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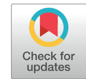
Patient-centered interaction in interpreted primary care consultations



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A B S T R A C T

In this article, we analyze the interactional work of interpreters from the viewpoint of patient-centered care. Interpreters can support patient-centered care by both translational and non-translational actions. They can calibrate the talk in rendition so as to benefit the intersubjective understanding of all parties, and can also help doctors and patients understand each other better through various embodied means. Our analysis draws on a multimodal analysis of interaction (see e.g. Goodwin, 2018; Mondada, 2016) and is based on a detailed analysis of three primary care consultations video recorded at a Finnish health center. In each consultation, the patient is a refugee or an asylum seeker and the interpreter is a professional community interpreter. We demonstrate three practices that seem to enhance patient-centeredness. Firstly, we show how interpreters can balance between direct interpretation and mediation to produce a clear yet precise rendition of turns at talk. Secondly, we demonstrate how interpreters display recipiency and provide interactional space for the patient by producing response particles that encourage the patient to continue talking. Thirdly, we illustrate how embodied co-operation in interpreted consultations makes the renditions more intelligible and tangible for all the parties involved in interpreter-mediated interaction.

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1. Introduction

This study is concerned with interpreter-mediated interaction in primary care consultations involving refugees and asylum seekers with physical and mental health problems. The aim of the study is to explore how the interactional work of the interpreters and the style of interpreting may both locally and systematically impact doctor-patient relations, and as a result impact the patient-centered care in primary care consultations.

Patient-centered care is a widely accepted institutional approach which seems to be the subject of several concepts and models concerning improvement to the professional help that patients receive (e.g. Körner, 2013). The two most important denominators among these models seem to be an emphasis on the quality of care and the care-provider's focus on distinguishing the patient from the patient's healthcare problem (Robinson et al., 2008). In other words, the aim of patient-

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centered care is to create an equal and collaborative relationship between patients and medical staff, for instance, in decision making over treatments, etc. (Epstein and Street, 2011; Institute of Medicine (US), 2001; Scholl et al., 2014; Stewart et al., 2000). As good communication is central to patient-centered care, encounters where the care-provider and the patient do not share the same language and culture are particularly challenging. There are many studies showing that if patients have a limited knowledge of the language in which they speak to clinicians, patients may encounter communicative difficulties, and lose trust in the service they receive. They may also perceive the experience as healthcare discrimination which, in turn, may impact negatively on their clinical outcomes (Schenker et al., 2010).

Using an interpreter, *ad hoc* or professional, to mediate between patients and clinicians enables multilingual communication in cross-cultural encounters. However, interpreter-mediated clinical encounters are not without communicational problems either, and many studies have in fact reported that interpreting may impact doctor–patient rapport-building negatively (e.g. Amato, 2007; Angelelli, 2004; Aranguri et al., 2006; Bolden, 2000; Hale, 2007; Hudelson et al., 2013; Rivadeneyra et al., 2000; see Chapter 3 in this article). Consequently, there is a need to elaborate on the interpreting practices in patient-centered care. Some studies have already recognized and presented the positive contributions made by interpreters to doctor–patient interactions (e.g. Baraldi, 2012; Baraldi and Gavioli, 2014; Farini, 2012; Raymond, 2014; Zorzi, 2012); this study continues this exploration by taking the concept of patient-centered interpreting as the starting point.

We demonstrate three interactional practices that seem beneficial to patient participation. These three practices include how interpreters (a) alternate between a direct and mediated interpretation style to produce recipient designed renditions that facilitate mutual understanding, (b) produce response particles that expand the patient's interactional space, and (c) bodily co-operate with doctors and patients in the course of the interpretation. Through co-operation, that is, contributing through various semiotic means to a shared action (Goodwin, 2018), we demonstrate how interpreters play a significant role in communication in order to make the other parties' turns[1] intelligible as well as tangible, concrete, and actionable.

2. Direct interpretation vs. mediation

In this study, we make distinctions between direct interpretation and mediation. We draw on the definitions of direct interpretation and mediation used by Bolden (2000, 391) and Hale (2007). Interpretation is considered direct when it follows the original as accurately and completely as possible without adding or omitting details. Directly interpreted interaction takes the form of a single conversation between the principal parties. Mediation, in contrast, takes the form of two interweaving conversations and gives the interpreter a more independent role.

In mediation, intelligibility is emphasized, which allows the mediator to add explanations and make alterations for the benefit of clarity (*expanded renditions* and *non-renditions*, Wadensjö, 1992). The drawbacks of mediating are that it may lead interpreters away from the original conversation and confuse their responsibilities in the interaction (Bolden, 2000; Hale, 2007; Hsieh, 2007; Pasquandrea, 2012). In the context of the primary care consultation, making decisions on what to convey, what to focus on, and what to leave out engenders risk, as the choices may indirectly affect the patient's health. Therefore, direct interpreting is often recommended over mediation, as is the case in Finland, where our data for this study were gathered, and where interpreters are trained according to this method (The Finnish Association of Translators and Interpreters, 2013).

However, recent studies on public service interpreting have given new support to the mediated style of interpretation. For example, Baraldi (2012) sees interpreters' autonomous expansions and modified renditions as actions that can promote patients' agency and empathy in interaction (see also Farini, 2012; Baraldi, 2018 on mediated interactions between migrants and social workers, and Davitti and Pasquandrea, 2013 on interpreted teacher–parent meetings). Moreover, as Zorzi (2012, 247) points out, interpreters' non-translational activities such as comforting and complimenting the patient or agreeing with the doctor, may be relevant activities in building affective relationships in healthcare settings. In this article, we continue the debate by demonstrating the possibility of combining the two styles of interpreting (see Section 6.1).

3. Interpreting and patient-centered care

In primary care consultations, the aim of the consultation is that the patient receives medical advice and support from the physician and that the patient's condition improves (see e.g. Heritage and Maynard, 2006; Mishler, 1984). In western medicine, the patient-centered approach guides care providers to meet their patients with respect as individuals within the context of their own social worlds (see e.g. American 'National Council on Interpreting in Health Care', 2005). Care providers are encouraged to listen to patients' views and hopes, give them information and emotional support, and involve them in their care. The Patient-centered approach also requires the ability to identify and respect cultural differences, and the ability to recognize one's own cultural influences (Saha et al., 2008). The approach has been reported to result in better recovery from discomfort, a greater number of decisions consistent with patients' values, and fewer patients remaining passive (See e.g. Epstein and Street, 2011; Institute of Medicine, 2001; Stewart et al., 2000).

However, the implementation of the patient-centered approach has proven challenging in cross-cultural clinical encounters where clinicians and patients do not share the same language and culture. Schouten and Meeuwesen's (2006)

[1] By turns we refer to turns-at-talk in conversation as analyzed in conversation analysis (Sacks et al., 1974; Drew, 2013).

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