Chinese expatriates' command of English was low. For example, Dr Tsui assessed his English language competence and confessed that he had a language problem:

> The most important language I cannot speak very good. Sometimes we have to discuss very deep problem, very serious problem, I have to consider some...and try to speak and sometimes I cannot speak. That's my problem.

This is a worrying situation since English is the bridge that links the expatriate service providers with their local counterparts and clients; and yet some of the expatriates have weak competence in this important language. The situation was worsened by the fact that all, except one expatriate staff, had no competence in any local language. Mr Chimalizeni, a Malawian who worked in the same department with Dr. Tsui, observed that whenever Dr Tsui had a non-English-speaking patient, his Malawian colleagues assisted by providing him with interpretation. This was the language practice norm with all the expatriate service providers.

Dr Tsui's case contrasts sharply with that of another expatriate working with him in the same department. This colleague, Dr Matata, did not have a serious linguistic barrier. Dr Matata's mother tongue is Kiswahili. She received her professional training through the medium of English. Coming from an ESL situation, making her to be more proficient in the use of English than her Chinese counterpart. When she first arrived in Malawi, she was posted to the Lilongwe Central Hospital where she worked for two years. Whilst in Lilongwe, she acquired Chichewa, the national language. Since both Chichewa and her mother tongue, Kiswahili, are closely related Bantu languages, learning Chichewa was

not a big hurdle for her. When she was posted to the MCH, she noted that her knowledge of Chichewa was less useful for communication. Though Chichewa is the national language, the MCH is located in a predominantly Chitumbuka-speaking area. Dr Matata, therefore, had to learn the dominant language of the hospital's catchment area, Chitumbuka.

Dr Matata believed, and indeed rightly so, that she had an edge over other expatriate staff as far as communication goes. First, culturally, she did not experience a big gap between Tanzania (her home country) and Malawi. Secondly, she received her professional training through the medium of English and also came from an ESL environment. She, therefore, did not face the English language problems that negatively affected the expatriates from the EFL countries. Thirdly, unlike other expatriates, she spoke at least one local lingua franca, Chichewa, and had partial competence in the regional lingua franca, Chitumbuka. Whenever she met a non-English-speaking patient, she first tried to communicate with the patient using Chichewa. If Chichewa failed, and Chitumbuka was required, normally she would ask for an interpreter given that her competence in the language was not adequate.

Her Chinese colleague in the same department, on the other hand, had both cultural and linguistic barriers to negotiate. First, for the Chinese, Malawian culture is alien to them. Secondly, the Chinese expatriate had inadequate competence in English. In addition, the Chinese expatriate had no competence in a local language. As such, Dr Matata found herself to be in a better position than her Chinese colleague:

> Chichewa, Chitumbuka, they are also Bantu languages. So most of the words that are found in Chichewa, Chitumbuka they are also found in Kiswahili. So I have a big advantage, far much than him; and him coming from Taiwan makes things worse because English is not even mostly spoken there. So on the language part, I think I am much better than him.

The linguistic inadequacies of the Chinese expatriates were further elaborated by a Malawian key informant and service provider, Mr Chigamba. He observed that: "The Chinese have got a problem with English. Our first XXX (The professional title of the expatriate has been deleted deliberately to conceal his/her identity) had problems in English, so it was looking like though he doesn't know his job. In general, I would say that he didn't assist us a lot (sic)." Mr Chigamba's point is that the linguistic handicap rendered ineffective an otherwise experienced professional. This underscores the critical importance of being able to use effectively at least one of the dominant languages of the work environment. Mr Chigamba contrasted the so-called failed expatriate with his replacement. The latter was better off in terms of her English language competence because "she did her education through English, so communication is not a problem (sic)", Mr Chigamba noted.

Another Malawian service provider, Mr Katola (a clinician), observed that on arrival

at the MCH, some of the expatriate staff from the non-English-speaking countries had problems with English, but "most of them now are so far familiar with English (sic)." The implication here is that on their arrival, the expatriates had a much lower level of competence in English. Since the situation in Malawi had forced them to use English daily in all their transactions, their fluency improved. Mr Katola elaborated: "Yes, they had problems with English. Some of them could get you speaking in English but for them to speak out in English, it was a problem (sic)." It is clear that the expatriates' comprehension of English was better than their production. This is a common universal linguistic trend. Often comprehension of a new or foreign language is higher than production. Mr Katola described his initial experiences in interacting with Chinese expatriates as follows:

> It's like you have to fill in the patches. There, I think what he has said here means A, B, C, D. But otherwise communication at the beginning was somehow a problem for some of us for who it was our first time to interact with such a society. It was really a kind of problem but they are friendly people. They are well mixing guys. So it didn't take a long time to really know their language, I mean their weaknesses (sic).

The problem of the intelligibility of the non-Malawian varieties of English was also mentioned in the service providers' questionnaires. For example, problems in comprehending non-native varieties of English, especially Egyptian and Chinese varieties featured highly. This prompted service provider 73, a clinician, to propose that the Government of Malawi should treat English language competence more seriously when recruiting expatriate staff, especially those coming from non-English-speaking countries. This key informant advised that: "The government should try as much as possible to send expatriate doctors who know English for better communication and management of patients at this hospital (sic)." This call presupposes, very correctly for that matter, that some of the current expatriates' English language competence was so low that it was a barrier to communication.

A Malawian service provider, a radiology technician (service provider 63) also described how difficult it was for him to understand the Chinese English, and also how difficult it was for the Chinese to comprehend Malawian English:

> Communication breakdown was there at first as we are of different nationality. We couldn't get what our friends meant and vice versa. For example, Chinese English was a problem and our English was so fast for them and it could take a long time to understand what each one of us was trying to convey.

Service Providers' Inability to Speak Patients' Language(s)

Service providers at the hospital were asked through their questionnaire the following question: Is it important for you to be able to speak the language(s) of your patient? The

vast majority of the respondents (91.1 %) said YES whilst 6.3 % said NO, and 2.6 % did not give any response. The reason that was cited for the YES response was that if a service provider spoke the language of his or her client, communication problems were minimised. One of the reasons why service providers would prefer to be able to speak the language of their patients, as opposed to relying on interpretation, was the fear of faulty interpretation. Faulty interpretation has its roots in more than one factor. Inadequate command of language can cause faulty interpretation. Another possible cause could be the tendency to leave out or edit what one of the interactants has said. This means that "an interpreter cannot say exactly what the patient is complaining about", a point made by one of the nurses (service provider 28) at the MCH.

Service provider 69, a trainee technician who had no competence in the hospital's most used language, Chitumbuka, (but spoke English, Chichewa and his mother tongue, Chisena), had to rely on interpreters whenever he was faced with Chitumbuka-speaking patients who spoke neither Chichewa nor English. From his experiences, he observed that "when you use interpreters, you cannot get exactly what the patient wanted to talk to you (sic)." Another form of faulty interpretation was to put words into the mouth of either the service provider or client as service provider 33 (a nurse) claims. She observed that: "If you speak the language of your patient, it makes it easier to solve your patient's problem because an interpreter can easily say what the patient hasn't said." There are other studies that have documented the existence of conflict between service providers and interpreters due to the fact that some service providers, usually doctors, accuse "the interpreter of censoring or inadequately translating the patient's reply" (Kaufert & Koolage 1984: 285; see also Saohatse, 1997, 1998, 2000; Crawford, 1999).

As mentioned earlier, sometimes interpreters are known to act as editors (see Bolden, 2000; Crawford, 1999). The view that interpreters can act as editors seriously questions the "popularly held metaphor used to describe interpreter's work is that of a voice box or a translating machine. According to this view, each utterance in language A is then transformed by the interpreter into an equivalent in language B" (Bolden 2000: 390). But as the service providers at the MCH observed, and research in other contexts has also shown (e.g. Bolden, 2000; Crawford, 1999; Davidson, 2000; Kaufert & Koolage, 1984; Saohatse, 1997, 1998, 2000), interpreters decide what to convey and what to leave out. In so doing, they do not always convey unaltered messages.

The Language Policy

Language policy can also act as a barrier to communication in a particular environment. Bamgbose argues that out of any language policy, "two classes of citizens are immediately created, the class of the advantaged, and therefore, included, and the class of the disadvantaged, and therefore, excluded" (Bamgbose 2000: 1). Given what we have discussed so far in this paper, it is clear that the policy that expatriates who work in the Malawian health sector must be competent in English as one of their local licensing

requirements results in the creation of classes of the included and the excluded. The policy leads to the exclusion of those clients who have no competence in English. They are excluded from having direct interaction with the expatriate English-speaking service provider. Such people have to communicate with the service provider through an intermediary, that is, an interpreter. This exclusion brings with it the usual problems associated with communicating through an interpreter.

As Bamgbose puts it, "life for those who cannot use the official language is as difficult as for those excluded by literacy. They need interpreters and translators to interact in official domains" (Bamgbose 2000: 11). At the MCH, almost all the expatriate doctors, except one, do not speak any local language, thus they are excluded from having direct and more informative dialogues with their patients through local languages. This stems from the fact that the current language policy does not demand local language competence from expatriate doctors.

Conclusion

For the Malawian service provider, knowledge and competence in Chichewa, the national language, is not enough if one is to communicate effectively at the MCH. Competence in Chitumbuka is absolutely essential. A service provider who has competence in Chichewa and Chitumbuka, in addition to English, stands a better chance of overcoming communication barriers at the MCH. As for the other local languages that one may not understand, there is always a reliable network of support that provides language facilitation. In the case of the expatriate service provider, competence in English is essential but not enough. Given the limited situations under which English is used in direct interactions with patients, knowledge of a local language, preferably Chitumbuka or Chichewa, or both, is an added advantage. The language needs of both local and expatriate service providers can be summed up as service provider 27, a local nurse, put it: "Being a central hospital, it serves patients of different languages, and also some of the staff are from abroad, hence for one to work comfortably, one has to understand and speak English as the official language and Chitumbuka and Chichewa as common languages in Malawi."

One of the important lessons noted in the study is the inaccuracy of the term English-speaking or Anglophone country. The findings presented and discussed in this paper agree with Schmied's assertion that:

> Calling African nations anglophone is obviously a gross exaggeration, because all of them - including the nations with sizeable number of English mother-tongue speakers - are primarily afrophone. When the term anglophone is used, it should be applied with caution and a due understanding of its special and restricted meaning in the African context (Schmied 1991: 27; see also Mazrui & Mazrui, 1998).

For Mazrui and Mazrui (1998), it is an anomaly to use the term Anglophone since it conceals the sociolinguistic reality. To this end, not attaching a local language proficiency requirement to the licensing of foreign medical practitioners in Malawi is an anomaly. It is the local languages, and not English, that are the main media of client-health service provider interaction.

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