Interpreted medical interaction: When doctors and patients do not speak the same language

It is widely recognised that when professionals interact with their clients, there is considerable scope for communication difficulties and breakdowns – misapprehensions, misunderstandings and even complete incomprehension – because they do not ‘speak the same language.’ Lawyers have their way of expressing matters – legalese – that can be quite opaque to the layperson; it is acknowledged in legal scholarship that difficulties arise when clients, particularly plaintiffs, do not understand the legal concepts and language of causality and responsibility, for instance [1,2]. And so it is in medicine: patients similarly may not ‘share the language’ of medical professionals. Medical vocabulary and terminology [3,4], the clinician’s use of statistical information in explaining to patients the growth of their tumour and the likely prognosis, the medical explanations of benefit and risk [5,6], even the broad differences between the ‘voice of medicine’ and that of the ‘lifeworld’ [7] may all result in patients not fully or accurately understanding the news they are being given or the treatment options that are being presented to them. In all these and other ways, doctors and their patients may not ‘speak the same language,’ the consequences of which can be various forms of misunderstanding and miscommunication [8]. Underlying the different ‘languages’ of doctors and patients is the asymmetry of their bio-medical knowledge, their epistemic asymmetry to which the present paper draws our attention [9]. Patients generally do not share doctors’ scientific knowledge of disease, its ontogenesis, trajectory and treatment. This, then – doctors’ medical authority [10], or what Raymond specifies here as the epistemic authority of doctors – can leave patients mystified by what doctors say to them, and sometimes not even aware of the extent of their non-comprehension.

The communication difficulties arising from doctors’ and patients’ asymmetries of knowledge, and in that sense not ‘speaking the same language,’ are likely to be greater when doctors and patients do not share the same culture, and do not share a common language in the more literal sense – in Raymond’s study, when the first language of doctors is English and the first language of their patients is Spanish. In our contemporary multi-cultural world of migration, diaspora, migrant workers, asylum seekers and refugees, medical professionals increasingly treat patients with whom they do not share a common first language. For instance in some circumstances the (British) National Health Service contracts doctors from other European countries to act as locum doctors; difficulties arising from these arrangements have led the Department of Health, supported by the GMC, to issue in April 2013 amendments to the Medical Act requiring doctors from the EU to prove they can speak “a necessary level of English” before they are permitted to treat patients in UK hospitals or GP surgeries [11,12]. Conversely in our multicultural, multilingual societies doctors commonly treat patients whose ability in the doctor’s (first or native) language is insufficient for the patient to participate effectively in the medical consultation without the assistance of an interpreter [13]. Interpreting services may be provided by more fluently bilingual family or friends of the patient, and or by trained, professional interpreters. The quality and ‘effectiveness’ of consultations, in terms of information gathered, completeness of history of past traumatic events, number of psychological symptoms elicited, errors that might have clinical consequences etc. are much dependant on the fluency and ability of interpreters; moreover there is some evidence that the errors made by ad hoc interpreters (such as family members, friends) are more likely to have potential clinical consequences than those made by professional interpreters [14,15]. There is anecdotal evidence that the proficiency of even professional interpreter services is variable, and that shortcomings in the services provided by professional interpreters may have an impact of the effectiveness of the consultation and thereby the health outcomes for patients [16].

Systematic reviews in this area suggest that the very concept of ‘interpretation’ is confused by different models of communication [17]; it is clear that a crude ‘conduit’ model is insufficient to explain the complexity of the medical interpreter role, and that this role can vary widely [18–20]. Raymond’s paper here takes us a step forward in coming to a clearer and more nuanced understanding of the role of interpreters when they mediate between doctors and patients.

Raymond’s article is of particular interest to me because his findings converge with those coming out of a project in which I am involved, led by Dr. Susan Bridges at Hong Kong University, researching triadic interactions in dentistry in HK typically involving Anglo or English speaking dentists treating monolingual (Cantonese) Chinese patients, mediated by bilingual dental assistants (on bilingual medical professionals as interpreters, see also [21]). Reviewing in detail many hours of video recorded dental treatment, and analysing these data using the methods of Conversation Analysis [22], it became clear that an assessment of the accuracy and effectiveness of interpreting based on the ‘conduit model’ of communication does not capture the complexities and richness of the interaction between dentist and assistant/interpreter, during which the dentist can use ‘shorthand’ forms to the assistant, relying on her to expand or explain to the patient. Reciprocally, the assistant/interpreter conveys the patient’s experience in terms that the dentist, from his entirely different cultural background, can understand. This is closely in line with Raymond’s findings here. The importance of his study lies in this: it
might appear that interpreters do not fulfil their role adequately or appropriately when they do not translate precisely and literally everything that, and only what, the doctor asks the patient, and translates precisely the patient’s response. However, this ‘literal translation’ model fails to grasp the complexity of the interpreter’s role, which is revealed more fully and realistically in such studies as Bolden’s account of how, in their participation in history taking in primary care, interpreters orient to the overall goal of the consultation; so that “far from being passive participants in the interaction, interpreters will often pursue issues they believe to be diagnostically relevant, just as they may choose to reject patients’ information offerings if they contain subjective accounts of their psycho-social concerns” [23]; which in a general sense is related to patient-centredness [24]. Raymond’s article here develops this a significant stage further, demonstrating that medical interpreters help to bridge or at least reduce the gap between doctors’ and patients’ domains of (cultural) knowledge and understanding; and in this way, help to enhance the relationship patients have with the medical care system.

References


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