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Moral mediation in interpreted health care consultations

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ABSTRACT

This paper reports on the moral work done in routine diabetes review consultations in primary care with nurses. Consultations with fluent English speakers are compared with consultations where an interpreter was present, largely involving patients of Bangladeshi origin. The study setting was Tower Hamlets in London, where type 2 diabetes is particularly common. Existing research has shown some dissatisfaction with diabetes care amongst Bangladeshi patients, and studies of care providers in other locations suggest that they at times experience the care of this group as particularly challenging. Through analysis of video-recorded consultations recorded in 2010–2011 we shed light on possible reasons for these difficulties. The 12 non-English speakers often experienced difficulties in raising issues that concerned them, particularly if their interpreter did not translate their utterance because it was deemed to be unrelated to diabetes. These difficulties were not shared by the 24 fluent English speakers, who also found it easier to convey a positive moral reputation and to excuse behaviour that deviated from recommended self-management practices. Interpreters at times also acted as moral mediators. For example, where a participant in the consultation made statements that appeared to convey a negative moral judgement of an other participant, these would often go untranslated. Probably, neither health care providers nor patients are fully aware of the nature of their communication difficulties. Given this, interpreters possess considerable power to influence matters. Understanding the moral work of consultations is important in explaining the findings of other studies showing difficulties in the provision of diabetes care to people with limited English language skills.

Introduction

Moral work is ubiquitous in health care consultations (Heritage & Lindström, 1998). Typically, patients feel obliged to demonstrate that their decision to visit a care provider is justified, since an unjustified visit fails to provide legitimate entry into the sick role, whereby the temporary deviance that would otherwise be imputed to the patient is forgiven or sanctioned (Parsons, 1951). Thus medical encounters often begin with an inquiry about the reason for the visit followed by a variety of responses by the patient in ‘accounting for the visit’ (Heritage & Robinson, 2006, p.48) and subsequent phases of consultations also demonstrate justificatory practices (Heath, 1992; Peräkylä, 1998). These interchanges are subtle and require participants to deploy considerable linguistic skills.

What happens to moral work, though, when participants do not share a common language? Some evidence suggests that where the patient lacks fluency in the language of the care provider it is harder for these patients to communicate about matters that are not strictly clinical and to influence how the care provider perceives them as a patient (Moss & Roberts, 2005). In particular, such patients have been found to convey their ‘moral self’ in different and less ‘orderly’ ways than fluent patients (Roberts, Sarangi, & Moss, 2004). The analysis reported here goes a step further, to examine the moral work done in consultations where the patient’s language skills are such that an interpreter is used. We focus on routine review consultations for patients with diabetes carried out by nurses in primary care, but our findings have general relevance for understanding the mediation of moral elements of interpreted consultations.

Review of literature

Moral reputations are at stake in a much wider range of situations than those associated with health and illness (Goffman, 1968).

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Arguably, this is a permanent underlying feature of our social lives. The consequences for interaction were explained by Scott and Lyman (1968) whose categorisation of accounts that involve excuses and justifications, and analysis of the circumstances in which different kinds of moral accounting are honoured by others, ends by pointing out that 'Every account is a manifestation of the underlying negotiation of identities' (1968: 59). It has been claimed that illness itself can be understood as a type of 'moral malaise' (Crossley, 2002), with the adoption of health promoting behaviour being a 'demonstration of a virtuous life' (Stephens & Breheny, 2008: 16).

Numerous studies have found moral accounting occurring in research interviews about the experience of health and illness. Baruch (1981), for example, describes the 'atrocity stories' that contributed to the moral presentations made by parents talking about the health care of their children. Moral accounting is also documented by Buchbinder (2010) studying accounts of pain, Howson (1999) on narrations of cervical screening experiences, McMullen and Herman (2009) on stories told by women quitting antidepressants and by Stephens and Breheny (2008) on women's reporting of decision-making about menopause. Some studies involving direct observation of consultations show moral accounting to be a prominent feature of these. For example, the use of an ADHD diagnostic label in negotiating a less stigmatised identity than that of an illicit drug user is shown in the observational study reported by Schubert, Hansen, Dyer, and Rapley (2009). Heritage and Lindström (1998) show how interactions between mothers and health visitors are 'drenched' (1998: 398) with moral judgements. Webb's (2009) study of an obesity clinic describes challenges and defences to moral reputations.

Concerning diabetes, Broom and Whittaker (2004) show that patients reporting on their encounters with care providers often felt (rightly or wrongly) treated like disobedient children, or wicked or foolish adults. Many felt their (sometimes indulgent) lifestyle had caused their diabetes; others denied this. The obligation to control diabetes through self management had moral components and a lot of guilt was expressed in talk about diet. Indulgence in 'bad' foods was perceived to be 'naughty' or, alternatively, a 'treat' for good behaviour elsewhere. Patients said they tried to protect themselves against stigmatised identities in encounters with care providers. Some patients admitted falsifying records of their daily monitoring of HBA1c (blood sugar) levels in order to hoodwink care providers.

Self-blame was explored in a comparative study of accounts provided, on the one hand, by white respondents with diabetes and, on the other, Pakistani and Indian respondents who were asked about what had caused their diabetes (Lawton Ahmad, Peel, & Hallowell, 2007). White respondents tended to emphasise their own personal choices and 'failings'; South Asian respondents tended to externalise responsibility, blaming for example the stress of migration and of living in a new country.

Self management of diabetes by patients is 'hard work' (Greenhalgh et al., 2011; Hinder & Greenhalgh, 2012) but is promoted by care providers as an essential component of care. It requires practical competence and knowledge about things like blood sugar monitoring and diet, the emotional task of coping with one's own and others' feelings about the illness, and considerable skills in negotiating paths through the health care system. Commitment to the work of self management is likely to be heavily influenced by whether this seems to bring beneficial results, so health care providers are often involved in encouraging patients' motivation.

Studies of the perceptions of UK care providers contain some evidence of negative evaluations of patients from minority ethnic groups. It should be stressed that no such study has been done in the area in which we did our fieldwork, and that it cannot be assumed that the attitudes of care providers studied at different times and in different places are shared by the care providers with whom we worked. Our own study largely involves observation of interactions rather than elicitation of their views.

Ahmad, Baker, and Kernohan (1991) surveyed general practitioners in Bradford, finding that they held less positive attitudes towards patients of Asian origin than other patients, believing them to be less likely to comply with recommended treatment regimes or know when a consultation was appropriate and to take up a lot of their time, so that consultations with them were less satisfying. Some of these sentiments were stronger amongst doctors who were themselves of Asian origin. Both Chevannes (2002) and Vydelingum (2006) found nurses caring for minority ethnic groups to be in need of improved 'cultural competence'. The first of these studies concerned the care of South Asian patients, and provided evidence of 'ethnocentric practices [and] victim-blaming approaches… which raise questions about the quality of service provision' (2006: 22).

Hawthorne, Rahman, and Pill (2003) report a study of primary care providers in Cardiff who commonly felt that Bangladeshi patients with diabetes did not take sufficient responsibility for self-managing their diabetes and were unwilling to change their lifestyles. General practitioners found poor timekeeping by Bangladeshi patients annoying. Some providers believed Bangladeshi patients misused the health care system wilfully, using their lack of understanding as an excuse. Both doctors and nurses said they found it hard to engage with these patients. Health visitors, though, had more involvement in the home lives of these patients and were often in a position of defending the behaviour of Bangladeshi patients. Feelings of frustration, anger and helplessness amongst providers were common.

Given these findings with diabetes it is perhaps unsurprising that research (reviewed in Seale, Rivas, & Kelly, 2013) demonstrates inequalities in the experience of diabetes and in care provision to these ethnic minority groups, as well as dissatisfaction with diabetes care amongst patients and others of Bangladeshi origin in locations as far apart as Bradford (Rhodes, Nocon, & Wright, 2003), Cardiff (Hawthorne et al., 2003) and East London (Grace, Begum, Subhani, Kopelman, & Greenhalgh, 2008) where the present study was done.

In the present paper, which reports a comparison of fluent English consultations with ones that involve interpreters (most of which were with Bangladeshi patients), we explore the moral work done by participants. The paper builds on an earlier one which reported a quantitative comparison (Seale et al., 2013), showing that interpreted consultations included significantly less humour and less discussion of the patient's feelings or personal circumstances. Patients in interpreted consultations were less likely to raise issues unrelated to diabetes, to discuss their own ideas about health, and to talk about clinical parameters relevant to diabetes such as HBA1c levels or weight, and medical problems unrelated to diabetes. Interpreters sometimes changed the meaning or did not translate talk and they added their own comments. These findings provide a context within which to understand the more focused, qualitative analysis presented in this paper.

Methods

This is an analysis of a subset of data from a larger collection of 57 video- and audio-recorded consultations with patients receiving diabetes care in primary care settings in London in 2010–2011. Here we consider 36 consultations occurring within the London borough of Tower Hamlets, excluding consultations where the patient was not fluent in English but did not require an interpreter. Details of the sample and response rate are given in Seale et al. (2013). The study was approved by London – Surrey Borders Regional Ethics Committee (Ref: 10/H0806/27).