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What do you do when you can't accommodate? Managing and evaluating problematic interactions in a multilingual medical environment

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A B S T R A C T

This study sought to better understand how speakers react, and what factors predict their evaluations of interaction, when a language barrier renders conventional verbal accommodation impossible. An analysis of conversation self-reports by $n = 30$ medical doctors working in multilingual hospital settings indicated that in these situations, speakers engage with their interlocutor to problem solve, and use their social and affective experiences as a basis for evaluating these conversations. These results underscore the importance of social connection when language barriers render conventional interaction impossible, and highlight how the cognitive and affective functions of accommodation work in concert.

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1. Introduction

In interaction, we accommodate (i.e., adjust our communication for) our interlocutors. According to communication accommodation theory (Dragojevic et al., in press; Soliz and Giles, 2014), such adjustment is proposed to have two primary functions. The first, labeled the *affective function*, is to manage social distance, and by extension interpersonal and intergroup relationships. The second, labeled the *cognitive function*, is to regulate comprehension (Street and Giles, 1982). To date, nearly all research examining the consequences of communication accommodation, even in multilingual contexts, has focused on the affective function of accommodation (for reviews in this context, see for example, Bourhis et al., 2012; Sachdev et al., 2012). In this, researchers have generally assumed that speakers are capable of adjusting their communication as they would like, as a means to achieve their social goals (though for an exception see Simard et al., 1976). However, this assumption does not necessarily hold when language barriers render linguistic convergence difficult to impossible. The goal of this study was to better understand how speakers react, and what factors predict their evaluations of interactions, when those speakers are in situations that necessitate linguistic accommodation for the clear transmission of information (cognitive function), but they are unable to linguistically converge because of a language barrier.

This study was undertaken in a multilingual medical context, where the clear transmission of information is critical to quality care, and the inability to linguistically accommodate one's interlocutor can have serious consequences. Lack of mutual understanding in doctor-patient communication poses very real risks for patient health, as it can lead to misunderstandings

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about both diagnosis and treatment (Epstien et al., 2005; Watson et al., 2012). Doctors' communication skills are also an important component of their professional identity, and are linked to perceptions of their competence as medical professionals (Gasiorek and Van de Poel, 2012). Outcomes of interactions, such as those studied here, may influence the degree to which doctors attempt to accommodate future patients or colleagues (per CAT; see below) they may also have implications for doctors' identities and sense of self-efficacy as medical professionals. For both these reasons, it is important to understand how they manage these conversations, as well as what drives their evaluations of these interactions.

Communication accommodation theory (CAT: Giles and Soliz, 2014) offers a framework from which to understand the process and effects of communication adjustment. According to the theory, speakers adjust their communication according to their interlocutors' communicative characteristics as well as their own pursuit of a positive personal and social identity. Generally, linguistic accommodation with fellow speakers (most frequently taking the form of convergence, or making one's speech more similar to that of one's interlocutor) is evaluated positively (Soliz and Giles, 2014), and speakers that are seen to put more effort into accommodating are evaluated more positively (Giles et al., 1973).

The overwhelming majority of research applying CAT assumes that speakers are capable of adjusting their communication if and when they want to, and focuses on the social predictors and consequences of these adjustments. When interactants do not share a common language, or share only a limited set of words or phrases, one speaker may want to accommodate their language to another, but not have the linguistic knowledge or skills to do so. In such a situation, a speaker's *affective* orientation is ostensibly accommodative/convergent, as he or she wants to facilitate a positive social interaction. However, this may be at odds with that speaker's nonaccommodative/divergent *cognitive* behavior, which consists of maintaining use of his or her own language rather than switching to that of the interlocutor, likely hampering comprehension (due to lack of linguistic skill). Within the framework of CAT, this lack of linguistic adaptation can, arguably, be conceptualized from the listener's perspective as an instance of *underaccommodation*. Underaccommodation is defined as a situation in which a speaker does not adjust his or her communication enough for the needs of a fellow speaker, assuming the target interprets it as such (Gasiorek, 2013; Williams, 1996). Such underaccommodative encounters can be source of frustration and difficulty, and have considerable potential for misunderstanding and/or communication breakdown. To better understand how speakers handle these situations, we posed the following research question:

> **RQ1.** *In a multilingual medical context, what interactional or communicative strategies do speakers use when they want to accommodate to their interlocutor, but are unable to do so linguistically?*

In addition to investigating how speakers navigated these situations, we were also interested in how they evaluated these problematic conversations. Simard et al. (1976) offers a framework suggesting that negative evaluations of non-accommodation should be attenuated when speakers' behavior can be attributed to lack of ability, rather than lack of effort (see also Gasiorek and Giles, 2012). However, this framework does not specify what factors beyond listeners' perceptions might predict evaluations. Additionally, this framework focuses on the listener as the judge; we were also interested in how *speakers* perceived and evaluated these interactions.

Theoretical and empirical work in both communication and language learning provide some suggestions for variables that could affect evaluations. First among these is the perceived social distance between speakers, a variable associated with the affective dimension of accommodation. Not surprisingly, past research has found that we generally evaluate those we perceive as close to us more positively than those we perceive to be more distant (Gasiorek, 2014; Watson and Gallois, 2002). Second, because being unable to achieve one's interactional goals can be a source of negative affect (Palomares, in press), this is likely to be a result of the interactions studied here, and may influence evaluations of conversation. Finally, the locus of the linguistic problem might influence evaluations; it is possible that some types of language-related issues could result in more negative experiences than others. With these issues in mind, we posed a second research question:

> **RQ2.** *To what extent do social distance, negative affect, and the locus of the linguistic problem that speakers experience predict their evaluation of a conversation when they are unable to linguistically accommodate to their interlocutor?*

2. Method

2.1. Participants and procedure

Participants in this study were a volunteer sample of doctors whose work involves use of more than one (non-native) language. They were recruited in 5 area hospitals in Brussels, Belgium, where bilingualism (Dutch-French) in staff is actively promoted by hospital policies, and the patient population requires staff's proficiency in many other, mainly European, languages. In these hospitals, although the professional context ostensibly requires multilingualism, individual doctors' language skills are often lacking. Participants were part of a larger study involving the autonomous language-learning tool Medics on the Move (MoM; see www.comforpro.com), which was designed to address this issue. Those who had agreed on using the online/mobile language application were also invited to participate in follow-up research, which included the questionnaire used for this study. This study focused on doctors whose primary language of communication (as indicated to us) was French, as this was a majority of respondents in these area hospitals.

Participants were sent a link to an online questionnaire via email. The questionnaire asked participants to describe and evaluate a recent professional interaction in a foreign [for the participant] language that they had experienced that "did not go

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