

Valero-Garcés, C. (2010). Challenging communication in doctor / non-native patient encounters. Two perspectives, three types of interaction and some proposals. *The Journal of Specialised Translation*, 14, 229-248. <https://doi.org/10.26034/cm.jostrans.2010.587>

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Challenging communication in doctor / non-native patient encounters. Two perspectives, three types of interaction and some proposals

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ABSTRACT

The progression toward multicultural societies, motivated in part by the rapid increase in migration over a short period of time, is having a noticeable impact on the quality of communication between professionals and their clients. This paper focuses on the analysis of communication in a specific setting, the Spanish healthcare system, from two different perspectives; that of the medic and that of the language specialist (the interpreter). Firstly, the importance given to language and its barriers as seen from both perspectives will be analysed; secondly evaluate the effectiveness of communication in medical contexts will be evaluated through the examination of the different modes of communication found in doctor / non-native patient interaction using a discourse-analytical approach; finally some conclusions about the quality of communication will be presented, together with some suggestions as to the best way of incorporating the results of this research into seminars for healthcare professionals and training programs for future interpreters. The results are not different from those of other studies, but we think that they serve as an illustration of reality and, using them as a starting point, we have an opportunity to improve communication in specific medical contexts, by combining theory, research and practice.

KEYWORDS

Cross-cultural communication, community interpreting, doctor-patient interaction, institutional conversation analysis, migration, intercultural pragmatics.

1. Introduction. New challenges in the healthcare setting

The continuous arrival of new migrants and the characteristics of the Spanish healthcare system, a universal system which guarantees by law¹ the right of all foreigners to healthcare and basic social benefits, are bringing about noticeable changes in healthcare practices. The norm used to be a monolingual consultation with two participants (doctor-patient) who share the same language and culture, and are only separated by the specific inequalities of the relationship between professional and end-user, however, nowadays other types of consultation in which there are a myriad of new elements, starting with the participants themselves, are common in most hospitals and healthcare centres in Spain. In this respect, two main two types of encounters can be distinguished:

1. Monolingual visits, also called dyadic exchanges, with two participants and one language.
2. Bilingual visits also called triadic exchanges, with three participants and at least two languages.

Each type of exchange has its own characteristics which are described in the following pages.

2. Communication in the healthcare system from the medical perspective

It would be appropriate to begin by explaining that in Spain there are no interpreters or specialized staff to resolve the growing challenges in communication. Those beginning to take an interest in this matter are healthcare professionals themselves, family members, volunteers, researchers and trainers in certain university translation departments who are showing some interest in Public Service Interpreting and Translating (PSIT) in healthcare contexts. Consequently, there is a high percentage of monolingual visits in which the participants—particularly the doctors—have had to bring into play a kind of knowledge beyond that generally required of their profession, and develop a series of strategies to communicate with their patients.

Viewing these challenges from the perspective of the healthcare setting greatly differs from viewing them from that of PSIT. Some of these medical professionals simply ignore these challenges in communication; while others recognize that language poses one of the main barriers to effective communication, and, have consequently, published materials, articles, even manuals for assisting non-native speaker immigrants (e.g. Vélez, Martincano, López Abuín, etc.). The fact remains, however, that there is still much to be done, as is attested to in the research by associations like SEMERGEN, SEMFYC or the FITISPos group.

Medical professionals themselves, like Simón Talero Martín (1997) or Martincano (2003), have identified some barriers in the healthcare process. These barriers are set out in the table below (Table 1):

1. System-dependant	2. Professional-dependant	3. Patient-dependant
<ul style="list-style-type: none"> - Inadequate accessibility - Excessive waiting times - Too much demand /too little time per visit - Noise and interruptions - Excessive bureaucracy - Uncoordinated services - Inadequate registrations - Lack of ongoing professional training 	<ul style="list-style-type: none"> - Medical professional has personality traits which are inappropriate for the clinical setting: excessive projection, too much control or too little empathy - Emotional interference related to either the activity itself or personal problems - Lack of training in communication skills - Lack of cultural awareness: medical professional has no understanding of the culture of the patient, or of frequent pathologies - Lack of training in mental health problems - Social interference - Inadequate follow-up 	<ul style="list-style-type: none"> - Physical problems: aphasia, deafness... - Extreme emotional conditions: anxiety, aggression... - Abnormal personality traits: dependency, obsession - Somatomorphic disorders - Non-complying patients - Language barriers - Social interference: socio-cultural distance

Table 1 - Barriers in the healthcare process

These problems are attributable to the situation described in Table 2 below, according to the medical professionals Martincano and García Bajo (2007):

- | |
|--|
| <ul style="list-style-type: none"> - Migrants are not a priority - Little recognition of the complexity of migration - Poor services for migrants - Little attention to epidemiological characteristics - Little sensibility to cultural characteristic |
|--|

Table 2 - Healthcare services and immigrants

Awareness has also been raised through conferences, seminars and workshops where information, projects and results are exchanged. One example is the 1st Conference on Intercultural Communication, held in Madrid in November 2006, where the Madrid Institute of Health (*Instituto Madrileño de Salud*), presented an interesting study in which four models of healthcare were described: magical, palliative, preventive, and healthy habit forming. Each of these was identified with specific societies, but without clear limits, the analysis thus appeared somewhat simplistic. Nevertheless, according to the researchers, in the case of Spain this identification should correspond to the main groups of the migrant populations. Thus, the first healthcare model (magical) should mostly apply to the Sub-Saharan African migrant population, the second model (palliative) should apply to Moroccan migrants, the third model (preventive) to Latin-American migrants, and the fourth one (healthy habit forming) to the model currently being used in the Spanish healthcare system. Investigators warned about the difficulty of changing from one model to another, as such change requires time and effort on both sides.

As López Abuin (2003: 13) points out:

Our [Spanish] healthcare system is conceived as a bio-medical concept that does not include (or includes few) social, cultural or religious factors. It tends towards an increasing use of technology (medicine and technology) and individualization (patient-sum of organs-deviation from normality = sickness). The concept of health is predominantly biological and Western whereas in other cultures, personal or social wellbeing predominates, or perhaps harmony with the divine. We tend to impose our medical model (the doctor as a professional and social group that takes on the responsibility of assisting people who present a dysfunction) but what is needed is a mediation between different cultures and different experiences of illness.

The above comments also demonstrate that language—even if it is recognized as a significant barrier—is not still a priority for most professionals working in the healthcare sector. Martincano's (2007) comment, taken from the online training course for healthcare providers

Atención al Inmigrante, illustrates this point: “If we do not speak the patient’s language and have no other means, we will attempt to communicate with gestures. *Science will not be adversely affected.*” (The emphasis is mine).

In another section Martincano even adds some comments about what he calls the “interpreters”:

Important *distortions* arise when patients evaluate themselves through the medium of *interpreters*, even when the latter are excellent. Interpreters achieve good results in obtaining the pertinent information for a case, but this is not so when they are asked to interpret emotion. (The emphasis is mine)

And he continues:

Translators² should be dedicated translators, well-prepared. They should not be a family member. They should be familiar with the patient’s culture. They should attempt to translate literally all utterances of both participants and should cooperate with the clinician to process the non-verbal and intangible components of the verbal interview.

A different example of professionals who demonstrate more knowledge and sensibility toward linguistic communication and the use of interpreters is the chart below (Table 3), produced by López Abuin (2007) as material to train healthcare providers.

Whenever interviews are mediated by a translator:

- Be certain of the accuracy of the information.
- Speak in the first person, look at the patient and verify that he or she is understanding what is being translated.
- Use simple and short phrases, speak slowly and be gentle when commenting.
- Gestures and expressions should be slow and gentle so they will be interpreted as calming.
- Be reminded that the translator’s presence may inhibit the patient from sharing intimate information.

Table 3. Medical visits mediated by a translator

Likewise, Alonso (2007) in the same online course, when referring to children’s vaccination certificates, indicates that “it is advisable to have qualified people translate the certificate.”

Apart from those mentioned above, allusions to language specialists or interpreters are scarce and not very accurate, partly because of a limited awareness of the lack of recognition of interpreters and translators as professionals, and partly because of the complexity of the communication process. Aspects related to proxemics, paralanguage, kinesics, body language, conception of time and space, silence, or even the way patients dress may affect communication. When not shared, these cultural aspects

increase cultural distance, as the anthropologist Albert Mehrabian (1972/2007) demonstrates in his study: only 7% of communication between people is effected through words, 38% corresponds to paralanguage (intonation, projection, tone) and the remaining 55% corresponds to body language (gestures, posture, eye movement).

These percentages are true for many medical interviews with migrants who do not have a good command of the contact language. It is even true for both medical professionals and patients who believe they have a good command of other languages (English and French, generally speaking for the first group, and Spanish for the second one). Both groups, doctors and patients, are faced with other accents and language varieties resulting from the mix of several languages (e.g. English and Swahili or other languages from African countries) which give rise to phenomena like code-switching, Spanglish (mix of English and Spanish) or Portuñol (mix of Portuguese and Spanish), which equally cause miscommunication.

Research from different fields, and professional experience itself, also indicate that misunderstandings in communication with foreign populations derive from some of the following causes:

1. Users do not know the contact language.
2. Users do not know the culture (and, therefore, how the institutions of the Spanish healthcare system work).
3. Healthcare staff do not know the culture of the users.

These problems lead us to doubt how effective healthcare visits are, if the following objectives laid out by Loyassa et al. (2004: 410) are meant to be fulfilled:

1. Obtaining the information needed for a sufficient diagnosis and to establish the reason which brought the patient to the doctor.
2. Ascertaining the patient's ideas, beliefs, and expectations and helping them to verbalize and control their fears and anxiety.
3. Providing significant and timely information that is clear, understandable, and easily remembered.

All of these elements generate a chain reaction that is different in each of the participants and can range from the feeling of abuse that some professionals have, to the segregation and racism that some immigrants allude to, as demonstrated in empirical research (Valero-Garcés & Taibi 2004, Valero-Garcés & Lázaro 2004, Valero-Garcés and Downing 2007, Valero Garcés 2002, 2008).

2.1. Findings

To summarise, healthcare staff are encountering new patients who have new requirements: different health and social problems, different practices and beliefs concerning health, and the ways in which diseases are contracted and recovered from, as well as non-native patients who do not speak the language of interaction (Spanish in this case), a fact that is provoking changes in doctor–patient interviews. These differences must be dealt with within the context of the specific healthcare system that must adapt itself to the new reality.

3. Communication in the healthcare system from the language specialist (interpreter) perspective

Now that we have presented the new challenges from the healthcare provider's perspective, the next step is an analysis of communication with migrants from the language specialist perspective, mainly focused on the area of PSIT. The objective is to make connections, on the one hand, with other disciplines (medicine, anthropology, social work, childcare, sociology, linguistics, translation studies, communication studies, to name but a few) and, on the other hand, between theory and practice. This will make possible an analysis of the origin of the different positions and apparently contradictory statements that often arise when the topic of quality in communication is discussed in conferences, workshops or seminars attended by medical specialists on the one hand, and language specialists on the other... Apparently a contradiction is perceived: it appears that communication is not a priority for the healthcare sector, while it seems to be overvalued in communication studies.

As a way of narrowing the gap between these two attitudes, it is my objective to demonstrate the reality by comparing dyadic and triadic encounters in the healthcare setting in Spain. The methodology used is based on a discourse-analytical approach and the data come from authentic recorded material. The three participants' roles—doctor, patient and intermediary—will be considered, with a view to analyzing what takes place.

As mentioned above, in Spain as yet there are no professional interpreters in healthcare settings, despite rising numbers of people who do not speak Spanish and need access to hospitals and healthcare centres. As a consequence, a high percentage of interlinguistic communication is carried out by volunteers who know the languages and cultures better than their interlocutors, but who do not have any formal training and very often are unaware of the existence of interpreting as a profession. From the healthcare professional point of view, they are also expected to perform a wider role in which the activities of interpreting and mediating are blended, without clear boundaries, in the sense that they do not see the need to translate everything, and may omit or add information.

For the present study, the participants' interventions in the two more common interaction types will be analysed. These are:

1. Dyadic exchanges (monolingual) between a doctor and an immigrant patient.
2. Triadic exchanges (bilingual) between doctor, immigrant patient and intermediary or third party.

Within each type, some subtypes can be included. Thus, in the case of dyadic exchanges two subtypes are common:

- a) Doctor / Spanish speaking patient;
- b) Doctor who speaks foreign languages / Patient who does not speak Spanish.

In the case of triadic exchanges, some of the more common subtypes are:

- a) Doctor / Immigrant patient / Adult accompanying who acts as an *ad hoc interpreter*;
- b) Doctor / Immigrant patient / Child accompanying who acts as an *ad hoc interpreter*;
- c) Doctor / Immigrant patient / Interpreter with some training and professional experience.

Of these, I will consider only three of all subtypes or modes of communication. These are, referred to as the Monolingual Mode (Type 1), Bilingual Helper Mode (Type 2), and the Interpreted Mode (Type 3). The examples used in this paper are excerpts taken from consultations recorded in Spanish hospitals and from role plays recorded in classrooms at the University of Alcalá, which are, transcribed and analyzed. Three main elements will be considered:

- The amount of direct speech used by each participant
- The number of turns taken by each participant
- The type of turn-taking produced in the three modes of interaction.

3.1. Turn-taking and direct interaction in the three modes of communication

3.1.1 Monolingual Type (Type 1)

Generally speaking, results of the analysis of the Monolingual Mode (Type 1) interactions show that every utterance is direct. Doctor and patient

alternate in speaking to each other, and the number of turns taken by each is similar. We could also expect each utterance to be more or less comprehensible, an assumption that is not always true and needs some sort of explanation.

As already mentioned, the data reveal two types of encounter:

- a. Doctor / Spanish speaking patient (Type 1a).
- b. Doctor who speaks foreign languages / Patient who does not speak Spanish. In both types, turn-taking can be considered as a special case as I will show in the following pages and for different reasons (Type 1b).

3.1.1.1. Doctor / Spanish speaking patient (Type 1a)

The analysis of Type 1a (Doctor / Spanish speaking patient) interactions reveals that many turns produced by the doctor have no corresponding linguistic answer, but instead are met by silence and a gesture, producing what we call a 'silence turn,' as the following examples illustrate:

Excerpt 1. D: Doctor; P: Chinese patient. Situation: The doctor visits the patient who has recently given birth. The doctor enters and approaches the patient's bed.

1. D: Do you speak Spanish?³
2. P: ...
3. D: A little? [gesturing with the index and thumb finger, indicating little]
4. P: Little [accompanied by a facial expression indicating strangeness, not understanding what is being asked]
5. D: None? [accompanied by a negation gesture of the head]
6. P: None
7. D: No. It's just to ask you a few things.
8. P: ...
9. D: You don't speak any Spanish? [crossing both hands, indicating nothing, zero]
10. P: ...[accompanied by a small smile]
11. D: None [accompanied by a desperate smile] How long in Spain? Here. [index finger pointing toward the floor] in Spain.
12. P: ...
13. D: Here [index finger pointing toward the floor] here [index finger pointing toward the floor]
14. P: ...[index finger pointing toward the floor]
15. D: Yes [index finger pointing toward the floor] How long?

When analysing Excerpt 1, we observe that out of seven turns 'produced' by the patient, five are 'silent turns,' and two are monosyllabic turns ("little" and "none"). The whole interview from where the excerpt was taken contains 45 exchanges. Of these, twenty two are produced by the doctor, two by the social worker, one by the woman in the bed next to the patient's, and twenty by the patient, who uses only seven turns to produce monosyllabic words: "A little," "Nothing" (twice), "Yes" (twice) "Lisa" and "OK," and remains silent in the other 13 (30%).

Excerpt 2. D: Doctor; P: Moroccan patient who has just given birth; RM: Roommate. Situation: The doctor visits the patient who has just given birth. The doctor enters and approaches the patient's bed.

1. D: Where are you from?
2. P: ...[accompanied by a facial expression indicating strangeness, not understanding what is being asked]
3. D: You [pointing to the patient and gesturing with both hands spread out, at the height of the head, elevating shoulders at the same time, asking for the place of origin]
4. RM: Moroccan.
5. D: Moroccan, ok. Sit down [pointing with the finger at the bed] Ok, let's see, you're Moroccan.
6. P: ...
7. D: Where did they track your pregnancy?
8. P: ...
9. D: Pregnancy control? [hands touching at the fingers, making a half-circle, as though forming the belly of a pregnant woman]
10. P: ...

In Excerpt 2 the patient does not even produce a word, turning the interview into a monologue except for the exchange produced by the roommate. The whole interview contains fifty-eight turns, and three monolingual exchanges. One to thirty-four turns are doctor / patient exchanges; thirty-five to forty-one turns are exchanges between the doctor and the patient's mother, and forty-two to fifty-eight turns are exchanges between the doctor and the patient's sister who is expected to act as a bilingual helper, but she acts as a second participant in the Monolingual Mode. As for the turns, the doctor produces seventeen out of thirty-four exchanges (50%); the nurse accompanying the doctor produces two; the woman in the next bed produces one turn; and the patient produces fourteen turns (41 %), twelve of which are 'silence turns' accompanied by gestures. She only answers the doctor's questions verbally on three occasions (Turn 14 *Eh, una hermana*, (Eh, one sister) Turn 20: *Sí* (yes); Turn 28: *Un año, tres meses* (A year, three months). The Mother enters the interaction to help her daughter as an intermediary but there is only one turn (40) in which she says something (grammatically incorrect) in Spanish with (*Espérate que llamar para su hermana* (Wait that to call for her sister)); of the other two exchanges—in 36 she does not answer the yes / no doctor's question: *¿Usted le ha acompañado a las visitas del embarazo?* (did you accompany her to the doctors?), and in 38, where the doctor rephrases her question: *¿Iba usted con ella?* (Did you go with her?), she says something in Arabic.

From forty-two to fifty-eight, the conversation is between the patient's sister and the doctor, the patient and her mother both being present. The yes / no question-answer pattern is the predominant one, and is a typical structure in this kind of encounter as revealed by previous studies mentioned above. This structure facilitates the interlocutor's speech which is reduced to monosyllabic words: *Vale* (OK), *Sí*, (Yes) *No* (No).

3.1.1.2. Doctor who speaks foreign languages / Patient who does not speak Spanish (Type 1b)

A special kind of turn-taking is also produced in the second kind of monolingual interviews considered. In this situation, when the doctor tries to communicate using a third language—English in this case—many exchanges take place whose aim is to establish the meaning of the words. Because of differences in intonation, lack of fluency, or being unfamiliar with different accents, the patient helps the doctor to understand by repeating, giving other options, or looking for synonyms, thereby producing what we call 'language turns.' The following examples illustrate these comments:

Excerpt 3. D: Doctor; P: Patient—Nigerian patient who does not speak Spanish; N: Nurse. Situation: The doctor visits the patient after the delivery.

1. D. *Muy bien.* (Very well) How long in Spain? [pointing with the finger at the floor]
2. P: Just a month
3. D. *¿Eso qué es?* (What's that?) [accompanied by a gesture meaning "I don't understand what you are saying"]
4. P: One month [accompanied by a gesture with her finger up indicating "one"]
5. D. *'Uam mon?' . ¿eso es inglés, francés?* (Uam mon?' ...what's that, English, French? [Accompanied by the same gesture meaning "I don't understand what you are saying"]
6. N: One
7. D: One, one month [accompanied by a gesture with her finger up indicating 'one']
8. P: I have been here, right?
9. D: yes
10. P. Yes, just for one month
11. D: Ahh.

Analysing Excerpt 3 shows that surprisingly enough the doctor needs eleven exchanges accompanied by gestures, monosyllabic words and repetitions to understand one single question!

A similar situation is repeated in the following example:

Excerpt 4. D: Gynecologist; P: Nigerian patient. Situation: P has been sent to the specialist by the family doctor to consider the possibility of an abortion as the fetus is dead.

1. P: *Mira. Me han dicho "seperar".* [Look. They have told me "seperar"]
2. D: *"Seperar?". No entiendo. Me estás diciendo, ¿qué idioma es "seperar"?, ¿es español?, ¿seperar?* ["Seperar." I don't understand. Are you telling me, what language is "seperar"? Is it Spanish? "seperar?"]
3. P: Separated. In English is separated.
4. D: In English, *¿cómo es?, ¿siprich?* [How is it? how do you pronounce it "siprich"?]
5. P: Separate.
6. D: *Sepreich. Seprich. No sé lo que quiere decir. Seprich.* ["Sepreich." "Seprich." I don't know what it means. "Seprich")]

7. P: *Seperar en español, ¿no?* ["Seperar" in Spanish, no?]
8. D: How do you write in English? Separit. ¿Sabes escribir? [Can you write?]
9. P: In English, separate, something that divide(s).
10. D: ¡ah!, iseparate!
11. P: But I don't know if what wrote the woman is about.
12. D: No, no. Separate is ...eh, you have this abortion now. Abortion, abortion.
13. P: Abortion.
14. D: Es decir [That is to say], the gestation is not, no, no longer going on. It's not going on.
15. P: Ah!, the baby is not going on.
16. D: The baby, the baby. Exactamente. [Exactly]
17. P: Is dead.
18. D: Is dead. *Efectivamente. No habías entendido eso, ¿verdad?, lo que te habían dicho de que ya, de que el embarazo no va a más. Te tenemos..* [That't it. You didn't understand that, did you? What they had told you about (the fact) that already, that the pregnancy is not continuing. We have to..] we must eh, eh, make you eh, some, o any treatment now.

Excerpt 4 again shows the doctor's problems in trying to understand the patient when she uses a third language (English in this case), and when she also tries to help the patient with terms like "abortion" or when explaining the patient's state

To sum up, in both examples (Excerpts 3 and 4) we observe that both participants have problems in understanding each other. The doctor uses longer turn-taking, mixing English and Spanish, and asking the patient to repeat or trying to understand what the patient says in English. The doctor also seems to have problems with the way in which the patient speaks English. This might be because of the doctor's lack of fluency or the patient's particular accent and intonation or both. The patient seems to have a better command of English than the doctor does, as she even tries to provide synonyms (Turn 3 and 7) or rephrase some utterances to make them more understandable (Turn 15).

3.1.2 Interaction in Bilingual Helper Mode (Type 2)

In the case of bilingual interviews mediated by the bilingual helper (or triadic exchanges, Type 2) very often the bilingual helper speaks directly to one party or the other, entering into the conversation rather than interpreting for others, producing a sort of monolingual interview. In these cases, no interpretation is provided for the party who is not being addressed, so that party cannot be expected to understand what is being said. In sum, doctor/patient interaction is being replaced by intermediary / doctor or intermediary /patient interaction. Excerpt 5 is a good example as it contains many of the above mentioned features:

Excerpt 5. D: General practitioner (male); P: Moroccan patient (female) who does not speak Spanish; A: patient's husband acting as *ad hoc* interpreter; Situation: The patient is suffering from stomach pains.

1. D: *El ácido del estómago sube por el esófago...* [The stomach acid comes up through the oesophagus]
2. P: [She says something in Arabic]
3. A: *Le molesta aquí y por eso no puede ni vomitar ni nada, aquí* [It bothers her here and for that reason she can't even vomit or anything].
4. P: (????) *bocio* (????) [goitre]
5. A: *Dice a ver si va ser el bocio, el bocio imposible porque ya te han quitado (????) el tiroides.* [She says it must be the goitre; it can't be the goitre because they have already taken out (????) the thyroid].

As we can see in the example above, first the bilingual helper (A) adds information (Turn 3) not given by the patient, and later he adds a comment (Turn 5) that completes the information for the doctor. As for the whole interview, of the thirty one utterances spoken by the doctor, only nine (29%) were interpreted in any way to the patient. Of the twelve utterances spoken by the patient, only three (25 %) were interpreted to the doctor.

Thus, the 'direct interaction' in the Bilingual Helper Mode is reduced to less than 50%. Data reveal that the bilingual helper contributes to the interviews in ways that are not, strictly speaking, interpretation but 'new speech,' directed to the doctor and to the patient, adding information, asking direct questions, making comments or giving advice, thus taking an active role.

Data also reveal that, from the perspective of the professional interpreter, the bilingual agent is not always a guarantee of effective communication, contrary to what many health professionals and institutional authorities seem to think when they recommend patients who do not speak Spanish to visit the doctor accompanied by relatives, or friends.

The following example illustrates the above comment:

Excerpt 6. D: Doctor; A: Accompanying person (bilingual helper, the husband in this case); P: Moroccan patient (female) who does not speak Spanish. Situation: P is suffering from neck and back pain

1. D to A: *¿Sabe lo que es la regla? ¿que es la regla? ¿Cuántos días, (...) cuántos días: cinco, seis?* [Do you know what the period is? How many days? How many days: five, six?]
2. A to D: *Sí, sí. Ella ahora tiene regla.* [Yes, yes, she has her period now. Is now with the period]
3. D: *¿Cuánto? ¿Cuántas veces te viene al mes? ¿Cuánto tiempo la tienes?* [How much, how many times do you have it a month? How long does it last?]
4. P: *Cinco* [Five]
5. Bilingual to doctor: *No, كئار* [No, more]
6. P: *Cinco (؟؟؟؟) كتجيني قوية وأربعيام كتجي* [Five, five days. A heavy flow for five days and then for four days... comes strong and four days comes ...]
7. D: *¿Cuántos días?* [How many days?]
8. A to D: *Nueve, ocho: cinco día fuerte y tres, cuatro día... manchas nada más* [Nine, eight: five days of heavy flow and strong and three, four days with... stains, that's all, no more].

In this case the doctor asks the bilingual helper directly to be sure that he understands what they are talking about as the patient indicated previously that she thought she needed some iron. In this case, communication is again made effective through 'direct intervention' between two of the participants, and using resources also shared with Type 1. Thus, the *ad hoc* interpreter acts more as an advocate and husband than solely as an interpreter.

Many scholars from the field of Translation Studies will point out the interpreter's failure to relay utterances by the doctor and the patient to the other participant, while other scholars from this and other fields will point out that the intermediary's role can save time. Nevertheless, it will also constitute a considerable communicative risk: the doctor feels that the husband knows his wife's (i.e. the patient's) problem but he cannot be sure about the husband's skills and ability to interpret accurately, and hence, often, uses similar resources to those employed in the monolingual interview (Type 1): direct questions, repetition of utterances, colloquial speech, avoidance of technical terms..... Such a situation is frequently repeated in other conversations recorded.

3.1.3. Interaction in Interpreted Mode (Type 3)

The third type of interaction analysed in healthcare visits is the triadic encounter in which three participants interact: Doctor / Patient / Intermediary. Data to exemplify Type 3 come from simulated role plays with semi-trained students⁴ who have little experience. The participants are a nurse, a student acting as a foreign-language patient, and a student acting as a trained interpreter after approximately 200 hours of training, including 16 hours of instruction on the standards of good practice. As in the case of the Monolingual Type interactions, there is direct interaction between the doctor and the patient through the interpreter.

Some cases of 'direct interaction' between doctor and interpreter, and patient and interpreter are also found, but mostly when repetition or more information is required by the interpreter, as also happened in a previous study with trained interpreters (Valero-Garcés and Downing 2007) The following example illustrates this:

Excerpt 7. D: General practitioner (male); P: Student acting as an Arabic-speaking patient (female) who does not speak Spanish; I: Student acting as an interpreter (female). Situation: P has been involved in a traffic accident

1. P: عند محاولة طلع حزام الأمان
2. I: *y también cuando voy a ponerme el cinturón* [And when I try to put on my seatbelt]
3. P: ومن خلال كذلك أوجاع في الظهر و خاصة كثيرة، و خاصة من هنا بالأسفل
4. I: *Tengo muchos dolores en la espalda y sobre todo en la parte más baja* [And I have a lot backpain, and specially down here]
5. D: *abajo...abajo?* [Down hereDown here?].

6. P: الخلفية، الأسف: *Trasera, abao*] Back, lower. [pointing to the back, down]
7. D: *lumbares*
8. I: *si, la parte más baja de la espalda.* [Yes, the lowest part in the back]
9. D: *¿y se ha notado mareada últimamente?* [Have you feel dizzy lately?]
10. I: هل لاحظت أنك لديكي دوران...؟ *¿Has notado si tienes mareos...?* [Have you noticed having any dizzy spells?]
11. P: فقط أحس (2). أوجاع بالرأس كثيرا *(Solo noto...mucho dolor en la cabeza* [I only notice...strong headaches]
12. I: *No, solamente he notado mucho dolor de cabeza* [No, I've only noticed a strong headache]
13. P: هنا...بالجبهة *(Aquí...en la frente/* [Here...in the forehead]
14. I: *En la frente* [In the forehead]
15. P: والأسوأ من هذا أنه لا يخب *(Y lo peor de esto es que no desaparece* And the worst part of it is that it doesn't go away]
16. I: *Lo peor de todo es que no se me quita* [The worst part of it is that it doesn't go away]

Excerpt 7 shows that the interpreter reproduces what the doctor or the patient says, thus producing the effect of a monolingual encounter. That is, cases of 'direct interaction' take place. Our data also reveal that there are cases where the interpreter, following the recommendations to interpret in the first person, produces changes with regard to what the patient said, as seen in the next example:

Excerpt 8. D: General practitioner (male); P: Student acting as an Arabic-speaking patient (female) who does not speak Spanish; I: Student acting as an interpreter (female). Situation: P is suffering from haemorrhoids.

1. P: إذا كان الدكتور إذن بأن العملية هي أحسن حل، فأنا أفضل العملية *[If the doctors then think that surgery is the best solution, I prefer surgery]*
2. I to D: *Si cree usted doctor que es mejor realizar la operación, entonces estoy, estoy de acuerdo.* [If you think doctor that it is better to perform the surgery, then I, I agree].

In other cases, the opposite is done or confusion arises as in the example below:

Excerpt 9. (Arabic-Spanish): D: General practitioner (male); P: Student acting as an Arabic-speaking patient (female) who does not speak Spanish; I: Student acting as an interpreter (female) (I). Situation: P is suffering from sclerosis.

1. D: *Bueno creo que con la información que me ha aportado es suficiente. Ahora pasaremos a hacerle una radiografía y partir de aquí es...*
[Well, I think that the information you have given me is enough. Now we'll get you X rayed, and from here it's....]
2. I to D: التشخيص بالصورة نديرو قال بأنه بعد المعلومات التي أعطيتني عندي المعلومات الكافية و الآن قد *[He said that with the data you have even given him I have enough and now we are making a diagnosis with a_??????]*

In this case, apart from the content errors (*ecografía* ("ultrasonography") instead of *radiografía* ("radiography") and the addition of some information (*hacer un diagnóstico* ('make a diagnosis'), we observe changes in the subjects of the sentence ("He said," "I have," "we are...").

This may mean that the students need further training and practice, but it may also illustrate the type of communication problems that professionals have to face, and /or the impossibility of adhering completely to the standards of fidelity: the interpreter always reproduces what is heard, without adding or omitting information or changing from 1st to 3rd person. This mode of interpreting known as the 'conduit mode,' is most commonly used in conference interpreting, and is now frequently being questioned in the field of public service interpreting and translating (Angelelli 2004, 2008).

3.2. Findings

To sum up, the main conclusions of this study on communication in the medical setting from a discourse analytical approach as seen by language specialists are the following:

In monolingual mode interactions, the doctor and the patient alternate turns throughout the entire interview, but the number of turns is not the same, and there are specific types of turn-taking: 'silence turns' and 'language turns' which make us think that communication is not as effective as it should be, a conclusion that is reinforced by typical last turns in many of the interviews recorded, when the doctor says, for example, "yes," "ok," "right," "that's it" (*sí, vale, pues eso*), accompanied by a gesture of desperation. At the same time, the fact that the patient does not speak Spanish fluently forces the doctor to use some accommodation processes such as colloquial speech, ungrammatical sentences, constant repetitions, a high number of questions—mainly "yes/no questions" and "assertion asking for confirmation" types—in contrast with situations in which both parties share the same language and culture.

When the doctor tries to communicate in a different language, problems related to fluency, intonation, different accents, lack of vocabulary and so on, also make communication difficult.

These aspects may not be considered important by the doctor and patient in so far as they manage to communicate; however, from the interpreter's or the language specialist's point of view, they are important and the conversation can seem, if not unacceptable, at least risky.

However, in the interpreted mode (Type 3) interactions, the semi-trained interpreter tries to maintain a narrowly defined interpreter role. They make it possible for each party to hear everything said by the other party even though the other is speaking a different language, without the processes and resources used in the Monolingual type (Type 1).

In the Bilingual Helper Mode (Type 2) interactions the bilingual seems to move freely between the roles of interpreter, counsellor, relative, and

adviser. As interpreter, they are frequently involved in relaying the doctor's questions and advice to the patient, as well as reporting the patient's responses to the doctor. In the role of accompanying person, they frequently take over the doctor's role of questioning and counselling the patient, leaving the doctor in the position of merely observing or supervising the exchange. They also assume the patient's role, asking the doctor questions directly, providing new information, or omitting part of the information given by the doctor. Whenever the bilingual speaks directly to either the doctor or the patient, no interpretation of the bilingual helper's utterance is available to the third party.

Judged by the standards of professional interpreting as applied mostly to conference interpreting, the accompanying person who acts as the intermediary usually does a very poor job in facilitating communication between doctor and client. According to our data, most of them do not act in the role of interpreter at all. Rather, they merely provide bilingual assistance to the doctor and act as the patient's helper and adviser.

From this perspective, the comments by Marticano (2007) mentioned above about the "important distortions (that) arise when patients evaluate themselves with the help of interpreters" are, without any doubt, considered incorrect for a large percentage of language specialists, translators, and interpreters. However, many professionals in the health sector still support this idea. From their perspective, there seems to be an underlying agreement between the doctor and the bilingual helper that the latter will act as informer rather than as interpreter for the major portion of the interview. This will save time—nowadays an important issue under discussion—by avoiding the repetition of utterances from one language to the other. This all proves just how necessary an interdisciplinary approach is, as well as uniting theory and practice.

4. Main conclusions

A closer look at healthcare services in Spain reveals important changes in the structure of a doctor's visit and in the attitude of medical professionals. One of the main causes of this is the arrival of migrant populations which bring different languages and cultures and which do not have a good command of the contact language—Spanish in this case. They are new patients with new needs and they require new solutions. Multidisciplinary efforts and team work could provide some solutions, given the disparity of opinions and the lack of knowledge people have of one another. This is true not only between professionals and immigrants, but also within the professions themselves that, in one form or other, assist immigrant populations; that is, doctors, nurses, psychologists, social workers, anthropologists, sociologists, educators, foreign language teachers, linguists, translators and interpreters, professionals in administration, teachers and researchers.

Some of the examples presented in this paper show that the quality of communication needs to be improved. One possible solution is the establishment of professional interpreter services; and this could be started with the design of adapted courses for the training of these bilingual helpers, incorporating the needs identified by the health professionals. At the same time, specific seminars and courses including some of the needs identified by the professionals as well as techniques about how to work with interpreters should be made available for doctors. I hope that the findings of this study will be useful for trainers, practitioners, future interpreters, and health professionals; and that the data and conclusions will encourage all sorts of practitioners and course designers to keep in mind some of these findings and to incorporate research, theory and practice in the training of interpreters and also of future service providers who need to become aware of the benefits of working with professional interpreters.

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Biography

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¹ This is set forth in the Ley Orgánica 8/2000 (*Law 8/2000*) of December 22nd, which amends the Ley Orgánica 4/2000 (*Law 4/2000*) concerning the “Derechos y Libertades de los Extranjeros en España y su Integración Social” (*Rights and Freedoms of Foreigners in Spain and their Social Integration*, published in the BOE, *Official Bulletin of the Spanish State*, on December 23rd) and explained mainly in articles 12 and 14. Article 12 specifies that the following have the right to healthcare:

1. Foreigners registered in the register of the town in which they reside, on the same standing as Spaniards.
2. Foreigners needing emergency care for grave illnesses or accidents, whatever their cause, as well as the assistance they require until being discharged.
3. Foreigners under 18 years of age.
4. Foreign pregnant women, during pregnancy, birth, and postpartum.
5. Article 14 of Law 8/2000 which amends Law 4/2000, states:
 - 14.2 Resident foreigners shall have the right to social services and benefits, both general and basic, as well as specific ones, on the same standing as Spaniards.
 - 14.3 Whatever their administrative situation, foreigners have the right to basic social services and benefits.

² In this context, “translator” is used in a generic sense meaning both “interpreter and translator.”

³ The numbers in the examples indicate the turn in the conversation. The translation offered is a literal one, reflecting as much as possible the often nonstandard use of Spanish in the original. The transcription code, which for the sake of readability has been reduced to a minimum, is as follows:

????? unintelligible

? interrogative rising intonation
....pause
((...)) extralinguistic comment
} overlapping

⁴ Students of the Masters in Intercultural Communication, Interpreting and Translating in Public Services Interpreting at the University of Alcalá. (<http://www2.uah.es/traduccion>)