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Research Paper

Investigating empathy in interpreter-mediated simulated consultations: An explorative study

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ABSTRACT

Objective: To explore i) the ways in which empathic communication is expressed in interpreter-mediated consultations; ii) the interpreter's effect on the expression of empathic communication.

Methods: We coded 9 video-recorded interpreter-mediated simulated consultations by using the Empathic Communication Coding System (ECCS) which we used for each interaction during interpreter-mediated consultations. We compared patients' empathic opportunities and doctors' responses as expressed by the patients and doctors and as rendered by the interpreters.

Results: In 44 of the 70 empathic opportunities there was a match between the empathic opportunities as expressed by the patients and as rendered by the interpreters. In 26 of the 70 empathic opportunities, we identified 5 shift categories (reduced emotion, omitted emotion, emotion transformed into challenge, increased challenge/progress, twisted challenge) in the interpreter's rendition to the doctor. These were accompanied by changes in the level of empathy and in the content of the doctors' empathic responses. **Conclusion:** The interpreters' renditions had an impact on the patients' empathic opportunities and on the doctors' empathic responses in one third of the coded interactions.

Practice implications: Curricula with a focus on intercultural communication and/or empathy should consider the complexity of interpreter-mediated interaction and the interpreter's impact on the co-construction of empathy.

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1. Introduction

Empathy is the ability to understand another's experience, to communicate and confirm that understanding with the other person, and to then act in a helpful manner [1]. Empathy is considered to be a basic component of all therapeutic relationships [2], it has demonstrably improved patient enablement and patient and doctor satisfaction [3,4] and it is a key factor in patients' definitions of quality of care [5]. Moreover, it is associated with positive effects on the doctor-patient relationship and health outcomes [6–11].

Despite the prominent position of empathy in the literature on healthcare communication, clinicians do not always articulate explicit empathic responses to their patients' emotions [12–14]

and instead focus on other aspects of care, such as change of therapy [15,16].

In language-discordant consultations, where the language barrier between healthcare providers and patients is one of the factors that undermine the quality of healthcare provision [17–20], empathic communication is compromised even more [21]. There is evidence that clinicians are more verbally dominant and behave less affectively when interacting with ethnic minority patients [21].

Against this backdrop, the way in which interaction between doctors, patients and interpreters occurs should be further explored before setting up curricula or adjusting existing ones with a focus on teaching doctors how to ensure empathic communication in interpreter-mediated consultations. For this reason, this explorative study aims to shed light on the following research questions: 1. How is empathic communication expressed in interpreter-mediated consultations? 2. What is the interpreter's

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effect on the expression of empathic communication in interpreter-mediated consultations?

2. Method

2.1. Data

Our dataset consists of 9 video-recorded interpreter-mediated simulated consultations, which formed part of a joint training between 7th year medical students and Master's students in interpreting at the University of Antwerp in 2016. At the time of the intervention the joint training did not officially form part of the curriculum; it was planned as an additional learning activity. The purpose of the training was to familiarise each group of students with the interactional practices of each other. For the purpose of the study, 9 different interpreting students acted as interpreters (henceforth interpreters), 9 different medical students acted as doctors (henceforth doctors) and 9 different native speakers of different languages enacted patient roles (henceforth patients). The patients did not rely on fully scripted scenarios; instead, they relied on a broad framework that describes medical conditions and patient's sociocultural experience. This allowed them to improvise and act in a natural manner as much as possible. The doctors were requested to hold a simulated consultation on a bad news delivery scenario with a patient who spoke a language in which the doctor was not proficient or of which they did not have any command. Efforts had been made to prevent any familiarity or acquaintance among doctors, patients and interpreters.

2.2. Operational definition of empathy

Drawing on the various definitions of clinical empathy in the literature [22,14], we see empathic communication as a transactional [23,24] and sequential process starting with the patient's explicit negative emotional expression, followed by an empathic response from the physician [25]. This approach is in line with our firm belief that the realization of clinical empathy is a process of co-construction between the patient and the doctor. The doctor's response to the patient's emotional expression might prompt the patient to expand further on their concerns, to which the doctor responds and so the discourse unfolds.

2.3. Coding

A large number of tools study doctor-patient interaction [7,26–32] but not many of them have been developed to study empathy in interaction [33,34]. We used the Empathic Communication Coding System (ECCS) [24] for the identification of empathic instances. This tool is a valid instrument for measuring empathic communication in monolingual physician-patient encounters and views empathy as a transactional process between doctors and patients. The ECCS focuses on behavioural aspects of empathy and divides patient-initiated empathic opportunities into statements of emotion, progress, or challenge. Emotion is defined as “an affective state of consciousness in which joy, sorrow, fear, hate, or the like, is experienced”. Progress is “a positive development in physical condition that has improved quality of life, a positive development in the psychosocial aspect of the patient's life, or a recent, very positive, life-changing event”. Challenge refers to a “negative effect a physical or psychosocial problem is having on the patient's quality of life, or a recent, devastating, life-changing event” [6].

The ECCS is used to measure empathy in interaction by identifying empathic opportunities expressed by the patient and the doctor's responses to them (seven levels: Level 0–6). (See [Appendices A and B](#)). As opposed to other tools, the ECCS

distinguishes between different levels of empathy, ranging from Level 0, which stands for the doctor's denial of the patient's perspective right through to Level 6, in which the doctor and the patient share a feeling or experience. This differentiation between levels of doctors' responses is interesting for the purpose of our study as it allows us: i) to zoom in on the doctor's responses and to avoid treating a simple acknowledgment of a patient's empathic opportunity as confirmation (i.e. legitimization) [24]; ii) to make a close and systematic observation of the doctor's responses as expressed by the doctor and as rendered by the interpreter by comparing the level of the doctor's empathy, as expressed by the doctor and as rendered by the interpreter.

Since the ECCS is primarily designed for spoken interaction and does not pay due attention to non-verbal cues, we focused only on verbal interaction. For an overview of the ECCS categories, see [Appendices A and B](#).

The ECCS was conceived with monolingual doctor-patient interaction in mind. Therefore, for the purpose of this study we used it in the following way: We coded the patients' and doctors' utterances in relation to the interpreters' renditions. It was agreed among coders to code first the interpreter's rendition in Dutch of the patient's empathic opportunity and then the doctor's response to it. In this way, the meaning of the patient's expressions was coded in the way it reached the doctor (through the interpreter) and not as it was intended by the patient. This allowed us to create conditions that resembled real-life situations as much as possible, as in interpreter-mediated consultations, doctors rely on the information they receive through interpreters and not directly from patients.

The data were coded by all authors who worked in pairs (GT & AR, KH & EdB, GT & SvDg, DK & SvDg, PP & DK. The first coder in each pair is a practising physician and/or lecturer in (interpreter-mediated) clinical communication; the second coder is a linguist and/or interpreter trainer). Each pair of coders was assigned to code a number of videos. The distribution of videos was subject to the language proficiency of the pairs of coders (GT & AR: Spanish, KH & EdB: French, GT & SvDg: German, DK & SvDg: German, PP & DK: English. For the simulated consultations in Italian and Portuguese, the coders (PP & DK) relied on enhanced transcripts, including the translation into Dutch and the translators'/proof readers' comments). All transcriptions and translations were conducted by native certified translators and/or lecturers in Translation Studies at the University of Antwerp.

All coders had studied the ECCS [24] before they participated in the practice session that was organised to secure mutual understanding of the categories and levels of empathy among coders. During the practice session, all pairs of coders coded the same consultation. All coders were instructed to flag up any differences in the content and/or intensity in the patient's and doctor's utterances and the interpreter's renditions. Codes and identified differences in meaning and/or intensity were then compared among groups and consensus was reached through discussion. In order for all coders to have access to the interaction recorded in the simulated consultations and to determine the codes and the accuracy of the interpreters' renditions, transcripts of the consultations were produced. These were translated into Dutch and made available to all groups of coders. The accuracy of the transcripts and their translation was verified by native professional translators who are lecturers in Translation Studies at the Department of Applied Linguistics at the University of Antwerp.

After the practice session, each pair of coders was tasked to code a number of videos depending on the coders' fluency in the languages of the consultation. Each consultation was coded by one pair of coders. Each pair reached agreement upon the codes each member of the pair had coded individually. Each pair's codes were

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