

Family interpreters in hospitals: Good reasons for bad practice?

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Citation: Meyer, Bernd, Birte Pawlack and Ortrun Kliche (2010) "Family interpreters in hospitals: Good reasons for bad practice?", *mediAzioni* 10, <http://mediazioni.sitlec.unibo.it>, ISSN 1974-4382.

1. Introduction

Experts such as professional interpreters and linguists usually see the use of family interpreters as bad practice. Regardless of this fact, bilingual second generation migrants frequently act as interpreters for their families and friends. There seems to be a discrepancy between scientific criticism of the involvement of family members as interpreters on one hand, and the perspectives of the families and the institutional agents on the other. We argue that this mismatch originates in the fact that German medical institutions are usually not prepared to provide services to patients coming from a variety of linguistic and cultural backgrounds. More specifically, the lack of interpreting services forces non-proficient patients and medical professionals to (ab)use bilingual family members as interpreters. Beyond that, such family interpreters, as we may call them, may offer certain advantages compared to interpreters from outside the family. Our study is based on transcriptions of interpreter-mediated interactions in hospitals and socio-demographic data from the German socio-economic panel (SOEP).

2. Research on family members as ad-hoc-interpreters in medical settings

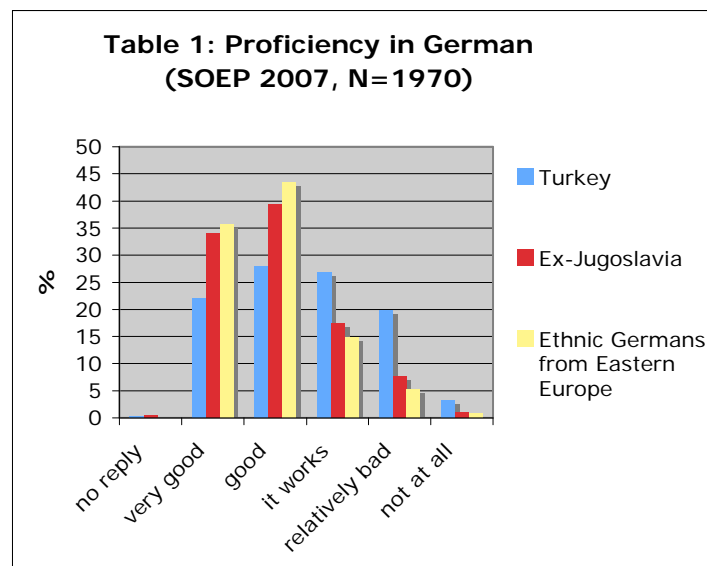
Some years ago, Glenn Flores, a professor of paediatrics at the Southwestern Medical Center in Dallas (USA), stated that “family members, friends, untrained members of support staff, and strangers found in waiting rooms or on the street [...] are more likely than professional interpreters to commit errors that may have adverse clinical consequences” (Flores 2006: 231). This view on family members as ad-hoc-interpreters is widely acknowledged among scholars who have looked at mediated medical encounters in detail (Bührig and Meyer 2004; Hardt 1995; Pöchhacker and Kadric 1999; *inter alia*). As Pöchhacker (2008) shows in a case study of a teenage interpreter, bilingual second generation migrants do not have a clearly defined role when interpreting for family members. As their parents are usually able to communicate in the host country's language to some extent, the ad-hoc-interpreters restrict themselves to acting as back-up language aids, joining the conversation only in certain moments when misunderstanding between the primary parties becomes obvious. However, their contributions do not always solve communication problems. Rather, they may aggravate existing difficulties and sometimes even create additional misunderstandings. Nevertheless, the participating medical staff assessed the conversation to be fairly normal and successful, despite all sorts of translation errors and misunderstandings. Thus, although interactions with ad-hoc-interpreters often appear to be fluent and unproblematic at first glance, a closer look reveals significant miscommunication. However, such miscommunication passes by unnoticed by the primary interlocutors. Consequently, organizers of interpreting services for public institutions, such as the British Chartered Institute of Linguists, argue in favour of independent interpreting and translation services catering to the communicative needs of migrant populations. Such registered interpreters and translators should have a high (academic) level of linguistic expertise and training as well as detailed knowledge of legal aspects and matters and processes in the respective institution (Corsellis 2008). Although this approach to tackling language barriers seems to be sound and appropriate, untrained family interpreters are still widely used in many European countries and professional interpreting services can only be found in specific institutional spheres such as in court.

2.1. Language barriers, language policies, and practice

Many countries seem to perceive language barriers as a transitional problem that decreases over time. Indeed, migrant populations usually develop some kind of bilingual repertoire that allows most members of these communities to get along in their daily affairs. Nevertheless, interest in the communication needs of people with limited proficiency in the national languages is growing. In 2002, the US-Corporation for National and Community Service issued a policy guidance document emphasizing that all recipients of federal financial assistance (i.e. public or private institutions such as schools, hospitals, etc.) have “a responsibility to ensure meaningful access to their programs and activities by persons with limited English proficiency (LEP)”. As a consequence, the US-census provides information on the number of people with LEP-status in each federal state, and institutions are requested to monitor the presence of LEP individuals in their programmes and to develop adequate measures to ensure that services are accessible, even when clients do not speak English well. These services may include written materials such as bilingual information sheets, signs, etc., and may even involve the implementation of translation and interpreting services. Though adherence to such policy guidelines is not always monitored and adequate measures are not always put into practice, such guidelines clearly indicate that language barriers are no longer regarded as transitional. In fact, in many countries that may appear to be linguistically homogenous such as Japan (Coulmas and Watanabe 2001) or Germany (House and Rehbein 2004), a smaller or larger minority of migrants considers itself to have limited proficiency in the national language. The question, then, is how these individuals obtain access to vital services such as those offered in the health care system.

Measuring the communicative needs of non-native populations with limited proficiency in the host language is notoriously difficult. German data available on the language proficiency of such migrants can mainly be found in the “socio-economic panel” (SOEP). The SOEP is a panel study of households that covers about 20,000 individuals in 11,000 households in all parts of Germany,

including foreigners and immigrants (www.diw.de/en/soep). Language is not a central topic of the survey, but questions concerning language proficiency have recently been integrated. In the 2007 sample, about 2,000 surveyed individuals (=10%) reported being from bilingual families or bilingual themselves. They were asked to rate their proficiency in German and their family language with regard to reading/writing and speaking/listening on five-point Likert scales. The SOEP data reveal that in each migrant group, the majority of interviewees rate their proficiency as good or very good, while a minority states their German to be limited to some degree (“it works”, “relatively bad”, “not at all”, see Table 1). Although the method of self-evaluation is not very precise, it allows for a rough estimate of the need for communication in languages other than German. In average, 20% to 25% of migrants state that their command of German is limited (“it works”, “relatively bad”, etc., Meyer 2009). The large group of immigrants with a Turkish language background, however, constitutes an exception: only 50% of the individuals from this group rate their command of German as “very good” or “good”. 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 group, the number of individuals with limited proficiency in German would be 1.75 million – just in the Turkish community.



The SOEP-data show that a relevant minority in each migrant group battles with language barriers in the truest sense. However, it seems that even for those migrants who rated their language skills as fair, communication may be difficult in medical settings. For example, patients with a migration background are

more likely go to the hospital in cases where a family doctor would have been sufficient (Riesberg and Wörz 2008: 74ff), and they are less satisfied with the medical care they receive (Borde 2002).

Although such observations are not necessarily indicative of miscommunication or limited host language proficiency, it seems plausible that communication problems represent at least one influential factor in addition to others. It seems that migrant patients prefer communicative assistance, even when their L2-skills would allow for direct communication. Khwaja *et al.* (2006) present data on the activities of an interpreter service at the “Central Manchester and Manchester Children NHS Trust” (CMHT). Between 1998 and 2003, the total number of hospital visits rose from 3240 to 5492. About 70% of all visits with (internal or external) interpreters included patients from former British colonies, mainly from the Indian subcontinent. In this region, English plays an important role as a Lingua Franca, as well as a language used for academic purposes. Thus, it is highly probable that these are patients that are able, at least to some degree, to communicate in English. Nevertheless, a considerable number preferred to communicate with the help of an interpreter.

As of yet, no quantitative investigation on communication with allophone patients has been conducted for the German health care system. However, some work has been done on the same topic in neighbouring countries, i.e. Switzerland and Austria. Bischoff and Loutan (2004) conducted interviews in 244 hospitals in Switzerland. They found that in 78% of the clinics, family members were frequently used as interpreters in doctor-patient-communication. Pöchhacker (2000a, 2000b) interviewed 508 employees of 12 hospitals in Vienna. The majority of the interviewees (59%) stated that often (45%) or almost always (14%), family members or friends would translate for patients with limited German proficiency, even though their interpreting competencies were generally judged to be deficient. The interviewees stated that family interpreters were not able to understand technical terms, had insufficient technical knowledge or would interfere in the communication by speaking for the patients themselves. These investigations are interesting when considering the situation in Germany, because the migration histories of Austria and

Switzerland are comparable to the German situation. Furthermore, the Swiss and Austrian studies clearly show that family interpreters are used despite the fact that organisations and/or individual institutional agents do not trust their interpreting skills. This contradiction between the low perceived quality of interpreter performance and the nonetheless frequent use of family interpreters is also confirmed by studies from the US (e.g. Baker *et al.* 1998; Bonacruz-Kazzi and Cooper 2003). Ramirez *et al.* (2008: 358) report that there is “a perception among providers that requesting and working with an interpreter increases physician time requirements, thereby discouraging the routine use of interpreter services”. Furthermore, the perceived costs of such services represent another obstacle to the use of professional interpreters (*ibid.*). Thus, it seems that the use of family members as ad-hoc-interpreters has mainly structural reasons, as it appears to save time and costs. When hospitals do not have established guidelines concerning the use of interpreters, a bilingual family member or friend of the patient may appear to be the most suitable solution. These individuals are available and their services are free of charge. On the other hand, patients with limited proficiency already know that hospitals are not prepared for dealing with language problems and therefore bring bilingual family members or friends with them right from the beginning of treatment. However, the perception of family members as a cheap solution is wrong: Bernstein *et al.* (2002) show that the use of trained interpreters may reduce the costs of emergency department visits for migrant patients. Additionally, Hampers and McNulty (2002) show that the costs of such visits (paediatric emergencies) increase when non-professional interpreters are used. Thus, family interpreters save time and costs only at first glance. Nevertheless, physicians see them as a helpful option in overcoming language barriers. After briefly discussing studies on the impact of interpreting on children and adolescents and their perceptions of this activity, we will present some “good” reasons for this option in section 3. These reasons are grounded in the interaction itself. As the discussion in section 3 will show, physicians, patients, and even the interpreters themselves may benefit (in a certain sense) from family interpreting in health care.

2.2. Burden or benefit? The self-perception of family interpreters

The existing literature on family members as ad hoc-interpreters deals mainly with the impact it has on children and adolescents. This practice, referred to as “natural translation” (Harris and Sherwood 1978) and mostly as “language brokering” (Tse 1996), is examined in numerous studies (reviewed by Hanson and Morales, 2005) for all kinds of settings, including that of health care. Dorner *et al.* (2007) stated that this brokering activity correlates with better reading comprehension abilities. Walichowski (2001) showed that language brokers utilize higher cognitive abilities and problem solving abilities in comprehending all kind of forms such as insurance forms or job applications. Becoming bilingual leads to feelings of pride; the brokering activity was most often considered a positive experience, but also a source of frustration. Similarly, McQuillan and Tse (1995) report that language brokering increases independence and maturity, though the authors also state that it can be a stressor or burden. Tse (1995, 1996) interviewed children that often broker for their parents in school settings. She reports that although they did enjoy brokering, she found no correlation between academic performance and language brokering (Tse 1995). In another study, she reports that at least half of the interviewed children stated that they enjoyed brokering and that it helped them to learn more about their first and second language (Tse 1996). Moreover, Valdés *et al.* (2003) found that none of the interviewed child brokers spoke negatively about their brokering experience. Orellana (2003) reports that children assumed that translating is “just normal” or “just something they do”. Furthermore, children that translated were better in standardized tests of reading and math achievement. Weisskirch and Alva (2002) observed that translating was viewed more or less neutrally by the interviewed children. Weisskirch (2007), however, states that child brokers with problematic family relations negatively evaluated their brokering practices and argues that the negative experiences can be ascribed to these difficult family relationships. Dirim (2005) states that the translation competencies of bilingual children are often neither acknowledged nor encouraged. However, these children interpret very often for family members or friends of the family and develop interpreting strategies that they can use to deal with special emerging challenges. Dirim (*ibid.*) investigated the translation competencies of

bilingual children by asking them to translate a story that was read to them. Analysing two case studies, she shows that even seven-year-old children were able to translate the story so that it was comprehensible and grammatically and syntactically correct. Along the same lines, Bullock and Harris (1995) claim that children have the ability to interpret. Their positive experiences with a school-internal child interpreter service led them to the conclusion that “a well-guided child community interpreting service becomes not only a service to others but also a means of personal development and socialization for the interpreters themselves” (*ibid.* 234).

Green *et al.* (2004) interviewed 76 young bilingual individuals concerning their interpreting activities in medical settings. On the one hand, they felt proud but on the other sometimes uncomfortable with the situation. For instance, one adolescent explained that he was embarrassed when he had to talk about intimate topics: “if it's a woman's problem then I can't speak, and it's difficult for my mother and for me, because I feel bad inside that I can't speak for that problem. I am the son, so it's like embarrassment” (*ibid.* 2106). The authors emphasize that interviewees “rarely saw themselves as ‘inadequate translators’ or exploited children, but as skilled mediators, helping to bridge misunderstandings between family members and the public sector” (*ibid.* 2108).

Pohl (2005, 2006) edited two booklets in which he documented findings from the project „Wir sorgen für Verständigung. Jugendliche dolmetschen in Kiel Mettenhof“ (*We provide understanding. Adolescents as interpreters in Kiel-Mettenhof*). In the project, participants were trained to interpret and reflect on their own interpreting practices in different settings (public health service, civil service, etc.). These reflections are presented in 15 transliterated interviews. The interviewees stated that they felt overwhelmed and overloaded on the one hand, but proud and pleased to help other people on the other. Similarly, Jacobs *et al.* (1995) report a case in which a ten-year-old girl interpreted between the medical staff and her parents when her baby brother was being treated. She became increasingly involved and later suffered an emotional trauma when her little brother died. The authors claim that such trauma was caused by “the very close involvement that this young child had in the care of

her dying younger brother, including her being used as interpreter between her family and the medical staff" (Jacobs *et al.* 1995: 474). Thus, in highly complex situations, a high price may be paid for the cognitive benefits young family members may receive by acting as interpreters or language brokers. Though facing the communicative challenges of adult discourse may train their linguistic and cognitive abilities, children run the risk of being overwhelmed by painful experiences and sensitive matters that are inappropriate for them.

2.3 Considerations about translation quality

Ebden *et al.* (1988) analyse doctor-patient-interviews in which family members acted as interpreters. Altogether, they analysed 143 questions and answers and stated that the translations were of astoundingly poor quality. The relatives especially had difficulties in translating complex questions and anatomical terms. Cultural aspects (e.g. patriarchal nature) were discussed as a possible interference in communication. Children had particular difficulties in translating questions about menstruation or bowel movements. Valdés *et al.* (2003) developed a simulated interpretation task with which the abilities of young interpreters were tested. They examined whether they could a) convey essential information, b) communicate the tone and stance of the original exchange, and c) keep up with the flow of information. Differently from Ebden *et al.*, the authors reported that the subjects showed a high level of performance in all three areas. Their study did not refer to the medical setting, however, but rather to communication in schools.

The General Practitioners (GPs) interviewed by Cohen *et al.* (1999) stated that children could not be competent interpreters because of their lack of technical and linguistic knowledge. In addition, the emotional impact on the children could be so great that it would not be appropriate that they interpret. However, two GPs claimed that older children could benefit from their interpreting practices (*ibid.*: 18), and most GPs stated that children are able to interpret in straightforward situations. They distinguished between straightforward and complex or sensitive consultations. Similarly, Orellana *et al.* (2003) distinguish between everyday and specialized encounters to be translated. This distinction

was made on the basis of interviews with language brokers. Because of its particular demands, interpreting in medical settings was considered to be a specialized encounter (*ibid.*: 517ff). Thus, the quality of the translation done by family members is not guaranteed, even though some studies claim that family members are able to translate even in complex situations.

2.4 Intervention of family interpreters

Referring to the Goffmanian concept of “footing” (Goffman 1981), Müller (1989) was the first to focus on the specific participant status of ad-hoc-interpreters in communication with individuals with limited German proficiency. In his analysis of ethnographic interviews with Italian migrants in Germany, he emphasizes that switching between mediated and direct interactions seems to be an adequate solution for the specific challenges found in the linguistic constellation between the German interviewer (with limited Italian proficiency) and the Italian interviewees (with limited German proficiency)

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.*: 735).

Thus, ad-hoc-interpreting is described as a “flexible instrument for the specific pragmatic and interactive needs of a constellation” (*ibid.*: 735). This shifting between more passive or supportive roles and an active involvement as a primary interlocutor seems to be a typical feature of ad-hoc-interpreting in communication with migrants. As the language barrier is not as impermeable as in other language constellations, direct and mediated modes of interaction may go hand in hand within the same interaction. This flexible use of linguistic resources, together with a specific involvement due to the family relation, however, may also open the door for the family interpreter to intervene and act as a primary interlocutor – even in institutionally constrained settings such as medical communication.

Recently, the notion of “intervention” has been more widely used to account for the active involvement of interpreters and translators in multilingual

communication. The view of translators and interpreters as “intervenient beings” (Maier 2007) is based on the idea that acts of translation are based on choices and that “each choice, reflected upon or not, represents an intervention” (Munday 2007: xiv). This notion points directly to questions of linguistic equivalence, cultural filtering, and cultural action in oral and written translation (House 1981; House and Rehbein 2004; Rehbein 2006). In using family members as interpreters, however, the notion of intervention takes on a slightly different meaning. As mentioned by Hardt (1995: 174) mentions, these interpreters tend to bring their own agendas into the clinical encounters. Similarly, Orellana *et al.* (2003) adopt the term “para-phrasers” for children that interpret for parents or family members because these children “speak *for* others and *in order to* accomplish social goals” (*ibid*: 15). The authors indicate that children that interpret for their parents interfere in the communication by pursuing personal interests. Valdés *et al.* (2003) ascertained that child language brokers try to protect their family members from embarrassment or humiliation and attempted to create a better image of their parents, for instance by being more polite than their parents.

Eksner and Orellana (2005) interviewed adolescents that interpreted for their parents in public civil service encounters (e.g. school, doctor’s offices and public aid agencies) and found that these adolescents act as advocates for their parents. By mitigating the utterances of their parents, they tried to create a better image of the father or mother so that they would have better chances to access “a range of resources, goods, information, or other services” (*ibid*: 191). Valenzuela (1999) interviewed child language brokers and their parents. One of the major findings of the study was that these children “intervene, advocate and mediate in behalf of their parents during complex financial and legal transactions or situations” (cited from Hanson and Morales 2005: 486). Thus, it seems that family interpreters are active participants, not only due to the intrinsic communicative demands of dialogue interpreting (Wadensjö 1998) or institutional discourse (Bolden 2000; Bührig and Meyer 2004). Indeed, they may get involved in order to achieve other goals related to the social status of their families.

3. Good reasons for using a family interpreter?

Why does the use of family interpreters seem to be a logical solution for all parties involved in communication? There seem to be reasons beyond those on a merely organisational level (costs, availability). To determine these reasons, we will use the qualitative approach of discourse analysis. This approach consists mainly of reconstructing the communicative acts performed by participants in detail, and relating this reconstruction to the social (i.e. interpersonal and/or institutional) purposes of the interaction (Stubbe *et al.* 2003; Redder 2008; *inter alia*). One idea common to all approaches to discourse analysis is that the interpretation of communicative acts is partly dependent on the knowledge shared by the speaker and the listener. The so-called “common ground” (Clark *et al.* 1983; Chafe 1976) is not a stable, static entity, but it is dynamically shaped in the interaction. Participants have to mark knowledge elements with regard to their knowledge status (new, given, known, shared, etc.), and they have to provide information about the source of knowledge (evidentiality). This allows listeners to reconstruct the intentions and motivations of the speaker, his or her “point of action”, and to subsequently perform an adequate action that fits with the sequential action pattern initiated by the speaker (Rehbein 1977: 192ff). Due to the knowledge differences between patients and doctors, reformulations and other types of verbal actions are used to facilitate the understanding processes of the patient as a non-expert (Bührig 1996). Thus, the discursive organisation of relevant knowledge is a major challenge in doctor-patient communication, especially when interpreters are involved (Bolden 2000).

The area in which the participation of family interpreters may yield advantages for all participants is in their role as providers and recipients of relevant knowledge resulting from their specific participant status. Family interpreters may serve as a source of additional knowledge for the physician and for the patient, and they may be addressed as recipients of knowledge verbalized by the physician. We will look at these aspects from the perspective of the physician, the patient, and the interpreter. Each perspective will be illustrated by examples from interpreter-mediated doctor-patient communication. The data

are taken from two projects on interpreting in German hospitals that were carried out at the Research Centre on Multilingualism at the University of Hamburg (Bührig and Meyer 2004). The patients are Turkish and Portuguese migrants living in Hamburg. As German hospitals usually do not provide professional interpreting services, the interpreters in the corpus are family members or bilingual nurses.

3.1. The physicians' perspective: addressing the interpreter as a primary interlocutor

Addressing the family interpreter instead of the patient as a primary interlocutor saves time and makes use of the advantages of native-native-interactions. Orellana *et al.* (2003: 518) present the following report of a young family interpreter ("Lucilia"):

I used to have to translate for my mom at the doctor's office so much that it came to the point where the doctor would only talk to me. He wouldn't even look at my mom. Instead he would ask me for updates and symptoms. Afterwards he would give me his recommendations and had me choose what the best options would be for my mom. Often I had to interrupt him to explain what had been going on with my mom and to ask her what she thought, but I must admit that sometimes I made choices for her without asking her first.

In this quote, the family interpreter gradually assumes the role of the patient: Lucilia is addressed as the recipient of the medical information, she provides first-hand information on the symptoms, etc., and she makes decisions without even asking her mother. This does not mean, however, that patients are always unable to follow the communicative exchange between the family interpreter and the physician. Even when patients are not able to participate directly in conversational exchanges, they may be able to track conversations; sometimes, their participation in making medical decisions comes in private conversations with their children, and not during consultation with the medical professional. However, the fact that the interpreter is a family member lays the ground for direct communication between the doctor and the interpreter, as seen in excerpt 1. In this case, a Turkish-speaking male patient suffering from asthma is accompanied by his adult daughter. The excerpt is taken from a briefing for

informed consent prior to preparing the patient for transesophageal echocardiography (TEE).

Excerpt 1

Doc: Female doctor for internal medicine, Int: Family interpreter, adult daughter of the patient, Pat: Male Turkish-speaking patient. “•” marks short hesitations of less than one second. The talk is number 8 from the DiK-corpus. This corpus can be accessed at www.exmaralda.org.

- 163 Doc Das zweite is, • was wir • morgen • *The second thing that*
oder übermorgen dann noch vorhaben, *we would like to do*
((atmet ein)) eine Untersuchung, die *tomorrow ((inhales*
von der Speiseröhre aus gemacht wird. *audibly)), is an*
examination that will
be done via the
oesophagus.
- 164 ((atmet ein))
- 165 Das is so ähnlich wie ne *It is similar to a*
Magenspiegelung. *gastroscopy.*
- 166 **Kennt er das?** *Does he know that?*
- 167 **Die Magenspiegelung?** *The gastroscopy?*
- 168 Int ••• Hat er gemacht. *He did that already.*
- 169 •• Ja. *Yes.*
- 170 Doc Ja? *Yes?*
- 171 ((atmet ein)) *((inhales audibly))*
- 172 Gut. *Fine.*
- 173 Er muss da einen Schlauch schlucken *Basically he has to*
im Prinzip. *swallow a tube.*
- 174 Und an diesem Schlauch ist ein... *And this tube comes*
with...
- 175 Int **Das ist aber/ das wird aber getaubt,** *But this will be*
ne? *denaesthetized,*
right?
- 176 **Oder?** *Right?*
- 177 Pat ((hustet)) *((coughs))*
- 178 Doc Ja, er bekommt • dabei eine Spritze, *Yes, he gets an*

		dass er n bisschen schläft.	<i>injection so that he will sleep a bit.</i>
179		Genauso wie heute.	<i>Just like today.</i>
180	Int	Ja.	<i>Yes.</i>
181	Doc	• Und ähm dann kann man von der Speiseröhre aus mit einem kleinen Ultraschallgerät, ((atmet ein)) das er praktisch verschluckt, ((atmet ein)) gucken, • ob man von dort aus diese Stelle auch noch sehen kann.	<i>And ehm then one can look from the oesophagus with a small ultrasound device, which he basically swallows, whether this point is also visible from that position.</i>

After having explained another diagnostic method (bronchoscopy), the physician starts the second part of the briefing by announcing the impending TEE (segment 163). In doing so, she does not address the patient or his daughter explicitly. Then, in segment 165, she compares the TEE to a gastroscopy. Such a comparison would only make sense if the patient is already familiar with this procedure. Otherwise, the comparison would not allow the patient to imagine how the TEE will be carried out. The physician is not sure, however, of whether the patient has already had a gastroscopy. Instead of asking him, she asks the daughter (segments 166, 167), referring to the patient in the 3rd person singular. The daughter responds after a short hesitation (segment 168) and affirms her answer (169). The doctor echoes the answer (170) and evaluates it (172). Then she continues with a brief description of the method (segments 173, 174). This description, however, is interrupted by the daughter, who brings up the topic of anaesthesia (“denaesthetized”, 175). Now, the physician responds to her question, again referring to the patient in the 3rd person singular. After giving the answer, the physician continues her speech in segment 181.

Thus, while the presentational parts of the briefing (announcement and description of method) are at least potentially designed to be rendered, the inserted clarifying sequences are exchanged solely between the physician and the interpreter. They talk with each other without integrating the patient into their

communication. The physician addresses the interpreter as a source of knowledge concerning the individual circumstances and experiences of the patient, while the interpreter asks for details about the method, which later may or may not be passed on to the patient. The advantage for the physician lies in the fact that she receives reliable information without having to wait for the rendition into Turkish and the rendition of the Turkish answer back to German. The flow of the briefing is slowed only minimally, and the patient's task in conducting the TEE (swallowing a tube) is explicitly mentioned and related to a previous experience.

3.2 The patients' perspective: referring to personal experience

Patients may benefit from the participation of family interpreters because these interpreters are able to link their renditions to the patient's living conditions and previous experiences. In such cases, the family interpreter is effectively engaged in enhancing understanding by translating standardized expert knowledge into more specific and experience-related terms. As a consequence, however, the renditions may only be loosely related to the versions given by the medical expert. This loose relation may result in renditions that are institutionally inadequate, as is often the case with technical names of medical procedures that are replaced by colloquial expressions (Meyer 2004). However, the advantage lies in the fact that the renditions are more likely to be understood by the individual patient because the content refers to his/her personal experience or habits. The interpreter shifts the relationship between vagueness and explicitness, or technical and colloquial language, found in the original rendition, resulting in a "lay version" geared towards patient understanding. This becomes obvious in excerpt 2. Here, an adult daughter translates for a Turkish-speaking cancer patient. The patient believes that he is terminally ill and asks the doctor about his chance to live.

Excerpt 2

Int: Adult daughter, Doc: Senior physician (male) for internal medicine. Talk no. 4 from the DiK-corpus.

413	Int	Er fragt nach seiner Lebenschance.	<i>He asks about his chance to live.</i>
414	Doc	Ja.	<i>Yes.</i>
415		((atmet hörbar ein))	<i>((inhales audibly))</i>
416		Das ist sehr ernst, das ist sehr ernst.	<i>This is very serious, this is very serious.</i>
417		Direkt übersetzen, bitte!	<i>Direct translation, please!</i>
418	Int	• Çok ciddi, diyor, durumun.	<i>Your situation is quite serious, he says.</i>
419		"Öteki defa gibi değil", diyor.	<i>"It is not like the last time", he says.</i>

In segment 413, the daughter translates a previous question of the patient. The patient has already been treated for lung cancer some years ago. Now, the disease has returned. The answer of the physician starts with a turn-taking signal ("Ja" - Yes) in 414, followed by an audible intake of breath. Then, in segment 416, he characterizes the condition of the patient as "very serious" and repeats this statement. In 417, he prompts the daughter to translate immediately. The daughter reproduces the statement in 418, and then adds in 419 that the situation is "not like the last time", referring to the previous illness, which had been treated with temporary success. By using a marker of reported speech ("diyor" – *he says*), she attributes her addition to the physician, the medical authority (Johnen and Meyer 2007). The comparatively vague concept of seriousness is thus related to the experience of the patient. Implicitly, the daughter refers to the likelihood of death: if it is *not* like the last time, the patient is probably going to die. This implication might have already been encoded in the physician's statement by prosodic cues or nonverbal communication. Thus, the addition may not be the result merely of inference on the part of the daughter. However, the explicit contrast between this time and last time allows the patient to infer what his chances to live actually are. While the physician has not explicitly referred to life expectancy in his answer, the daughter does so at least implicitly, allowing the patient to deduce the answer to his question.

3.3. The interpreters' perspective: bringing in one's own agenda

“Language brokers”, according to Tse (1995), “influence the content and nature of the message they convey, and ultimately affect the perceptions and decisions of the agents for whom they act” (cit. from Weisskirch 2007: 546). This possibility for intervention makes interpreting attractive for family members: they get the opportunity to become part of the treatment process, and ultimately influence the patient's decision-making.

In excerpt 3, a male Turkish-diabetes patient receives diet instructions from a German dietician. His adult son interprets for him. The son uses his role as an interpreter to criticise the eating habits of his father, who has not been following his diet, and explicitly complains in Turkish about the small portions of food he gets in the hospital. These complaints, however, are not rendered into German. Rather, the son selects those bits of information that can be used to his advantage in the argument between him and his father. While the dietician provides diet information in a neutral and objective manner, the son argues with his father and tries to convince him to follow diet instructions. The neutral tone of the dietician is changed into a personalized type of discourse, full of references to previous talks, the specific eating habits of the patient and his lay perceptions of diet.

Excerpt 3

Diet: Female dietician, Int: Family interpreter, adult son of the patient, Pat: Male Turkish-speaking patient. “•” marks short hesitations of less than a second. The talk is number 1 from the DiK-corpus.

288	Diet	Deswegen also so n Teller mit Spaghetti Bolognese oder Spaghetti mit Tomatensoße oder so.	<i>Therefore a plate with spaghetti Bolognese or something.</i>
289		Das wär halt • • • ziemlich schlecht, weil da die Menge ja sehr • • • groß ist, ne?	<i>That would be pretty bad, because it is usually a huge amount.</i>
290		Deswegen lieber denn • • paar	<i>Therefore better a few</i>

		Nudeln, Stück Fleisch und Gemüse oder n Salat dazu, ne?	<i>noodles, a piece of meat and vegetables or a salad, right?</i>
291		((2s)) Deswegen also bei Nudeln n/ ((3s)) nicht so zuschlagen.	<i>Therefore do not dig in with noodles.</i>
292	Int	((schmunzelt kurz))	<i>((smiles))</i>
293		Dedim ya sana ben.	<i>I already told you.</i>
294		• • • Senin her sevdiğin şey • • hastalığına ilerleten şeyler.	<i>Everything you like [to eat] is going to reinforce the disease.</i>

The dietitian talks about pasta because the interpreter had previously informed her that his father cannot stop eating it. In segments 288 to 291, she gives examples of how to include pasta into a meal according to the diet. More specifically, she highlights the need for eating a combination of vegetables, meat and noodles instead of only noodles. She does not address the patient directly in her utterances. Rather, she uses depersonalized constructions such as those in segments 290 and 291. The information given is not verbally linked to the specific patient. Rather, the dietitian picks the example of pasta and uses it to illustrate how a dish should be composed. The interpreter, however, resumes his participation with a reference to a previous discussion (293, “I already told you”), addresses his father (“you”) and then makes general statements emphasizing that his father's eating habits cause and exacerbate his diabetes.

In excerpt 4, we present a portion of another briefing for informed consent with the Turkish patient suffering from cancer already introduced in excerpt 2. In this case, a female physician explains the next steps of treatment to the patient. The medical staff has opted for another round of chemotherapy. Again, the daughter of the patient interprets for him. The physician announces that the planned chemotherapy does not have “as many” side effects. The interpreter, however, claims that it has no side effects: “there is no thingy at all”.

Excerpt 4

Doc: Female doctor of internal medicine, Int: Family interpreter, adult daughter

of the patient, Pat: Male Turkish-speaking patient. The talk is number 7 from the DiK-corpus. The patient and the interpreter are the same as those in excerpt 2.

- 39 Doc • ((atmet hörbar ein)) Wir haben uns • *((inhales audibly)) We*
deshalb überlegt, dass wir jetzt • *decided therefore that*
eine neue Chemotherapie, oder *we would like to do a*
eine andere Chemotherapie *new chemotherapy, or*
machen möchten, • • • als die • *another chemotherapy,*
erste, die wir gemacht haben. *different from the first*
that we did.
- 40 Int Jaha. *Yes.*
- 41 Hm.
- 42 Doc Mit einem Medikament, was nicht *With a medicine that*
so viele Nebenwirkungen hat. *does not have as many*
side effects.
- 43 ((3s)) Wollen Sie ihm *Would you like to tell*
zwischenmal was erzählen? *him this as we go?*
- 44 Was wir das... *What we...*
- 45 Int Jaa. *Yes.*
- 46 • Ähm bak! *Uhm look!*
- 47 Doc ((lacht kurz)) *((short laughter))*
- 48 Int Ähm ((1s)) ee doktor diyor ki, baba *Uhm the doctor says,*
• • • ((atmet tief durch)) şimdi seni *daddy, if you go now to*
Strahlung'a Sankt Johannes'e *St. Johns Hospital for*
gönderirlerse, ya' bütün vücudun *radiotherapy, your*
etkilenir. *whole body would be*
affected.
- 49 Çünkü sade senin (bellinde *Because your disease*
şikayetin var), biliyor musun? *is only in your pelvis,*
you know?
- 50 Bütün vücudun etkilenmemesi için, *To avoid your body*
ikinci (süklus) eee dedikleri birşey *being affected there is*
var/ ee şemo terapi var. *something they call the*
second circle, there is a
chemotherapy.
- 51 **Ama yan etkileri yok.** *But it has no side*
effects.

52		Yani hiç e şeyi yok.	<i>It has no thingy at all.</i>
53		Öbürüki gibi değil.	<i>It is not like the other one.</i>
54	Pat	He.	Yes.

The physician makes a distinction between the first and the second (planned) chemotherapy and refers explicitly to side effects in segment 42. His formulation “nicht so viele” (*not as many*) clearly indicates that there will be side effects. The difference lies in the quantity. The daughter, however, first compares the method of radiotherapy, which, in her words, affects the whole body, with the fact that the cancer is located in the pelvis, and not in the rest of body (segments 48, 49). She then presents the planned chemotherapy as a method that has no effects for the rest of the body (segment 50), and then emphasizes that there will be no side effects (51-53). Thus, the method is presented as more effective, the cancer appears as a local problem that will be treated locally, and negative effects are glossed over. In this way, the daughter paints a relatively positive picture of the situation, and she clearly argues in favour of the proposed method, without, however, revealing her partisanship to either the patient or the doctor.

4. Conclusions

In this paper, we have presented reasons why family interpreters are widely used in medical settings. Our main argument is that, beyond structural reasons (availability, no other solutions to language barriers provided), all participants may benefit (in a certain sense) from the presence of family interpreters. Family members are able to provide information and participate in the interaction in ways that other interpreters cannot. Their active participation may help patients to understand specialized or technical information, and they may provide second opinions or additional information that the patient is unable to recall. Furthermore, they may shorten the communicative exchange by interacting directly with the medical staff. This active participation, however, can also lead to subtle or open interventions in decision-making and knowledge transfer, leading to inadequate formulations and advice that differs from the advice given

by the doctor. This is especially relevant in situations in which family members are strongly affected emotionally by the fact that someone from the family is ill. The dramatic situation may even seduce them into abusing the interpreter role. Therefore, it seems necessary in each case to reflect on whether the use of a family interpreter is really an appropriate approach to overcoming language barriers in the given situation. Evidence from Switzerland suggests that patients themselves are critical of the service provided by their family members. While the study of Valdés *et al.* (2003) indicates that patients prefer family interpreters, the survey of Bischoff *et al.* (2001) suggests the opposite. They interviewed 232 patients lacking language abilities in French, one of the official languages in Switzerland. The majority of these patients were least satisfied when family members or friends interpreted and most satisfied when professional interpreters were employed.

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