

Diagnosing Illness Across Languages: The Role of Interpreters in Medical Discourse

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Diagnosing illness across languages: The role of interpreters in medical discourse.

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Recent research on medical discourse has focused on the problematic nature of talk between physicians and patients (cf. Freeman 1987, Ong et. al. 1995). Power relations inside the medical institution inform the medical interview, at all levels; the typical social, economic, and educational differences between doctors and patients, as well as their relative positions of authority within the institution, have been shown to influence the diagnosis and recommended treatment of illnesses (Fisher 1995, Hein and Wodak 1987, Waitzkin 1991, *inter alia*). Clinical visits where an interpreter is needed represent an especially problematic area of clinical discourse; in interpreted discourse, the patient and physician must deal with an added 'barrier' to communication, the linguistic barrier. In addition to the potential complications of communication related to the differing goals and expectations of physicians and patients, there is the added difficulty of communicating through an intermediary, who brings his or her own frame of reference, as well as linguistic skills at interpreting, to the interaction.

There has been a recent, significant increase in patients who need interpreters when visiting their physician. According to the 1990 census, there are 14 million people in the United States who have limited or no English proficiency. The co-indexing of non-English language competence with recent immigration, recent immigration with poverty, and poverty with severe illness means that, for the majority of the non-English speaking patient population, the effective delivery of health care is both critical and compromised. The necessary presence of an interpreter makes clinical discourse linguistically (and often socially) complicated for non- or limited English speaking patients (Bendix 1988, Buchwald et. al. 1993, Woloshin et. al. 1995). Many physicians feel that language barriers are not eliminated, but are rather replaced by other (usually lexical) barriers, when interpreters are used (Ebden et. al. 1988, Vasquez and Javier 1991). Hospital based interpreters, on the other hand, see interpreting as an opportunity. They view themselves as potential 'ambassadors', patient advocates as well as linguistic bridges between doctors and patients (Haffner 1992). They argue that the job of the interpreter goes beyond the strict translation of utterances, and that their knowledge of the social realities of immigrants' lives and cultures gives them insights into reported symptoms that are crucial to diagnosing illnesses and treating them appropriately.

This paper looks at the effects of (Spanish-English) interpretation on medical interviews, specifically asking the questions, 'what are the effects of interpretation on clinical discourse?', and 'what is the role that interpreters play within clinical conversations?'. The data were collected at the General Medical Clinic of a large, public, county-run hospital in Northern California between April and October, 1997. All of the data come from tape-recordings and observations of clinic visits where a professional, hospital based Spanish interpreter was used for communication between a Spanish monolingual patient and a Non-Spanish speaking physician. Three major findings are reported: 1) interference in professionally interpreted cross-linguistic conversations comes overwhelmingly at the pragmatic (inferencing), and not the semantic (propositional) level, a fact which is significant for the process of diagnosing illnesses; 2) 'interpreter' is not a role

that is sanctioned inside medical interviews; and 3) the turn-taking mechanisms for interpreted conversations are largely infelicitous when compared to same-language interactions. All of these findings are mutually reinforcing: role confusion (2) leads to interruption of discourse (3), and interruptions (3) lead to pragmatically strange conversations (1). I address these findings in order, then, with the understanding that the progression is apparent, and not causal.

The first finding is that pragmatic interference results in many of the clinical misunderstandings in interpreted discourse. The process of diagnosis, especially in general or internal medicine, is essentially one of the co-construction of the 'story' of an illness (Schechter et. al. 1996). Patients provide physicians with an account of 'what is wrong', either on their own or in response to specific questions, and physicians take the *relevant* facts, throwing away the irrelevant ones, and through this process create a diagnosis (Fisher 1983, Mishler 1984). Gricean maxims of relevancy in the clinic are essential, especially given the time constraints on physicians in a public institution: often they are given no more than 15 minutes of actual consultation time. So if a physician asks, 'How long have you been ill?', and the patient's response is, 'Since my brother moved in with us', there had better be, from the patient's point of view, a logical connection between the illness and the brother moving in, because it is almost certain that the physician will not only assume this connection, but will immortalize it in the chart notes which will follow the patient forever (cf. Cicourel 1981, 1983, Garfinkel 1967, Smith 1996).

When an interpreter is present during the medical interview, the process of diagnosis must happen through the interpreter; this means that, whatever is said by the physician or the patient must be conveyed through the interpreter. Almost without exception, the interpreter's contributions to the conversation are viewed as being equivalent, in both referential meaning and in the inferences that can be drawn from them, to the contributions of the speaker who is being interpreted. This equivalence, however, is only partial, though not because interpreters are incompetent. Rather, there are two reasons why interpreters' utterances are not, nor can they be, perfectly equivalent to those of the speakers whom they are representing. First is that absolute equivalency is impossible to attain for two utterances in two different languages, a fact universally recognized by all students of interpretation (Nicholson 1992). Second, the real-time 'question and answer' pattern that is typical for medical interviews is lost- there is a significant temporal, as well as linguistic, lag between what is said to a physician/patient, and what is eventually conveyed through the interpreter. This lag leads, at times, to the loss of relevance of some utterances, and strange or unintended interpretations of other. Excerpt 1 shows exactly how the act of interpretation causes the relevance of some utterances to be lost:

Excerpt 1: (D = Doctor, I = Interpreter, P = Patient)

- D: Ok, right. And how long has this been going on for?
- I: ¿Y por cuanto tiempo le ha venido sucedir esto?
And for how long has this been happening to you?
- P: Pues, yo traté de decirle al doctor de, de hace mas, cuatro cinco visitas para atras
Well, I tried to tell the doctor, more than, four five visits ago

I: mm-hm.

P: que ya me estaba sucediendo. Pero, que no sé si él me entendía o no.
that it was already happening to me. But, what I don't know is if he understood or not.

I: Pero, hace, hace cuando le comenzó a, a sucedir esto?
But, since, since when did this begin to happen to you?

P: Más o menos como un año, yo creo.
More or less about a year, I think.

I: About a year.

D: Ok. (9 second pause). And it goes away by itself?

Just before the dialogue in this excerpt, the patient has just reported, through the interpreter, that his eyes burn periodically, as if they had 'chili' in them. The physician asks how long the symptoms have been occurring. The interpreter chooses not to interpret a response which is in fact clinically, pragmatically relevant, which is that they have been occurring, *and the patient has been reporting them*, for over a year. Instead, she reiterates the physician's question, 'but how long?', looking for a directly temporal answer, which she takes to be more directly relevant. This is partly an attempt by the interpreter to keep patients 'on track'; interpreted visits take nearly twice as long as uninterpreted visits, and one of the reasons this interpreter is so popular with physicians is because she is extremely fast.

In this case, however, keeping the patient on track results in a mis-assessment of the importance of the symptom. To the physician, a symptom that the patient has had for over a year, but which he only now chooses to report on, is far less serious, and more importantly, far less *credible* than one which the patient has been complaining of continuously for over a year. The physician then asks the patient the question, 'does it go away by itself?', which means, 'is the disease self-limiting, and do I need to treat you for it?', which is a typical question for a symptom that is not considered serious. To the patient, the question implies that the physician does not take the symptom seriously; he could easily repeat, at the next visit, the same lament, that he does not even know if the physician understood him. Remember that the only verbal information that the physician and the patient receive comes from the interpreter herself, and that the responses they receive from her can be, and are necessarily, assumed to be a reasonably complete version of what was said in the other language. The interpreters choices of what to interpret and what not to interpret are essentially invisible; strange or odd statements are almost always attributed to the interpretee (cf. Bendix 1988).

This excerpt is also an example of the second finding, which is the 'role confusion' of interpreters in interpreted discourse. The role of 'interpreter' is not conversationally available for the hospital-based interpreter; by that I mean that the interpreter virtually never injects meta-commentary, either on the process of interpretation or as a participant in the conversation. Even though the interpretation of meaning is by no means an easy task, interpreters will struggle to interpret incoherent and patently strange comments, rather than make themselves 'visible'

within the conversation. On a purely linguistic level, there is no 'neutral' pronoun in English- the interpreter must either report speech, or produce it as her own. Socially, the interpreter is again forced to choose how to ally herself— if both speakers talk at once, she will choose one of them to interpret, effectively silencing the other.

In excerpt 1, we see that interpreter neutrality is difficult on a more conversational level, as well. The interpreter essentially is acting as a surrogate for the doctor in this instance, determining the clinical relevance of facts and interpreting them on the basis of this determination. There is no 'neutral stance'; the interpreter is an informational gatekeeper. One could say that this example is in fact 'lexical interference', because there are words that were simply not interpreted by the interpreter. What is significant about this excerpt for this analysis is that it is the diagnostic process that is being disrupted, *not* the confusion of lexical meanings, and this disruption is a function of the interpreter's conversational role as something more than a neutral conversational 'pivot'.

In excerpt 2, the lack of an appropriate, sanctioned role for an interpreter inside the conversation is even clearer:

Excerpt 2: (D = Doctor, I = Interpreter, P = Patient)

- D: Ok, did you bring your peak flow meter with you? (1.5 second pause).
That meter with the little red dial?
- I: Eh, traje, lo unao, un:, como meter?
Eh, did you bring, the uh, a, like, meter?
- > I-I-don't know what you're talking about (softly).
- D: You have something at home, it looks like THIS.
- I: Ud. tiene [algo en su casa]
You have [something in your home]
- P: [xxxx]
- D: And it has a little:=
- I: =que parece=
=that looks like=
- D: =a [red piece]
- I: [como asi]
[like this]
- D: that goes up and down?
- I: Y tiene: una:, partecita roja que va arriba y abajo.
And it has: a: little red piece, that goes up and down.

One hallmark of a legitimated conversational role is the right to question what has just been said. In this excerpt, the physician asks the patient a question about a device which the interpreter is unable to interpret, because she has no idea what it is. The physician, however, takes the interpreter's comment, 'I don't know what you're talking about', to be coming from the patient, even though the patient has not at this juncture said anything in response to the question. The physician does not even address the interpreter, but rather continues to talk to the patient. What is significant about this excerpt is not only that it brings to the fore the difficult conversational position of the interpreter, but also that this is the only example in all of my data of an interpreter saying, 'I don't know what you mean'.

The final finding, that of turn-taking interference, is more easily demonstrated with a quantitative analysis of the transcribed data. The process of interpretation, if it is simultaneous, necessarily means that the interpreter will be speaking while the person she is interpreting for is speaking, and in a different language. The same is true for consecutive interpretation, except that in these cases the interpreter, in lieu of responding to the last utterance of her interlocutor, will begin talking in a language this interlocutor doesn't understand. Table 1 is an analysis of the patterns of overlaps (speakers speak simultaneously), interruptions (one speaker begins talking before another is finished; the overlapped speaker stops talking before his or her utterance is finished), and latches (one speaker begins talking just as another speakers stops talking, with no silence in between the two utterances) possible within an interpreted conversation:

TABLE 1: Possible patterns of interruption in interpreted discourse.

Speaker on the left overlaps (>), latches (=), or interrupts (#) right-hand speaker				
	Patient	Doctor	Interpreter Spanish	Interpreter English
Patient	*	4	1	3
Doctor	4	*	3	1
Int. Spanish	1	2	*	*
Int. English	2	1	*	*

- 1) Conversational overlaps, interruptions, and latches (same lg.):
 Is >,#,= P, P >,#,= Is
 Ie >,#,= D, D >,#,= Ie
- 2) Interpretation overlapping, latching, or interrupting to interpret (quasi-simultaneous interpretation in progress):
 Ie >,#,= P, Is >,#,= D
- 3) Overlapping over interpretation, interrupting or latching interpretation:
 P >,#,= Ie, D >,#,= Is
- 4) "Blind" overlaps, interruptions, or latches (speaking different languages):
 P >,#,= D, D >,#,= P

Because the interpreter can have conversations with the patient in Spanish, and with the physician in English, we can say that, in a sense, there are 3 participants in the conversation, but 4 participant roles: the patient, the doctor, the interpreter when she is speaking in Spanish, and the interpreter when she is speaking in English. Within the conversation, then, patterns of turn-taking can be classified as they in Table 1: the types of interference are interruptions, overlaps, and latches. Interruptions are the most intrusive and potentially disruptive, as they take the floor from a speaker in the middle of his or her utterance, as judged by syntactic and intonational cues. The relevant categories are turn taking mechanisms within the same language (type 1), and turn taking mechanisms across languages (types 2-4). Type 2 is the interpreter interrupting, overlapping, or latching on to a speaker's turn, in another language: this is, in effect, simultaneous, or quasi-simultaneous interpretation. Type 3 is the reverse: the patient or the physician interrupting the interpreter while she is talking in another language. Type 4 is the most potentially disruptive type of interference, between the patient in Spanish and the physician in English, because neither participant knows what the other is saying, and consequently has no idea what he or she is overlapping or interrupting.

An analysis of this type could be performed on an interaction, tallying all of the different possible overlaps, latches, and interruptions. Table 2 shows the results of tallying up the analyses of five different, professionally interpreted conversations. The left-hand speaker in each column heading (P, D, Is, or Ie, representing the Patient, the Doctor, the Interpreter speaking in Spanish, or the interpreter speaking in English) is counted as interfering with the speaker on the right. Thus, the first column tallies the number of times, in five visits, the patient overlaps, latches or interrupts the interpreter while the interpreter is speaking in Spanish; the second column represents the number of times the Interpreter, speaking in Spanish, overlaps, latches or interrupts the patient (who speaks exclusively in Spanish); the third column represents the number of times the physician interferes with the interpreter while he or she is speaking in English; etc.

TABLE 2

Total interruptions (#), overlaps (>), and latches (=), for all visits:									
P - Is (1)	Is - P (1)	D - Ie (1)	Ie - D (1)	Ie - P (2)	Is - D (2)	P - Ie (3)	D - Is (3)	P - D (4)	D - P (4)
Visit 6:									
# 9	# 2	# 1	# 0	# 3	# 2	# 3	# 1	# 1	# 1
> 5	> 2	> 3	> 0	> 11	> 1	> 2	> 0	> 2	> 1
= 1	= 0	= 0	= 0	= 0	= 1	= 0	= 1	= 0	= 0
15	4	4	0	14	4	5	2	3	2
Visit 28:									
# 13	# 5	# 6	# 0	# 13	# 0	# 5	# 0	# 1	# 7
> 6	> 2	> 0	> 3	> 24	> 1	> 18	> 4	> 5	> 4
= 3	= 2	= 0	= 0	= 3	= 1	= 0	= 1	= 0	= 1
22	9	6	3	40	2	23	5	6	12
Visit 48:									
# 5	# 6	# 10	# 6	# 12	# 2	# 4	# 2	# 1	# 1
> 1	> 1	> 4	> 1	> 3	> 2	> 7	> 1	> 0	> 0
= 3	= 0	= 1	= 1	= 1	= 0	= 0	= 1	= 0	= 0
9	7	15	8	16	4	11	4	1	1
Visit 49:									
# 0	# 2	# 0	# 0	# 7	# 2	# 2	# 4	# 0	# 0
> 6	> 7	> 2	> 2	> 4	> 11	> 2	> 4	> 1	> 0
= 5	= 2	= 4	= 2	= 5	= 6	= 0	= 2	= 0	= 1
11	11	6	4	16	19	4	10	1	1
Visit 50:									
# 13	# 9	# 2	# 2	# 27	# 10	# 19	# 3	# 4	# 3
> 7	> 2	> 1	> 1	> 5	> 5	> 6	> 2	> 2	> 0
= 5	= 0	= 0	= 0	= 5	= 7	= 2	= 0	= 1	= 1
25	11	3	3	37	22	27	5	7	4
TOTALS									
# 40	# 24	# 19	# 8	# 62	# 16	# 33	# 10	# 7	# 12
> 25	> 14	> 10	> 7	> 47	> 20	> 35	> 11	> 10	> 5
= 17	= 4	= 5	= 3	= 14	= 15	= 2	= 5	= 1	= 3
82	42	34	18	123	51	70	26	18	20

In the five conversations analyzed so far, interpreters are interrupting patients to interpret far more often than they are interrupting physicians. Patients, on the other hand, are interrupting interpreters during Spanish conversations, and to talk over the act of interpretation. In the one case where a physician was interrupted more than the patient in an interview (Conversation 49), we see that in fact the interruptions were mostly overlaps; the patient is still more frequently interrupted than the physician. Far from being patient advocates, interpreters are being patient interrupters. Appendix A (Table 3) shows the same data, represented in bar graph form.

What we learn from this is that, as a discourse process, medical interpreting is immensely complex. The interpretation of pragmatic as well as semantic content requires a delicate balance between roles of advocacy and fidelity, or between creative and literal interpretation. There are numerous constraints on the ways in which this process is carried out; time constraints in the clinic, a shortage of interpreters, and a misunderstanding of the process of interpretation by those who use interpreters, all seem to add to the difficulties in medical interpreting. Before recommendations can be made regarding the use of interpreters in clinical settings, the interplay between the process of diagnosis and the process of interpretation will first need to be explored more fully; the findings presented here are only intended as a rough guide to what approach such an exploration might take.

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Appendix A (Table 3): Total interruptions, overlaps, and latches for 5 conversations

