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Ad hoc interpreting for partially language-proficient patients

Participation in multilingual constellations

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The article discusses the notion of 'language barrier' in communication with patients with a migration background. These patients usually show some level of proficiency in the official language of the hospital. However, their proficiency is usually limited so that they still need interpreters to communicate effectively with medical staff. Thus, the language constellation between participants is partly "transparent", to use Müller's (1989) term. Based on two case studies it will be shown that the forms of interpreter participation in such interactions are influenced by the specific multilingual competencies of the patients.

1. Introduction

Research on interpreting normally uses the metaphor of a "language barrier" to describe differences in the linguistic resources available to the primary interlocutors (Corsellis 2008; Pöchhacker 2005). Although the notion of "barrier" may be adequate for some of the language constellations in which interpreters work, the barrier is usually, to some extent, permeable in communication with migrants. Especially in countries with established migrant populations, the vast majority of migrants show different types and degrees of proficiency in the language(s) of their host countries.[1]

This chapter focuses on how the limited linguistic proficiency of migrant patients influences the course of interaction in doctor-patient consultations

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1. "Language constellation" is used here with reference to House and Rehbein (2004: 3) who consider it among others parameters such as the socio-political status of languages, typological distance, language skills of participants.

where an *ad hoc*-interpreter is present. My claim is that medical interpreting in migration settings is usually shaped by a certain accessibility of linguistic means, mainly on the side of the patient. For many migrant patients, linguistic expressions from the dominant or host language are to some extent accessible. This partially transparent constellation, as described first by Müller (1989), influences interpreter-mediated doctor-patient communication, because it changes the "footing" (Goffman 1981) or participant status of interpreters and primary interlocutors: if participants understand each other at least partially, the interpreter is more likely to adopt other roles, apart from being an interpreter in the normative sense. Thus, the patient's limited proficiency in German serves as a resource for establishing native/non-native discourse as a second mode of interaction, taking place in parallel to interpreter-mediated communication. However, the combined use of native/non-native discourse and interpreter-mediated communication does not always facilitate communication between doctors and patients. Rather, it may also contribute to the emergence of parallel discourses; in other words, it may lead participants on "discrepant discoursal paths" (Wadensjö 1992:224).

Figure 1. A faithful interpreter? (from Bischoff and Loutan 2001)

The different types of participation of interpreters, and especially of *ad hoc*-interpreters, are often taken as indicating a lack of faithfulness and reliability. Figure 1 shows the problem: a patient speaks to the doctor, he produces a long turn, and the interpreter renders only a short version. This makes the physician think that something is going wrong in the interaction. However, one could also say that an interpreter always has to make decisions about how detailed and close to the original the rendition needs to be in a given context. The concept of interpreters

working "as faithful as sound amplification" (Glémet, cited from Pöchhacker 2005) turns out to be misleading and descriptively inadequate.

2. The data

The data presented in this chapter are from two projects on *ad hoc*-interpreting for Turkish and Portuguese patients in hospitals in Hamburg. The conversations were recorded between 1998 and 2001. Patients were selected on an *ad hoc* basis: whenever we were informed that there was a need for interpreting, we tried to record the conversation. The 35 patients in the corpus speak Turkish, Portuguese or Spanish as their mother tongue, and most of them also speak German to some extent. They are all migrants living and working in Hamburg, most of them for many years at the time of recording, though with different residential titles and in different socio-economic conditions. Most of the patients in the sample were over the age of fifty. Only four patients were younger and two of these were exceptional in that they had the lowest level of German, presumably because they were in Hamburg for a short period of time. The *ad hoc*-interpreters in this project were mainly nurses or family members, most of them born in Germany. More details about the data corpus and online access can be obtained via www.exmaralda.org.[2]

3. Sociodemographic data on linguistic diversity in Germany

It is assumed here that the situation represented in the corpus is not exceptional, but rather typical for migrant contexts in Europe. Due to "super-diversity" (Vertovec 2006), i.e. an increasing complexity regarding the socioeconomic, legal, and linguistic situations of migrants, individuals from the same migrant group and with similar biographical backgrounds may show a high level of variation regarding their levels of linguistic integration. Despite this, migrant patients are often able to communicate in the dominant or host language, though not always sufficiently for all communicative purposes.

The number of individuals with limited proficiency in German is difficult to determine: the fact that people have a nationality or native language other than German does not say anything about their proficiency in German. For instance, an ethnic German from Russia with a German passport may have severe difficulties

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2. The transcription method adopted for data presentation here is the one adopted in the rest of this volume (see Introduction: Note on transcripts and transcript notation).

with his or her supposedly 'native' language German. Thus, socio-demographic data such as those captured by the census may provide insights into the increase of diversity among the population living in Germany, but they do not tell us a lot about the need for communication in languages other than German.

The need for communication in languages other than German is linked to the population with limited proficiency in German: migrants that rate their proficiency as limited need to communicate with German institutions and service providers in a language other than German. Data on language proficiency of adult migrants from established communities can be found in a socio-economic panel called SOEP. The SOEP panel is a study on households covering about 20,000 persons in 11,000 households in all parts of Germany, including foreigners and immigrants (www.diw.de/english/soep). The survey is on different aspects of living conditions, values etc. Language is not a central topic, but questions on language proficiency have recently been integrated into the study. In the 2007 sample, about 2000 individuals (=10%) in the survey are from bilingual families or are bilingual themselves. They were asked to rate their proficiency in German and in their family language with regard to reading/writing and speaking/listening. Although the method of self-evaluation is not very precise, it allows a rough estimate of the need for communication in other languages. On average, 20% to 25% of migrants declared that their command of German is somehow limited ("it works", "relatively bad", etc., Meyer 2009). However, the large group of immigrants with Turkish language backgrounds were an exception: only 50% of individuals from this group rated their command of German as "very good" or "good", with 50% rating it as somehow limited. According to the national census, 2,5 million people in Germany have a Turkish migration background. Assuming that the SOEP sample is representative of this population, the number of individuals in the Turkish community with limited proficiency in German would be 1,25 million.

4.   Interpreter roles: individual deficits and multilingual resources

Although some type of bi- or multilingualism is widespread among migrant populations, institutions sometimes impose a concept of individual monolingualism by prohibiting the use of bilingual resources, even in cases where this regulation has a negative effect on the communicative exchange. Angermeyer (2007, 2008) reports from research on communication in Small Claims Courts in New York City that volunteer arbitrators or judges impose the use of native languages and communication via an interpreter instead of direct communication in L2 English even if clients wish to use English: "If you need an interpreter, then be

interpreted" (Angermeyer 2007:134). As Angermeyer points out, such construction of individual monolingualism may be related to institutional requirements, such as legal regulations of language use in court. Nevertheless, it is an obvious paradox that the language barrier the interpreter is expected to bridge is in some cases established by the institutional agent. In the data presented here, however, the opposite seems to be the norm: if, for some reason, migrant patients switch to German or *ad hoc*-interpreters stop interpreting because they think it is not necessary, doctors usually do not insist on communicating via an interpreter.

Limited proficiency of migrants in the host country's language (i.e., the language of the physician) may be a good reason to call an interpreter, even if communication in that host language may be possible to some extent. The language deficits of migrants, however, usually do not lead to a complete breakdown of communication, but rather to different and unusual ways of communicating. Müller (1989) was the first to investigate conversations in which different levels of proficiency are not taken as a deficit but rather as interactive resources which, instead of hindering communication, foster it. He also described *ad hoc*-interpreting as a "flexible instrument for the specific pragmatic and interactive needs of a constellation" (1989:735). In his analysis of ethnographic interviews with Italian migrants living in Germany, he highlights that switching between mediated and direct interaction seems to be the adequate solution for the specific challenges of the linguistic constellation between the German interviewer and the Italian interviewees: "It leaves the active competences of all participants in the constellation fairly unrestricted and all participants can express themselves in the language they have best command of" (ibid.). Referring to Müller's work, Apfelbaum (2004:119ff) shows that such a way of dealing with available linguistic resources is not restricted to *ad hoc*-interpreting, but also occurs in formal settings with trained interpreters. Thus, different from normative approaches to institutional communication and interpreting, the study of interpreter performance reveals that the proficiencies of all participants, including the interpreter and the less proficient client, may help to achieve the communicative purposes of an encounter.

These observations clearly contradict Knapp and Knapp-Potthoff's (1985) concept of a "normal format of mediated discourse structure". The "normal format" model is a systematic, adjusted structure in which a speaker says something in language A to an interpreter, the interpreter renders this turn to the addressee in language B, the addressee then responds in language B, and this is understood by the interpreter and consecutively rendered to the first speaker in language A. Knapp and Knapp-Potthoff already noted in their original text that this is an idealized description and that, in many cases, interpreters may diverge from this model. Thus, the "normal format" should not account for every single course of

interaction in interpreter-mediated talk (1985: 458). However, from the perspective of the data presented in this chapter it is specifically the underlying concept of individual monolingualism that needs to be questioned.

From a dialogical and interactionist perspective, Wadensjö (1992: 1998) argued against the model presented by Knapp and Knapp-Potthoff because it paints not just an incomplete or abstract, but misleading picture regarding the role of interpreters in dialogic settings in general. She highlighted that the task of dialogue interpreters is relaying *and* coordinating talk. This means that activities such as facilitating turn taking or pointing out possible misunderstandings are constitutive parts of the interpreter's profile, and not just deviations from the norm. Subsequently, Bolden (2000) showed that hospital interpreters, in particular, act in accordance with the underlying goals of the encounter, i.e. the collaborative selection and presentation of relevant knowledge (Figure 2). Thus, the interpreter may use his or her role to elicit knowledge from the patient that would have been usually elicited by the physician or, otherwise, would not have been verbalized by the patient. Therefore the exchange between interpreter and patient in Figure 2 is not a clarification turn but rather an attempt by the interpreter to elaborate on relevant medical knowledge, which then is ultimately summarized and told to the physician.
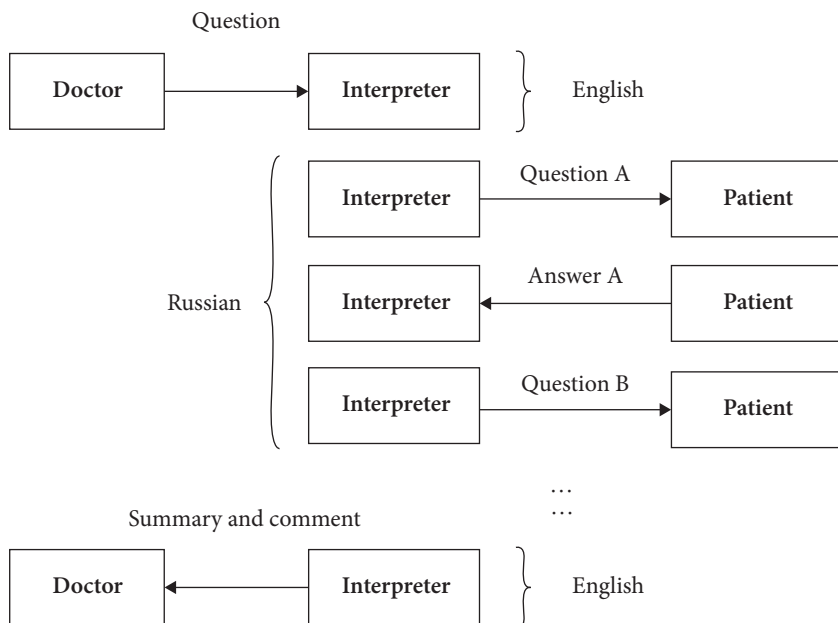

Figure 2. Involvement of interpreter in diagnostic interaction (from Bolden 2000)

Such interactional patterns may emerge due to the need for dialogue coordination, clarification, and technical language, or because participants attempt to contribute to the communicative outcome of the specific activity type they are involved in. However, Bolden's and Wadensjö's work is still based on the assumption that the language barrier is non-permeable:[3]

1. In Wadensjö's concept of dialogue interpreting, the interpreter's involvement is triggered by the fact that the primary interlocutors cannot assume specific tasks due to their limited linguistic resources. Hence, the interpreter, as the only bilingual person in the setting, takes these roles to facilitate communication.
2. In Bolden's analysis, the communicative drift towards specific institutional goals, i.e. the need to elicit knowledge that is relevant for diagnosis, seduces interpreters to ask questions and to summarize the content of the patient's answers. Thus, by eliciting and presenting relevant knowledge, the interpreter takes an institutional role that is usually performed by the doctor. As in the concept developed by Wadensjö, s/he is able to do so because the language barrier is perceived as not being permeable.

In transparent language constellations, however, the range of possible interaction formats and participant roles increases. Here, we may find sections of discourse in which interpreter-mediated and direct communication between the primary interlocutors co-exist (see also Anderson, this volume). A patient may receive a question in his or her native language and may answer in the language of the physician, and vice-versa. It is also possible that a physician, instead of waiting for the interpreter, directly reacts to the patient's response if it is formulated in German. The interpreter may then only add a short version of what has already been communicated in the official language of the hospital.

The language constellation underlying this increased complexity still requires dialogue coordination by the interpreter because the doctor usually does not speak the patient's language. Furthermore, the doctor's lack of proficiency in the patient's language may also give the interpreter the opportunity to take other roles without being noticed (by the doctor). It may be argued that these phenomena are simply the result of the participation of *ad hoc*-interpreters in the conversation and that investigating trained or professional interpreters would have yielded different observations. The purpose of this chapter, however, is not normative in the sense that it argues in favour of a specific approach to overcome language barriers in healthcare. Rather, the aim is to describe the standard practices of

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3. This also true for other authors working in the area of medical interpreting, including Bührig and Meyer (2004), Davidson (2002), or Pöchhacker and Shlesinger (2005).

communication with migrant patients in German hospitals and, more specifically, how transparent language constellations shape the participation framework.

5.   Two cases of limited German proficiency: Mr. Gomes and Mr. Sahin

In this section I will present data from two consultations with patients with limited proficiency in German. More generally, I will draw attention to how interpreters come into play in situations where the language barrier is partly permeable. The rationale for choosing these cases is that the language biographies of the individuals are typical for a specific set of migrants: working class, first generation migrants who immigrated as adults and have limited contacts to Germans. The first patient, Mr. Gomes, is a senior citizen with Portuguese nationality who came to Germany in his 20ies and worked until retirement in several positions as an unskilled worker. His social contacts were restricted to family members who live in Hamburg, and other Portuguese compatriots. He never received any formal language teaching in German. By the time of the recording he had lived in Germany for more than 30 years without having intense contact to native Germans. The second case is Mr. Sahin, a patient with a Turkish migration background. His personal history is similar to that of Mr. Gomes, though he was considerably younger at the time of the recording and had slightly more social contacts, partly because his children were born in Germany.

5.1   Mr. Gomes – a medical interview on depressive disorders

The patient came to the hospital because he had a blackout and was found helpless at home. During his visit, several examinations were carried out on him to clarify the reasons why he fainted. After a couple of days in the hospital, the patient declared that he also suffers from depressive disorders. Therefore, a neurologist came to the ward where Mr. Gomes was located. The diagnostic talk between Mr. Gomes (henceforth: PAT), the neurologist (DOC), and a bilingual nurse (NRS) took about 45 minutes. In Extract (1), I present only the first few lines of the transcript to exemplify how the language constellation impinges on the interaction format and the participant roles of the *ad hoc*-interpreter.

(1)
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01  DOC  Man hat mich gebeten, nochmal nach Ihnen zu gucken, weil
         äh Sie sagten, dass da wohl so depressive Störungen da
         sind.
         They asked me to look after you because you said that
         there are such depressive disorders.
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02  PAT  Ja, stimmt. Ja.
          Yes, right. Yes.
03  DOC  Seit wann ist das denn so?
          Since when is this the case?
04  PAT  Seit- (3.0) Als ich gefalle hab. D- desde que eu caí.
          Since (3.0) When I fell. Since I fell.
05  NRS  Seit er hingefallen ist.
          Since he fell down.
06  DOC  Seitdem ist da Depression.
          Since then there is depression.
07  NRS  Seitdem
          Since then
08  PAT  Ja.
          Yes.
09  DOC  Und vorher?
          And before?
10  PAT  (1.0) Vor mehrmals eh gewese, ja. (2.0) Ähm aber mas
          (2.0) eh jetz wer- eh werd ein bisschen mehr schlimm.
          (1.0)    Before several times was, yes. (2.0) Uhm
                   but but (2.0) uh now is a bit more worse.
11  DOC  Uh-hum. ((affirmative))
12  PAT  E agora é mai/ mais pesado.
          And now it is mu/ much heavier.
13  NRS  Ja, jetzt, jetzt fühlt er sich auch schlimmer. Also jetzt
          findet er diese Depressionen auch schlimmer.
          Yes, now, now he also feels worse. That is to say, now he
          experiences these depressions more intensely.
14  DOC  Ähm, seit wann haben Sie denn ü- überhaupt mit
          Stimmungsschwankungen zu tun?
          Uhm, how long do you have to deal with these emotional
          disorders?
15  NRS  Há quanto tempo você tem (1.0) que nota diferenças assim
          no seu estar? Assim que-
          How long do you (1.0) have noted such differences in your
          condition?
16  PAT  Já há vários meses.
          Since several months already.
17  NRS  Já há mais tempo que agora você tem eh depressão mesmo?
          It is already since more time that you have a depression?
18  PAT  Há, há mais tempo. Há vários, há vários meses.
          Yes, since more time. Since several, since several months.
19  NRS  Schon länger, also das is schon n paar Monate her.
          More time yet, already a couple of months ago.
20  DOC  Paar Monate. Nich schon Jahre?
          A couple of months. Not years?
21  PAT  Nee.
          No.
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The neurologist starts her visit with a statement about the patient's complaints. The patient, Mr. Gomes, confirms in German with "Ja, stimmt" ("Yes, right") and "Ja". The neurologist then continues with a question regarding the duration of complaints (turn 3). The patient starts his answer in German, and then repeats it in Portuguese (turn 4). The nurse takes this as a signal to start interpreting: she reproduces his utterance in German (turn 5). The neurologist repeats the answer, receives confirmation in German from the patient (turn 8), and then continues with a question concerning his condition before the accident ("And before?", turn 9). The patient responds in German (turn 10), and then repeats parts of his preceding statement in Portuguese (turn 12). The nurse gives his statement a more subjective tone by using *verba sentiendi* in turn 13 ("he feels", "he experiences"). The neurologist then asks about the beginning of complaints (turn 14), the nurse renders this question in turn 15, and receives the answer of the patient in Portuguese (turn 16). She then inquires to make sure that she understood well (turn 17), which is confirmed by the patient (turn 18). The fact that he has suffered from depression for several months is rendered into German in turn 19, and the insisting question of the neurologist in turn 20 ("Not years?") is then again answered directly by the patient in turn 21: "Nee" ("No").

This short extract comprises four different interaction formats:

1. Direct interaction between doctor and patient in German
2. Partial or reduced renditions, in which parts of a complex turn are rendered from Portuguese to German
3. Complex turns that are produced in Portuguese and then rendered into German
4. Question-answer sequences with a question in German, an answer in Portuguese (without previous rendition of the question), and a subsequent rendition of the answer into German.

Thus, a set of different ways of interaction between doctor, patient, and *ad hoc*-interpreter can be observed in the data. Patient and nurse collaboratively make use of their linguistic resources to bring the questions and the answers of the patient across. In some cases, the nurse goes a step further and makes the patient's statements fit into the diagnostic patterns the neurologist presumably follows, as in turn 13. Thus, not only does her contribution provide linguistic support, but it is also an attempt to contribute to the achievement of institutional goals, i.e. diagnosis (as observed by Bolden 2000). The constant shifting between different types of footings characterizes the interaction as a whole, and not just the first two minutes.

5.2 Mr. Sahin – misunderstandings about "chemotherapy"

Mr. Sahin (PAT) is a worker with a Turkish migration background who has lived
in Germany for almost twenty years. He went to the hospital because there were
indications of cancer. He already had cancer treatment some time ago and now
it seems that the disease has come back. The basic diagnostic information has
already been given to him. In this consultation, a senior physician (DOC) explains
to him, how the chemotherapy will be carried out. The room is full of people: vari-
ous family members, two physicians, and a male nurse (NRS) from another ward
that acts as an interpreter. The nurse knows the patient because they live in the
same neighborhood. At the beginning of the consultation, the senior physician
invites the patient to ask questions. Then he explains the course and aims of the
chemotherapy. In Extract (2), he talks about when the effect of the chemotherapy
should become effective. His pronunciation of the word "chemotherapy" differs
slightly from the norm due to his dialectal background (Bavarian). The patient
picks this up and gets the false impression that the physician is talking about two
different therapies.

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    (2)
01  DOC  (0.6) Wir werden ((clears throat)) nach ein Mal
         Chemotherapie und auch nach zwei Mal Chemotherapie (.)
         überprüfen, (..) ob die Herde kleiner geworden sind.
         (0.6) After the first session of chemotherapy and also
         after the second session of chemotherapy we will check
         whether the tumours are getting smaller.
02  NRS  (0.6) Birle ikinciden- e bi- birinciden sonra da, diyor e
         bakıcaz, diyor, ikinciden sonra da bakıcaz, diyor.
         (0.6) From the first and the second uh as well as after
         the first, he says, uh we will look, he says, and also
         after the second we will look, he says.
03       Küçülüyor mu küçülmüyor mu, diye.
         Whether he is getting smaller or not getting smaller, he says.
04  PAT  (.) Evet. Ee (0.6) bu şemo terapi mi oluyo, yoksa kemo
         terapi ayrı şemo terapi ayrı mı oluyo bu?
         Yes. Uh (0.6) is that a chemotherapy, or is kemotherapy
         something and chemotherapy something else?
05  NRS  Yo, şemo terapi.
         No, chemotherapy.
06       (1.0) Aynı. Hepsi aynı ya.
         (1.0) The same. That is somehow all the same.
07  PAT  (0.6) He. (0.6) O bizim Mehmet'in olduğu gibi?
         (0.6) Yes. (0.6) Just as with our Mehmet?
08  NRS  He.
         Yes.
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09   PAT   hh Alle Haare weg, ne? Oder was?
            hh All the hair gone, right? Or what?
10   DOC   Ja.
            Yes.
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In turn 1, the physician mentions explicitly that he is talking about the intervals of the therapy, and not about different therapies ("ein Mal Chemotherapie", "the first session of chemotherapy"). This, however, is not picked up in the subsequent rendition of the nurse in turn 2. The nurse simply talks about "the first" and the "second", which then prepares the ground for the confusion of the patient in turn 4. This confusion, however, is not only triggered by the less explicit rendition, but is also based on the pronunciation of the word "chemotherapy" by the physician. In his turn, the physician shifts between standard and dialectal pronunciation of the word, and the patient rephrases this pronunciation in his question in turn 4. Thus, there are two sources for the confusion about how many different therapies will be applied: a less explicit rendition of the *ad hoc*-interpreter, and dialectal variation in the original utterance of the physician. The example shows that Mr. Sahin, similarly to Mr. Gomes, follows the contributions of the physician. His understanding of the therapy explanation is not exclusively based on the renditions of the nurse, but partly also on what the physician says.

Furthermore, the example shows how new, additional topics may arise out of the communication between the *ad hoc*-interpreter and the patient, as can be seen in turn 7. Here, the patient uses the clarification turn to make the assumption that the treatment is equal to the cancer treatment received by a friend ("Just as with our Mehmet?"). The nurse confirms this is, and then the patient addresses the physician in German: "Alle Haare weg, oder?" ("All the hair gone, right?"). Thus, the patient links the notion "chemotherapy" to one of its obvious and well-known side effects. By doing so, he shifts the discourse away from the threatening talk about post-therapeutic measures ("check whether the tumors are getting smaller"). The topical shift may be interpreted as an attempt to counter the relatively direct style of the physician and wrap up the fact that the therapy may also not be successful (and indeed it wasn't).

6.   Conclusions

In communication with migrants, language barriers are often permeable to some extent. Thus, the common idea of the pivotal role of interpreters needs to be questioned – in transparent constellations interpreters are still there to translate, but they may also adopt other roles more easily. The specific features of transparent language constellations open the floor to different types of participation beyond

the classical concept of interpreters as invisible and imperceptible participants. The data presented in Extracts (1) and (2) are thus similar to the shifts between dyadic and triadic talk observed by Valero-Garcés (2005). She analyses medical communication with non-native patients, supported by *ad hoc*-interpreters, trained interpreters, or without participation of interpreters, and observes that doctors and patients accommodate less to each other when a trained interpreter is present. The study by Valero-Garcés shows that different interaction roles and contribution formats emerge in relation to the level and the quality of direct interaction. Similarly, *ad hoc*-interpreters in the data presented in our study automatically step back and leave the floor when direct interaction is initiated by the patient. In other sections, patients' deficient utterances call for additional emphasis and correction. Reduced statements produced by Mr. Gomes that seemingly do not fit with the expectations of the neurologist lead to a "mentalization" ("he feels") added by the *ad hoc*-interpreter.

Hence, a normative judgement on how participants should make use of existing linguistic resources seems, therefore, to be misleading. Rather, one should look at how these resources contribute to the discursive exchange between the doctor and the patient, and to the achievement of institutional purposes. The forms of participation practised by the nurses in these extracts are not triggered by the specific language constellation alone, but the constellation can be regarded as an important factor that opens the floor to different ways of participation in the interaction. Other factors are the role perceptions of the *ad hoc*-interpreters, their levels of expertise and knowledge, their understanding of the purposes of the interaction, as well as the communicative needs of the patient (e.g., Mr. Sahin's attempt to shift the topic from tumour development to hair loss).

The data from these two cases show that the specific language constellation in communication with migrant patients makes interpreter-mediated interaction more complex. It allows doctor and patient to communicate directly, and, at the same time, requires that the interpreter is available as soon as s/he is needed. Furthermore, the interpreter may elaborate on the patient's contributions or repeat parts of the conversation in the other language. In these cases, a shift towards the role of an institutional agent may take place. The specific usage of linguistic resources reflects the participants' attempt to organize the interaction on the basis of their linguistic competencies.

These competencies are different for the three participants: usually institutional agents in Germany, such as doctors, judges, police officers, etc., do not speak migrant languages. Migrants, however, may have reached different levels of linguistic expertise in the language of their host country. Although the large majority of migrants in Germany rates their linguistic skills as relatively good, in certain communities or among specific subgroups the level of proficiency in

German is generally lower. Furthermore, the study suggests that migrant patients face communication problems in hospitals even if their German is good enough for daily communicative purposes. Thus, *ad hoc*-interpreting in German hospitals constitutes a specific form of interpreting not only for being dialogical, and shaped by the institutional setting, but also because it occurs in combination with direct interaction.

Typical ingredients of interpreter-mediated communication with migrant patients are the insecurity about the patients' reception, i.e. their understanding, and the interactional dynamics caused by the specific language constellation, i.e. the tendency of interpreters to perform multiple roles within one encounter. However, the fact that this type of communication does not follow the normative patterns of conference interpreting should not lead to the imposition of individual monolingualism: Mr. Gomes should have the right to use German if he wants to, even if his German is deficient in some aspects, and even if an interpreter is there. Linguistic competencies of the patients should neither be neglected, nor should they automatically be taken as sufficient. Instead of imposing individual monolingualism, institutional agents and interpreters should be prepared to work under such conditions. Future research could explore how the specific demands of this language constellation can be integrated into interpreter training curricula (Bührig and Meyer 2009; Meyer et al. 2010).

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