

Analyzing Interpreted Doctor-Patient Communication from the Perspectives of Linguistics, Interpreting Studies and Health Sciences

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Abstract

The linguistic manifestation of an authentic case of interpreted doctor-patient communication - a briefing for informed consent - is analyzed from the perspectives of various disciplines. With only the transcript as their 'common ground', the analyses from the vantage points of Functional Pragmatics, Conversation Analysis, Interpreting Studies and Health Sciences yield different findings, particularly with regard to the performance of the ad hoc interpreter. Nevertheless, the paper demonstrates that an interdisciplinary approach to authentic discourse data can lead to an enhanced understanding of the multiple dimensions and functions of language and language use in mediated doctor-patient communication.

Résumé

Nous présentons ici l'analyse multidisciplinaire d'une situation d'interprétation dont les acteurs sont un médecin et un malade, ce dernier se faisant expliquer les modalités du consentement éclairé. La forme «objective» de la situation est la transcription de l'événement, qui a servi tant aux spécialistes de la pragmatique qu'à ceux de l'énonciation ou de l'interprétation ou encore, des sciences de la santé. Ces analystes sont arrivés à des conclusions fort différentes pour ce qui est de la performance de l'interprète spontanément mis à contribution. Malgré ces divergences, nous allons démontrer qu'une étude multidisciplinaire d'un acte de langage authentique peut améliorer notre compréhension des faits de langue en jeu dans la relation médecin-patient facilitée par un tiers.

Each section of this article is written from the perspective of one of the authors: section 1- Bernd Meyer; section 2- Birgit Apfelbaum, section 3- Frank Pöchhacker, section 4- Alexander Bischoff.

Section 1: The data

The paper is based on data from the research project 'Interpreting in hospitals'.¹ Within the project, monolingual and multilingual interactions are compared so as to investigate the differences between interpreted and non-interpreted doctor-patient communication. The languages in question are German, Turkish, and Portuguese. The sample consists of 100 monolingual and bilingual interactions, almost 30 of them preparing patients for invasive medical intervention. The participants of these interactions are German doctors of internal medicine, German, Portuguese or Turkish patients and bilingual relatives or nurses as *ad hoc* interpreters.

Preparing for medical intervention

The data presented here stem from an encounter in which a doctor of internal medicine (DOC) informs a patient (PAT) about plans for two invasive procedures during a briefing for informed consent. The patient is a retired Portuguese worker who has been living in Germany for about 35 years. His command of German is poor. The interpreter (INT) is his 28-year-old niece, who grew up in Germany bilingually.

Table 1: The course of events

Utterances	Actors involved	Activities
1 - 3	DOC	Announcement
4 - 19	DOC, PAT, INT	Establishing mode of interaction
20 - 25	INT	Partial renditions of DOC's announcement
26 - 30	INT, PAT	Clarifying
31 - 39	INT, DOC	Clarifying
40	INT	Attempt to render isolate expression
41 - 45	INT, PAT	Clarifying
46 - 47	INT, PAT	Partial renditions of announcement
48 - 55	INT, PAT	Elucidating isolate expression - Identifying parts of the body
56 - 59	INT, PAT	Partial renditions of announcement
60 - 79	DOC, PAT	Description of course and purpose of the medical intervention
80 - 95	DOC, PAT, INT	Clarifying
96 - 104	INT, DOC, PAT	Clarifying course of interaction
103 - 108	INT, PAT, DOC	Clarifying
109 - 121	DOC, INT, PAT	Pointing out and illustrating possible risks
122 - 125	DOC, PAT	Announcing taking of samples
126 - 140	DOC, PAT, INT	Monitoring further need for information

Table 1 shows that the course of events is divided into several sections. First, the doctor announces the planned procedures [1 – 3]. Then, the mode of

interaction needs to be established. Subsequently, the interpreter tries to render parts of the announcement into Portuguese [20 – 25], followed by several clarifying sequences between interpreter and patient, and interpreter and doctor [26 – 38]. Again, the interpreter tries to render parts of the doctor's announcement into Portuguese and elucidates isolated expressions of the announcement by pointing towards parts of the patient's body so as to identify parts that she cannot name [39 – 59]. In the subsequent section [60 – 79], the doctor describes the course and purpose of the intervention in direct interaction with the patient. This section is followed again by several clarifying sequences [83 – 108]. Then the doctor points out possible risks to the patient [109 – 121] and monitors the patient's need for further information [126 – 140]. These last sections are only partially interpreted by the niece.

Discrepant discursal paths

From the perspective of Functional Pragmatics, doctor-patient communication in medical institutions is basically characterized by an asymmetric distribution of knowledge. Stocks of knowledge differ not only with regard to medical issues, but also in relation to institutional types of discourse. The type of discourse called 'briefing for informed consent' is based on a pre-organized plan of action, which doctors sequentially adapt to the knowledge and the communicative needs of the specific patient.

In interpreted briefings, this process of adaptation seems to be more difficult because of the interpreters' lack of institutional knowledge, which may lead them onto 'discrepant discursal paths' (Wadensjö 1992: 224). In the case under study, this happens, for example, at the beginning of the interaction when the modal verb used by the doctor ('we *want* to'; [2]) is changed to a periphrastic construction ('they *will*'; [21]) indicating that there is no doubt that the planned procedures will be executed.

Section 2: Negotiating interaction modes in a bilingual setting – The Conversation Analytical perspective

Looking at the transcript from the perspective of Conversation Analysis will allow us to follow the unfolding interaction in this particular briefing for informed consent from a member's perspective. The sequential development of turns taken by the German doctor, her patient of Portuguese origin and the niece escorting her uncle then shows – among other things – how the participants deal with the bilingual and (possibly) cross-cultural setting, especially how they negotiate and switch naturally between different interaction modes in order to help the elderly patient with a limited knowledge of German to understand the doctor's explanations of the planned medical procedures (*gastroscopy* and *ultrasound*; cf. [2/3]).

At the very beginning, repair activities and interruptions reflect differing and conflicting concepts as to how to communicate with the patient and about how to make use of the niece's knowledge of German *and* Portuguese as an interactive resource for bridging linguistic gaps. While the niece seems to prefer to serve as an *ad hoc* interpreter and switch to Portuguese only when her uncle does not understand the German doctor, the doctor interrupts her and reminds her to translate systematically [14], arguing that "that would be easiest" [17]. The patient himself seems to share his niece's preferences, since he claims (in Portuguese) to understand the doctor's German explanations [7, 11] and repeats spontaneously in Portuguese what he thinks the doctor has just told him [9, 13, 16, 19]. He uses a third person singular past tense form of a *verbum dicendi* (*disse / (she) said*), introducing a subordinate clause that finally on the fourth try is achieved by the German term *Spiegelungs*² [19]. With his niece correcting this last element of reported speech [20/21], the translatory mode (cf. Müller 1989) is locally established and the niece, rendering step by step the doctor's initial announcement (cf. [2/3]) for her uncle, thus ensures a specific recipient design [22ff]. From this point on she anticipates potential comprehension problems, especially as far as medical terms are concerned [22-60], and she involves both her uncle and the doctor in a bilingual search for words and terminology:

- The niece starts out by trying to refer in Portuguese to the first of two examinations [23], and her uncle, in keeping with the syntactic structure under construction, fills in the German word *Spiegelung* / *scopy* again [24] which she completes in her next turn by using the more specific term *Magenspiegelung* / *gastroscopy* and also comments on by using an element of ratification which is produced in German, too³ [26];
- She then asks her uncle if he knows the (German) term *Ultraschall* / *ultrasound*, which is first left as an isolated transfer element in her Portuguese utterance [25] and then worked on by a switch back to German, corresponding to a search for equivalent terms together with the doctor⁴ [30-39];
- By switching back one more time into Portuguese, the niece seems to test these solutions using possible loan words in Portuguese [40-43], but her addressee still manifests non-understanding [44];
- By then reformulating the term in a less specific way (*esse exame ao coração* / *this examination of the heart*; [46]), she moves on to the next term (*Speiseröhre* / *esophagus*, 47) which is again left as an isolated transfer element in an otherwise Portuguese contribution; this leads to a further side sequence in which the German term is explained by making systematic use of deictic references⁵ [48-57];
- She proceeds to sum up the whole idea about the second examination [58], which is ratified by her uncle [59] and is followed by the doctor's turn [60].

When the doctor starts explaining the first examination (*Magenspiegelung* / *gastroscopy*; 61-79), the Portuguese patient replies a number of times in German, considering himself, as it were, the immediate addressee and able to follow her explanations [62, 65, 70, 74]. As a result, this part of the encounter is mostly conducted in another interaction mode, i.e. almost without any code-switching into Portuguese and without the niece's participation as a mediator. The niece does not intervene again until the doctor comments explicitly on the issue of comprehension [80ff] and she then encourages her uncle to signal non-understanding if there is something he has

not understood. When the uncle repeats what he remembers from the doctor's talk [91], it turns out that he had been able to anticipate explanations referring to the second examination. His niece corrects him however by telling him in Portuguese that this comes next [94], switches back into German in order to check her hypothesis with the doctor [96] and finally tells her uncle in Portuguese what she found out [101]. This part of the encounter is closed when all three participants have made sure that there are no more problems of comprehension [103-108], and the doctor then introduces the next topic, i.e. possible procedural risks for the patient.

Further explanations are given to the niece (in German) by the doctor, who refers to the uncle in the third person [109-114], and the niece does not intercede for quite some time. When she does, she switches back to Portuguese and relays step by step various possible complications, mentioned by the doctor one at a time. She also comments on the role of the doctor who has to mention possible risks (*they always have to tell the patients this*; etc., 116, 119), thus categorizing her as an institutional representative quite different from herself, as it were.

When this short part of the encounter conducted in the translation mode is closed, the doctor addresses the patient directly in German and the patient replies in German [122-125], the encounter being conducted from now on without any code-switching back to Portuguese [126-141]. The uncle even participates much more actively [127, 130, 136], but seems to focus especially on pragmatic aspects, namely on the signing of an agreement at the end of the briefing (*und ich muss unterschreiben / and I must sign*; 130).⁶

From the perspective of Conversation Analysis, we can say in conclusion that the participants finally agree upon a rather flexible management of different interaction modes as resources in this particular briefing for informed consent. After a rather difficult beginning where repair activities reflect differing concepts of how to deal with the patient's limited knowledge of German, the patient's active participation in German is not only accepted but also encouraged and the translatory interaction mode is negotiated only locally.

Section 3: The professional interpreting perspective

Approaching our discourse data sample from the perspective of professional interpreting, I would like to discuss some of the assumptions shaping the mediated encounter as evidence of a particular “translational culture”. With regard to the assumption of understanding, I will highlight the problem of limited proficiency, which requires further examination as a special challenge in professional interpreting practice.

Assumptions shaping the mediated encounter

What is obvious from the way the doctor goes about her business is the *assumption of communication*, i.e. the belief that the communicative task at hand – briefing a patient with limited proficiency in German – can be achieved without the need to plan for and resort to “professional help”. To use a simple metaphor, clinicians such as the doctor in the case under study happily see the glass half-full when it is in fact half-empty and would need to be filled up.

There is evidence that some “lack” is being perceived after all, but the fact that the patient’s niece is cast in the role of interpreter testifies to a second, closely related assumption – the *assumption of linguistic transfer*. In other words, if it is not (quite) possible to communicate directly, then someone who “knows” both languages can be asked to “fill the gap”. When operating on this assumption, which is shared by all parties to the event, questions of language proficiency or translating skills do not arise – unless they erupt from the communicative process itself. The interpreter’s difficulties with rendering key technical terms (*Ultraschall, Speiseröhre*) elicit surprise and amusement in the doctor; it is unlikely that these challenges to the natural translation model would prompt her to question the underlying assumption that it “would be the easiest” [17] for the bilingual accompanying person to “translate everything directly” [8].

Yet, even the belief in simple linguistic transfer for filling the cross-cultural communication gap is overridden by the *assumption of understanding*, a more specific manifestation of the assumption of communication, which is

held particularly by the doctor. When the patient uses his limited German to give verbal feedback signals (*Magegeschwüre* [70], *Ja* [79]), the doctor takes this as evidence that her lengthy explanation has been understood [80], and sees no more need for linguistic transfer. While she makes no attempt at verifying the patient's understanding, which would seem critical to the entire undertaking, the *ad hoc* interpreter actually does so repeatedly. Though initially [12] she seems all too hopeful about her uncle's understanding of German, and thus about ending her interpreting duties then and there, she subsequently manages very well to elicit and actively address the problem that her uncle has understood only "more or less" [88, 105].

Translational culture and standards of practice

These findings from the analysis of the transcript can be viewed as telling features of what Prunc (1997) has labeled "translational culture", i.e. the set of socially determined norms, conventions, expectations and values governing translational activity in a given society or institution. The assumption of natural linguistic transfer reflects a naïve translational culture in which there is little room for the kind of assumptions that underlie professional (community) interpreting services, i.e. that it takes a trained interpreter to enable communication between a client and a service provider who do not share a common language. On the other hand, one could view the behavior of the untrained bilingual as more sophisticated than that mandated by some codes of professional practice: providing explanations in language more readily understandable to the – elderly – patient [48], including the use of third-person forms, and monitoring for any lack of understanding, go beyond the stipulation of "just translating" and vindicate an interpreter's active role in facilitating a satisfactory level of understanding.

Since codified standards of practice are but another, albeit highly significant, aspect of "translational culture", they are not universal truths but are socially determined in and for a given environment. It must be permissible, and may indeed be productive, then, to view the conduct of the *ad hoc*-interpreter as a challenge to professional interpreters' code(s) of practice and

ask how these provide for cases like the one under study, where the service provider is all too happy to make do with an elderly client's limited proficiency (i.e. make do without interpreting) and fails to make sure that the client has understood "more" rather than "less".

The client with limited or, rather, "some" proficiency in the service provider's language (the half-empty or half-full glass, again) poses a special challenge to the role conduct of the professional interpreter – provided that the translational culture is such that it ratifies the provision of interpreting services also for those who "speak a little" German or English or whatever other majority language. I hope to have shown that discourse-based analyses such as this one are worth undertaking from an interpreting studies perspective so as to investigate the "translational culture" in which interpreters – of any kind – will have to operate, and to examine strategies for dealing with specific problems facing the professional, as in the case of (elderly) clients with "only some" proficiency in the provider's language.

Section 4: The "health" perspective

Informed consent agreement is a pivotal event of trust in the doctor-patient relationship. The following points are to be achieved (Kaufert, O'Neil and Koolage 1991):

- (1) full information about risks, benefits, alternative treatments;
- (2) patient competence;
- (3) understanding by the patient, and
- (4) patient's ability to act on his/her own accord.

In a cross-cultural setting like the present one – a 30-year old female junior physician and an elderly Portuguese worker – the negotiation of meaning, information and trust may be difficult, and the biomedical and "native" frameworks may be incompatible. Medical anthropology has shown that there are always two different systems at play: the illness system – the

patient's perspective – and the disease system – the health professional's perspective – (Helman 2000). Thus every medical encounter is a negotiation with the goal that both sides find a common ground of understanding, enabling them to reach a compromise. The health professional's imperative is to use an interpretive approach to explore the meanings of the patient's perceptions and “decode the patient's semantic network of the illness” in order to arrive at appropriate therapeutic responses (Marshall 1988).

In order to assess to what extent the consent agreement, negotiated between the three actors (i.e. the physician, the Portuguese patient and his niece acting as ad hoc interpreter) has been successful, we compare the conversation with the four points of informed consent:

- (1) Patient information. The doctor has her agenda: to inform the patient about the two examinations; she fails, however, to explain the concept of informed consent, and does not elucidate the objective of the encounter any further. Later on, she rejects the niece's cue to clarify one of the patient's apparent misunderstandings [91] by sticking to her own way of speaking: “No, first I would like to say something more about. . .” [98]. The ad hoc interpreter, on her part, makes an effort to convey possible hazards as comprehensively as possible, by summarising and bite-sizing the different pieces of information provided by the doctor.
- (2) Patient's competence. Although the doctor is aware of her task (to inform the patient), she makes no clear attempt to increase the patient's competence: no enquiries about the patient's view, no contextualisation of the conversation (e.g. putting the signature in the context of consent agreement). One of the patient's quests for competence is postponed [100]), but later forgotten. Nevertheless, the ad hoc interpreter, taking the patient's side, takes initiative to negotiate meaning, thus transgressing the rules of “just translating” imposed by the doctor.
- (3) Patient's understanding. Even though the doctor is implicitly admitting that the patient's understanding must be made possible

by a third party and is therefore willing to co-operate with an ad hoc interpreter, the strategies to help the patient understand are not clear, nor is the role which the doctor assigns to the niece. At the beginning of the interview she opts for “just translating”, assigning a limited role to the relative, a role which she later implicitly modifies by letting the relative do a lot more than just translating. The communication remains unilateral: the doctor does not verify whether the patient has understood or not, nor does she intervene when obvious misunderstandings occur. The interpreter seeks to clarify her role by saying at the beginning (“Shall I translate directly?”[8]). She tries to make medical terms understandable [33] and draws on her own knowledge to explain procedures [58]. She even panics, not knowing how to convey the medical vocabulary (“Oh my God”[30]). Several times she attempts to verify whether the patient has understood [87].

- (4) Patient’s autonomy. The doctor does not provide any cue that would allow the patient to take the initiative in the conversation. She even loses control during a longer stretch of conversation and does not step in to empower the patient [39-59]. At one point, the interpreter also withdraws from translating [61-82], being eclipsed by the doctor who is seemingly no longer aware that the patient does not have the ability to act on his own.

On balance, the briefing for informed consent has only partially been successful. The interpreter makes many efforts to do a good job, but does not have the necessary skills implicitly expected by the doctor. The doctor sees the need for linguistic mediation, but not the one for cultural mediation, and fails largely to negotiate the consent agreement in the cross-cultural context. Almost ironically, at the end of the encounter, the patient shortcuts the whole negotiation and wants to give the necessary signature, independently of any possible clarification about what is at stake and regardless of whether the four points have been achieved. Doctor and patient speak with discordant voices,

the “voice of medicine” and the “voice of the lifeworld”, as Mishler (1984) put it, and only sporadic merging of the two voices has taken place.

Tandems of health professionals and interpreters trained to work in settings like the one described, could no doubt enhance the quality of the care provided. Outcomes are most likely to be better if interpreters are assigned a role of not only translating but also of having the function of cultural brokerage, mediation, and advocacy: “Interpreters may play a significant role in mediating consent agreements between clinicians and clients. They link clinicians’ messages with the client’s personal framework for interpretation.” (Kaufert, O’Neil et al. 1991).

Notes

1. Within the theoretical framework adopted in this project (Functional Pragmatics), features of interpreted interaction in hospitals are reconstructed in terms of ‘linguistic action theory’. The project is part of the Research Center on Multilingualism at the University of Hamburg, Germany (www.rrz.uni-hamburg.de/SFB538).
2. The Portuguese patient might have used here the (in this particular instance ungrammatical) plural morpheme *-s*, since the word is preceded by the numeral *dois / two* (19).
3. The fact that the niece uses a German word here can be interpreted as a form of contamination (cf. Auer 1998).
4. The doctor’s short laugh (in 34) might indicate her embarrassment due to the fact that she can not continue her explanations until the side sequence dealing with terminology and translation problems is closed.
5. The way the niece explains the term to her uncle seems to reveal that she does not know at all the corresponding Portuguese terminology, which would not be surprising since she grew up in Germany and probably did not get introduced to medical terminology in a Portuguese environment.
6. The transcript does not indicate, however, why exactly the patient mentions the fact that he will have to sign.