Qualitative research across boundaries of language: the representation of lived experiences.

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Abstract

Background:
Qualitative methodology has a growing importance in primary care research, reflected in projects submitted for the degree of MFamMed at The Medical University of Southern Africa (Medunsa). These projects were completed in multilingual settings and sought highly subjective information. This paper aimed to demonstrate how researchers handled issues of language within their work.

Methods:
All dissertations successfully submitted for the degree of MFamMed at Medunsa between 1993 and 2000 were examined. Those using a predominantly qualitative methodology were subject to content analysis.

Results:
Researchers acknowledged issues of language and developed a range of strategies to ensure the faithful representation of their subjects' beliefs and attitudes in the language of the final dissertation.

Conclusions:
Working across boundaries of language presents a potential threat to the faithful representation of qualitative data. Examination of these examples of qualitative research point to some ways in which loss of meaning may be minimised. The paper calls for a close examination of issues of language in research of this nature.

Introduction

South Africa recognizes eleven languages as having equal status. Health workers in South Africa may have any, or none, of these languages as their mother tongue. Dealing with this diversity in the clinical setting is an everyday experience for most health workers. This paper explores the question of language as it applies to qualitative research.

Qualitative research has been described as a family of approaches whose goal is understanding the lived experience of persons who share time, space and culture.[1] It is considered especially appropriate to explore many of the complex phenomenon that are encountered in primary care[2], and there is a growing literature regarding its methodology[3].

The literature points to the salience of language within qualitative research[4] and calls for the validation of language exchanges[5] but provides few examples from primary care settings .

This growing usage of qualitative research is reflected both in the literature and in the teaching programmes of medical schools, especially at postgraduate level. This trend can be demonstrated in the growing number of qualitative projects submitted as dissertations in partial requirement for the degree of MFamMed in the Department of Family Medicine at The Medical University of Southern Africa (Medunsa). Since qualitative research seeks to uncover the meaning people attach to themselves and the world around them, and language is the means whereby this meaning is expressed, it is pertinent to ask how the question of language is dealt with by qualitative researchers in a multilingual setting.

Method

It is a requirement of the MFamMed degree at Medunsa that all dissertations be presented in English, although this may not be the mother tongue either of the researcher, their research assistants or of those who are the subjects of the research. All dissertation that had been successfully presented for the degree between 1993 and 2000 were examined. Those projects that had a predominantly qualitative methodology were selected for further analysis. Evidence was sought regarding the authors' first language, the language of normal discourse of the subjects of the research and the first language of any assistants engaged in the collection of data. Descriptions of methodology were examined to ascertain how data was collected, from whom and by whom. Particular attention was given to the way in which researchers moved their data across boundaries of language in the necessary processes of transcription, translation and analysis.

Results

Fourteen qualitative studies (Arbitrarily referenced as studies 1 to 14 in the presentation of results) were identified from a total of thirty successfully presented for the MFamMed degree. These studies were seeking information in areas that were both complex and potentially sensitive such as personal lifestyle, sexual behaviour and mental health. Although all studies were conducted in a multilingual context, not all of them identified language as an issue. In general, the studies fell into two groups:

Group one: Studies where English is assumed to be a common language.

In a number of studies the researcher sought information from other health care colleagues. In these, English was assumed as *lingua franca* for both researcher and subject alike and was the only language employed within the study.

> *The nurses were selected because their spoken English is expected to be better than the other nurses due to their high level of education.* (Study 11 - that looked at the experience of treating patients with AIDS)

That a second language might not be wholly sufficient for expressing personal material was raised in one study where (Venda speaking) student nurses appeared able to talk in English about their training in the format of a focus group but, when asked to submit similar material as a written report, none did so (study 1). In another study, staff working on a TB ward were asked to talk about their working

experience through a focus group conducted in English.

> *The use of English, which is a second language to all members of staff, may have influenced how members of the group expressed their ideas.* (Study 2)

On the other hand, doctors, many of whom had a mother tongue other than English, appeared to have no difficulty in talking about their participation in a higher degree course (study 8), their perceptions of patient centredness (Study 12) or their handling of sexual matters (study 10). Otherwise, the assumption that people who worked in English could easily express deep meaning in English went largely, but not entirely, unchallenged. Returning to study 2;

> *The focus group with the staff members was conducted in English, This was because the researcher felt that they were sufficiently fluent and comfortable with English, to be able to express their feelings, ideas and thoughts freely. This preconception was not checked out with the participants and they were not given the opportunity to participate in a FG discussion in Zulu.*

Group two: Studies where language was acknowledged as an issue.

In the other studies, the differences in language between the researcher and those from whom information was sought was acknowledged as problematic. There appeared to be three strategies for dealing with this language gap.

Strategy 1: Researcher continues despite language barrier.

Here, the problem of language was acknowledged but not considered to be sufficiently large to prevent the researcher from personally collecting qualitative data of a high standard.

> *Free attitude interviews were conducted by the researcher in the vernacular language, Tsonga.* (Study 4)

The researcher did however express some concern:

> *It was a disadvantage that the interviews were conducted in the interviewer's third language. He is fairly fluent in the vernacular used for the interviews. The interviewees experienced the interviews in their mother tongue.*

Since this study was concerned with personal lifestyles, the question arises whether *fairly fluent* is sufficient? In order that *the Tsonga words and phrases were translated directly to capture as much as possible of the original meaning*, the researcher employed a mother tongue speaker as a research assistant to provide a parallel translation which was used as a check against the researchers. *The two separate translations helped capture the true meanings of the interviews.*

Strategy 2: Researcher samples only English speaking subjects.

In these studies, the language gap was considered to be too large for the researcher to personally cross. The answer was to select a sample from the target population who were English speakers. In one such study, one of the selection criteria was;

> *Fluency in the English language as researcher had command in this language and distortion of the first hand information was avoided.* (Study 9)

Some doubt was expressed by the researcher about the adequacy of this to allow women to talk (to a man) about personal health issues which included cervical cancer;

> *It was felt that two of the ten interviewees nevertheless did have some difficulty in expressing themselves completely, which may have affected the flow of information from them.*

In another study, secondary school children *from different parts of the country* were selected to talk in focus groups about their attitudes to patients with TB and patients with AIDS, on the basis that *they were English speaking* (study 6) In another study that sought to limit all transactions to English;

> *All the study population consisted of mothers who had a child between the ages of 3 and 18, who could speak English well enough to participate in a group discussion, who lived in..., and were willing to participate in a group discussion about sex education.* (Study 13)

The potential drawback of this particular solution to the problem of language was acknowledged;

> *In the group of black mothers, there was the potential problem that the mothers may not have felt confident to discuss the issues in their second language.*

Strategy 3: Researcher uses alternative interviewer.

This strategy was the most frequently employed. Here, the researchers recognised their capacity to understand the language of their research subjects as insufficient to capture the data being sought.

> *Although the researcher has a reasonable understanding of Zulu, she does not speak it well enough to conduct free attitude interviews in this language.* (Study 7)

The solution here, as in other studies, was to engage a third person who was considered to have sufficient capacity in both English and the vernacular to be entrusted with the faithful collection and transfer of meaning across the language divide. The third party, usually designated as a *research assistant*, was frequently another health worker, usually a nurse. Evidence for competence in both relevant languages was occasionally sought, but more often assumed;

> *The translator is a Zulu women fluent in Zulu and English. She passed Matric in English and Zulu.* (Study 2)

> *The interviews and the focus groups were done in Zulu by the assistant because this is the first language of the patients as well as the assistant.* (Study 7)

The potential loss of meaning that could occur through the necessary transfer process of transcription and translation was widely recognized and steps were taken to minimise it, by means of comparing two, or more, independent accounts;

> *Two translators were used who made separate translations which were then compared and adjustments were made in order to stay as close to the original text as possible.* (Study 7)

The chief problem with regard to assigning the collection of data to a third person was the sense that the researcher handed over this vital step in the research process, and could never be entirely sure about its quality. One researcher;

> *Felt left out because he could not interfere (sic) with the interview and the first part of the analysis.* (Study 14)

While another recognised;

> *The value of being able to understand people in their own language cannot be overstated and much interesting and valuable information may have been lost because of this lack of fluency.* (Study 2)

That this concern may be well founded is suggested by one study (3) where a senior nurse was assigned the task of interviewing mothers about their perceptions of childhood diarrhoea on the grounds that;

She is Zulu speaking and able to do free attitude interviews in Zulu and because of her friendly attitude which makes people feel at ease with her.

In further describing her, the researcher notes;

She can listen very well to other people's stories but she has sometimes difficulty in expressing her feelings and thoughts. I know from talking to her before the project that she has a negative attitude towards traditional treatment. She thinks that it can be harmful and dangerous and she often tries to dissuade patients from using it.

In the event, twenty, *free attitude interviews* were conducted by this nurse, the longest being ten minutes, the shortest one minute and the average a little over five minutes.

Having made the decision to assign the task of collecting data to someone else, researchers faced the question of what role they should take for themselves in the data collecting activity?
A range of responses emerged;

The researcher absents herself from the data collection process.

An example of this is the researcher who;

Has a reasonable understanding of Zulu (but) *does not speak it well enough to conduct free attitude interviews in the language..,* and therefore engaged *three Zulu speaking nurses to conduct the interviews, lead the focus groups, transcribe and translate the material.* (Study 7)

Here, the researcher made the decision to absent herself;

For the reason that the interviewees might feel less free to talk when a third person was present.

This researcher rejoined the research process at the stage of translating the transcripts, a process she shared with her Zulu speaking research assistants.

The researcher remains within the data collecting process, but in a subsidiary role.

Another option was demonstrated by the researcher who remained present while *three research assistants* (nurses) *proficient in the three local languages - Ndebele, Zulu and Xhosa,* conducted interviews with families of patients with mental illness, but who *sought interpretation at certain points in the interviews so that he was able to follow the discussion as well as asking for clarification when necessary* (Study 5). In yet another study, the researcher, having conducted some interviews with English speaking patients, asked a research assistant to conduct the remainder, including focus groups, in Zulu. The researcher remained present in these interviews, acting as an audio visual technician;

During these interviews the researcher was present as well to tape the interviews on video
(study 14)

Disappointment with the limited amount of information obtained during these qualitative studies was frequently expressed and mostly ascribed to;

Non- experience of the researcher and his assistants with the skills of the qualitative approach (study 14)

There was however, in addition, recognition that language had been a limiting factor and a number of these researchers were guarded in claiming that they had been entirely successful in representing the thoughts and feelings of their subjects in the final English text of their dissertations. They sensed the problem was twofold. First, more might have emerged at the level of data collection, and second, some of what did emerge was lost in the process of transferring it across the boundaries of language.

Discussion

This analysis is presented on the basis of a small number of studies drawn up under rigorous conditions for a higher degree and which may, therefore, not be typical of other studies conducted in these settings. Conclusions have been drawn by examination of the texts alone and interviews with the authors and their research assistants would undoubtedly have given a more complete picture of the problems involved in completing studies of this kind.
These studies do, however, make an important contribution, not only through their insights into the "lived experience" of their subjects, but also by developing qualitative research methodology in a multilingual setting, a methodology that is probably better seen as being "in progress" rather than "settled". As well as clearly illustrating the problems of conducting this kind of research across differences of language, culture, race and ethnicity, they also offer possible solutions. By considering these studies some tentative guidelines might be offered for others wishing to further this exciting and relevant kind of research.

- Be explicit about the language exchanges inherent in the study.
- Ask all participants in the research to declare their preferred language of conversation.
- When engaging interpreters, always place competence above confidence, enthusiasm or mere availability.
- Consider ways in which the competence of interpreters can be objectively demonstrated.
- Consider engaging expert linguistic advice at the planning stage of any qualitative study that aims to work across a language boundary. (An equivalent would be engaging a statistician in planning a quantitative study)
- Within the research process, remain with the language of the subjects for as long as possible; for example, where possible, analyse the data before translating it.
- Be explicit about the way in which the validity of language transfers is to be demonstrated.
- Consider the making of a true representation of the subject's beliefs, attitudes and perceptions an ethical obligation.

Conclusion

Qualitative research is likely to continue to make important contributions to our understanding of the lives of the recipients of primary care services. In order for these experiences to be fully taken into account by the providers of these services it is important that they be expressed in a language that faithfully represents that of their originators. This places a great burden of responsibility upon those who seek to conduct qualitative research across boundaries of language. This paper seeks to present the work of a group of such researchers and to use their experiences as a guide for future studies.

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Chronic obstructive airway diseases: Is the EDL sufficient? A study done at the Heidedal CHC in Bloemfontein.

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Abstract

Background:
With the implementation of the Standard Treatment Guidelines (STG's) and Essential Drug List (EDL) in 1996 some of the traditional medication for the treatment of asthma and chronic obstructive pulmonary disease (COPD) were removed from the medication list, e.g. slow release oral theophylline. The objective of this study was to establish whether we were able to treat patients with chronic obstructive airway disease (which includes asthma and chronic obstructed pulmonary disease) effectively with the guidelines and medication on the Standard Treatment Guidelines and Essential Drug List for Primary Health Care (STG's and EDL), 1996.[1]

Method:
In this follow-up study all patients with chronic obstructive airway diseases (COAD) at Heidedal Community Health Center (CHC) over a 3-month period were evaluated and a lung function test was done on them. Their old medication was stopped and the treatment guidelines of the STG's and EDL were followed. A repeat lung function test was done on all patients after three months on the new treatment. Four indicators were used namely: FVC, FEV1, FEFmax and FEF25-75.

Results:
Fifty patients were included in the study. Improvement in all four lung functions were noted after the new guidelines were implemented.

Conclusions:
The implementation of the EDL guidelines for asthma and COPD controlled the diseases, the guidelines were easy to use and are comparable to the latest international standards. Standard guidelines also create better patient compliance and give confidence to health workers. The revised STG's and EDL for Primary Health Care (1998) are comparable with the guidelines used in this study.

Introduction

The objective of this study was to establish whether we were able to treat patients with chronic obstructive airway diseases (which includes asthma and chronic obstructed pulmonary disease) effectively with the guidelines and medication on the Standard Treatment Guidelines and Essential Drug List for Primary Health Care (STG's and EDL), 1996.[1]

The treatment of asthma and COPD changed markedly once the mechanisms of the diseases were understood more clearly. Centuries ago the Chinese started to inhale herbs with B-agonist like actions, in the 17th century Datura species (with anticholinergic actions) were discovered and at the turn of the 19th century adrenaline was first use to treat asthma. In the latter half of the 20th century inhaled steroids became part of asthma treatment.[2]

After a joint meeting in 1995 of all concerned parties involved in the treatment of asthma in Britain the Step model [3] was accepted as the gold standard for the treatment of asthma. These guidelines compare well with the guidelines in the STG and EDL.

In the treatment of COPD the use of ipratropium inhalations is associated with improvement in lung functions. It is therefore recommended that COPD must be treated with ipratropium and low dosage beta $_2$ agonists to decrease the side effects of beta $_2$ agonists. [4-9] The routine use of inhalation steroids in COPD is uncertain, but more useful in patiens with an allergic background.[10-12] This is also the same as in the STG and EDL.

The use of long acting oral theophylline is not standard according to guidelines[1,3] in the treatment of asthma, although it is much cheaper and easier for the patient to use than the metered dose inhalers. The problems with the drug are the narrow therapeutic window, unpredictable blood levels, drug interactions and toxicity even within normal values.[13, 17-18]