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Research Paper

Patient involvement and language barriers: Problems of agreement or understanding?

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ABSTRACT

Objective: This study aims to explicate efforts for realizing patient-centeredness (PCC) and involvement (SDM) in a difficult decision-making situation. It investigates what communicative strategies a physician used and the immediate, observable consequences for patient participation.
Methods: From a corpus of videotaped hospital encounters, one case in which the physician and patient used Norwegian as lingua franca was selected for analysis using conversation analysis (CA). Secondary data were measures of PCC and SDM.
Results: Though the physician did extensive interactional work to secure the patient's understanding and acceptance of a treatment recommendation, his persistent attempts did not succeed in generating the patient's participation. In ratings of PCC and SDM, this case scored well above average.
Conclusion: Despite the fact that this encounter displays some of the 'best *actual* practice' of PCC and SDM within the corpus, our analysis of the interaction shows why the strategies were insufficient in the context of a language barrier and possible disagreement.
Practice implications: When facing problems of understanding, agreement and participation in treatment decision-making, relatively good patient centered skills may not suffice. Knowledge about the interactional realization of key activities is needed for developing training targeted at overcoming such challenges.

1. Introduction

Patient-centered care (PCC) has become the norm of quality health care in many countries. A central component in PCC is the involvement of patients in treatment decision-making, i.e. through exploring patients' preferences and concerns, as conceptualized in shared decision making models (SDM) [1–3]. Patients' opportunities to accept or reject treatment recommendations can be seen as a basic form of patient involvement, built on the ethical requirement of informed consent [4–6]. A precondition for accepting or rejecting a proposal is to understand it [7,8], and most PCC and SDM guidelines advise physicians to check and clarify understanding [1,3,5]. However, patients do not necessarily express their lack of understanding, or they may overestimate what they have understood, whereas physicians may overestimate the clarity of their own talk, and rarely check what patients have actually understood [9–12].

Achieving and securing understanding may be particularly challenging in encounters with non-native speakers [13], and ineffective communication with non-native speaking patients constitutes a risk to patient safety and health [14–16]. Interpreters can be used to overcome language, culture and knowledge barriers [17], but interpreters are not always used when patients have 'some' proficiency in the second language [18]. Despite these challenges, little is known about what communicative strategies physicians actually use to secure understanding on a micro level, turn-by-turn, in authentic monolingual and multilingual encounters [13,19], let alone how understanding is accomplished in situations where not only the patient, but also the health professional speaks a non-native language. The use of lingua franca is far from uncommon in contemporary multilingual societies, where immigrants partake considerably in the health care work force [20,21]. Contributing to fill this gap in research, the present study takes a conversation analytic approach in order to

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explore interactional strategies and consequences in a decision-making sequence where the physician and patient, with different native languages, use Norwegian as a lingua franca. The analytical starting point was to investigate the physician's various attempts to secure understanding and generate participation from a seemingly 'passive' patient, whose dominant contribution was minimal responses.

1.1. Minimal responses claim understanding

Minimal responses, such as "mm" and "yes," serve a variety of functions in talk. Which function is realized in a given instance depends on such things as prosodic delivery and both what it is responsive to and what happens next, making them a useful, but possibly ambiguous resource for communication. Minimal response tokens *claim* understanding, by passing the opportunity to initiate repair and giving a go on-signal to the speaker, but do not *display* any evidence of what has been understood [22,23]. Thus, minimal responses provide weak evidence of what is actually understood. Indeed, a study of simulated physician–patient interaction found that, in multilingual dyads, minimal responses were misleading in terms of recipient recall [24]. Another experimental study demonstrated that minimal responses, produced by distracted listeners, in positions where more specific responses (i.e. assessments) would be expected, affected the quality of speakers' narratives negatively in that speakers, for instance, "circled around and retold the ending more than once" [25].

1.2. Minimal responses in decision-making

The impact of minimal responses has been amply demonstrated in decision-making sequences across various settings. A study of ordinary conversations showed that proposals for future action require explicit statements of commitment and not merely a minimal confirmation in order for the proposal to be heard as accepted by the addressee [26]. A similar pattern has been found in treatment recommendation sequences, where physicians regularly treat *acceptance of their treatment recommendation as necessary* before moving on to the next activity [27–29]. In most settings, physicians treat patients' minimal responses, like "mm", as insufficient acceptance (i.e. displaying *passive resistance*), while explicit or elaborate affirmative responses (e.g. "okay", "that sounds good") are required to be heard as accepting the proposal [28–30]. When such acceptance is not forthcoming, a negotiation sequence usually follows, dealing with potential problems of acceptability. These two trajectories of treatment recommendation sequences are illustrated in Fig. 1.

1.3. Objective of study

The present study examines a series of treatment recommendation sequences that all fall under the second trajectory (see Fig. 1). The analysis focuses on the third part, on what the physician does after responses by the patient that are heard as insufficient acceptance. The study aims to explicate efforts for realizing patient centeredness in an encounter where achieving patient participation in decision-making was particularly challenging. It provides empirical specification of 1) what communicative strategies the physician used in order to overcome problems of establishing understanding and generating patient participation, and 2) what observable consequences the physician's efforts had for the patient's understanding and participation *within* the encounter.

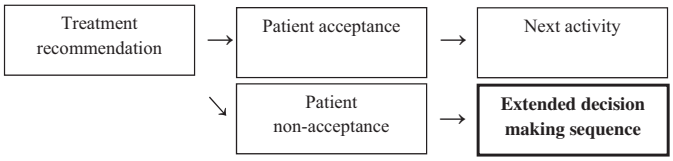

Fig. 1. Two trajectories of treatment recommendation sequences.

2. Data and method

Available for our study by broad consent were 380 video-recorded physician-patient encounters collected at a Norwegian teaching hospital in 2007–2008 [31]. The primary data for this study were all 18 encounters with non-native speaking patients, which were transcribed and inspected for potential challenges related to language barriers. We selected one encounter for close analysis where the physician and patient used a lingua franca, and where it appeared to be particularly challenging to achieve mutual understanding and progressivity; after more than ten minutes without achieving mutual understanding and a decision, the physician suggested scheduling a new consultation with an interpreter. Additionally, as the video corpus has been measured for PCC [31] and SDM [32,33] for other studies, performance scores for this particular case compared to total scores were extracted as secondary data. Detailed analysis of particularly difficult cases can offer insight into the 'black box' of how disruptions from the routine organization of treatment decision-making (cf. section 1.2) are generated and dealt with in actual interaction [34]. This can further our understanding of communicative challenges and potential solutions for achieving more patient-centered decision-making in encounters with a language barrier.

Conversation analysis (CA) [35,36] is an empirical, qualitative methodology for describing 'the interactional machinery' participants rely on for accomplishing social action in authentic interaction. CA builds on accumulated evidence of the "orderliness of conduct in interaction" [37]. The present case study draws on this past work (cf. sections 1.1-2) for examining a specific episode of interaction. Based on the 'next-turn-proof procedure', detailed analysis of video-recorded interaction and transcriptions [38] enables the analyst to describe how participants understand and treat their co-participant's turns at talk. In this case, how the physician interpreted and treated the patient's minimal responses is made *publicly available through his next actions* [36].

3. Results

The following analysis of five extracts includes approximately half of the decision-making phase during the encounter. The extracts are chosen to represent a development from the physician first orienting to problems of understanding, then concentrating on potential problems of acceptability, and finally returning to problems of understanding.

The patient, with Southeast Asian background, has had a liver inflammation for several years. The etiology has proved difficult to clarify, so the patient has seen several specialists previously, including the physician in the present case. The physician also speaks Norwegian as a second language. His pronunciation and vocabulary are heavily influenced by his first language – a neighboring Scandinavian language. The resulting mixed variety can be difficult to understand for non-native Norwegian speakers.

3.1. Orienting to problems of acceptability and/or understanding

In extract (1) the physician introduces his recommendation of taking a liver biopsy. However, repeated minimal responses lead the physician to produce several explanations and reformulations of the proposal (see extract (1)). Transcription symbols are described in the Appendix A.

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