Using Non-Professional Interpreters in a Multiethnic Primary Care Clinic

Cecilia Fredericks
University of Malaya
Malaysia
frederix@tm.net.my

Abstract

In multiethnic countries such as Malaysia more than six different languages are spoken by patients in publicly-funded clinics. Sometimes doctors are unable to speak the patient's language and there are no professional interpreters. Research on doctor-patient communication has rarely included the language variable and its impact on information exchange and patient outcome in consultations where the doctor does not speak the patient's language. The few studies carried out in linguistically plural societies show that doctors and patients can face language barriers and trained interpreters are not always available. This paper illustrates some of the problems of using untrained interpreters in a primary care setting. Consultations were audio-taped and the transcripts were used to show how messages underwent distortion, condensation, and omission in interpreter-mediated consultations. Research needs to be carried out based on a model of doctor-patient communication which reflects the realities of the multilingual consultation.

Introduction

Patients attending Malaysian government-funded clinics come from diverse ethnic backgrounds and possess varying levels of proficiency in the languages spoken in the country. Some patients are monolingual and may not be able to speak the main languages used by clinicians which are Malay and English. There are no professional interpreters and doctors who cannot speak the patient's language have to rely on patients' friends or relatives, nurses or anyone around. Two studies carried out to investigate doctor-patient communication and cognitive outcome were conducted in 1993 and 1995 in the Department of Primary Care General Clinic in the University of Malaya Teaching Hospital. The purpose of this paper is to describe some of the problems of using non-professional interpreters drawing on data collected in these two studies. First, the background, methodology and results of the two studies will be briefly presented to show the relationship between the communication of information and patient cognitive outcome. The scope will then narrow to describing how information is transmitted in consultations through interpreters using the transcripts of audio-taped consultations.

Prior Research

It is now widely recognized that doctor-patient communication is a core component of clinical work with consequences for the diagnosis and treatment of illness (Mishler:1984, Ong et al:1995:903) and this is reflected in the literature on doctor-patient communication. However, not much empirical research focusing on the role of language and the difficulties experienced by doctors and patients in communicating with one another in multilingual societies has been done. Specifically, few systematic studies have been carried out which look at how information is communicated without trained interpreters where patient and doctor do not speak a common language.

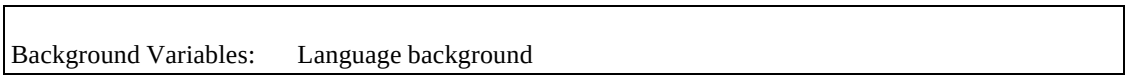
This dearth exists despite the fact that the ethnic compositions of countries such as Australia, Canada, and the United States have undergone dramatic changes as a result of immigration. For example, more than one-quarter of Australia's population in 1989 was overseas-born (Eisenbruch 1989), and Southeast Asian refugees alone contributed over one million immigrants settling in the U.S. in 1990 (Buchwald et al 1992:507). In these English-speaking countries, significant numbers from the immigrant groups do not come from English-speaking backgrounds.

Effective communication in the consultation enables adequate and accurate history-taking and contributes to reduced patient anxiety, increased patient satisfaction and compliance (Waitzkin & Stoekle 1972:183 , Pendleton & Bochner 1980, Simpson et al 1991), while miscommunication of medical information and communication gaps can adversely affect patient care. Quesada (1976) discussed communication barriers experienced by the Mexican-American patient population in five southwestern states of the United States and their adverse effects on access to medical care, compliance and follow-up. Health professionals interviewed in Pauwels' Melbourne study identified the communication barrier caused by the absence of a shared language as a major obstacle to adequate and effective health care delivery (Pauwels 1990:100). Haffner, working as an interpreter and translator at the Stanford University Medical Centre documents his observation of children being pressed into service as interpreters, and in one case how a patient returned to the hospital very ill after her granddaughter wrongly interpreted the prescribed medication regime (Haffner 1992). An example of miscommunication is provided in the transcript of a tape-recorded face-to-face encounter in English between a NESB (non-English speaking background) patient and a clinician in a Melbourne hospital (Worley et al 1990:24). Finally, Launer's study of medical history-taking through medical orderlies acting as interpreters in a Nigerian outpatient clinic provides some examples of gross miscommunication (Launer 1978).

It might be argued that if language is an important factor in effective doctor-patient communication, why has it not been included in most studies? Where the variable of language in relation to communication difficulty is mentioned (Shuy 1976), it is usually in the intralingual context, for example, that of dialect miscommunications (Milroy 1984 in Giles & Coupland 1991:192). One reason could be a bias in the conduct of research which excludes minority patient populations not out of principled choice but for reasons of convenience, or because their problems do not seem to warrant attention. Thus, although cultural and linguistic diversity is a characteristic of most industrialized countries as a result of migration caused by war, political upheavals, repression or economic hardship, ethnic minorities and their problems continue to be marginalized. Hospitals, like law courts, are among society's most powerful institutions, exerting immense influence over the lives of disadvantaged minorities who are unable to participate fully because of the language barrier.

A theoretical model (adapted from Ong et al:1995, Pendleton & Hasler:1983) of doctor-patient communication in linguistically plural societies which reflects the realities of doctors communicating with patients in the absence of a shared language is proposed in Figure 1:

Figure 1



	Sociocultural background
	Cognitive and value orientation
	Disease characteristics
Communication in the consultation	Language/s spoken
	Communicative behaviours
	Instrumental vs affective behaviours
Patient Outcomes:	Satisfaction
	Compliance
	Cognitive outcome

Background of Study

The data for this paper is taken from two studies on doctor-patient communication and its relationship to patient cognitive outcome conducted in 1993 and 1995 in the University of Malaya's Department of Primary Care General Clinic which is located in Malaysia's capital city of Kuala Lumpur. Patients come from a variety of ethnic and socioeconomic backgrounds and most of them live in the city and its surrounding suburbs. The hospital is funded by the government, and nominal fees are charged for consultation, treatment and medication. The clinic was attended by approximately 600 patients a week in 1993 but by 1997 the number had risen to 1,200.

In the DPC General Clinic, the main languages used by clinicians are Malay and English whilst those spoken by patients include Tamil, Cantonese, Mandarin and Hokkien in addition to the languages of migrant workers from Bangaladesh and the Philippines. Doctors often have to communicate with patients whose language they do not speak. In consultations, language can be a barrier to effective information seeking and exchange between patients and their doctors. Although doctors exercise their prerogative in the choice of language at the start of the consultation, patients often lack proficiency in Malay or English and as a result other languages have to be used, sometimes involving interpreters.

Method

The samples for the studies were made up of every tenth first-visit patient attending the DPC General Clinic. Less than 2% of patients refused to participate and only one doctor refused to continue participation in the 1995 study. Patients were administered questionnaires / interviewed before the consultation to collect data on their sociodemographic, educational and language background . Each doctor-patient pair were were also given check-lists immediately after the consultation to measure patient cognitive outcome. The consultations were audio-taped. Signed consent was obtained from patients for the audio-recordings.

The check-list responses of each doctor-patient pair were compared and the audio-tapes transcribed. For the purposes of this paper, some of the transcripts will be analysed for the occurrence of significant deviations by interpreters and the impact they had on discourse and information exchange.

Results

The language backgrounds of patients and doctors and the languages used in consultations is displayed below:

Table 1
LANGUAGE BACKGROUNDS OF PATIENTS AND DOCTORS
AND LANGUAGES USED DURING CONSULTATION

	Language Dr most proficient in	Language spoken by patient at home	Language used during Consultation
	%	%	%
Malay	63	43	70
Tamil	20	24	5
Cantonese	0	11	0
English	17	2	25
Other Ls*	0	20	0

* These include the dialects and languages spoken by the various ethnic groups in Malaysia as well as the language of non-nationals

The language backgrounds of doctors and patients as well as the language used during each consultation were used to classify consultations as language-concordant (where the doctor and patient shared a common language background) or language-discordant (where the doctor and patient did not share a common language background). In the 1993 study, 77.4% (24/31) were language-discordant and in the 1995 study 69.8% (44/63). In most consultations therefore doctor and patient did not share a common language background.

To measure patient cognitive outcome, comparisons were made of responses in doctor-patient check-lists. The findings indicated that approximately a quarter of the patients failed in the recall of information on diagnosis and medication and more than half could not recall the doctor's advice. Recall was associated with how well patients and doctors communicated with one another. Communicative effectiveness was positively associated with the ability of doctors to speak their patients' language and with higher patient educational levels.

Communicating in the Absence of a Shared Language

The findings indicated that a significant number of patients left the consultation with inadeaquate knowledge pertaining to their illness and treatment. As one of the key variables which function as input to communication in the consultation, language was shown to influence communicative effectiveness which in turn affected patient cognitive outcome.

As Table 1 shows, Malay and English were the main languages used during consultations but they were the home languages of less than half the patients. In most consultations doctors and patients had to communicate with each other in a language which they were not proficient in. Although clinicians attempt to tackle the language problem by trying to match the ethnicity of patient to doctor whenever possible, this is not always possible given institutional constraints and the repertoire of languages spoken by doctors.

Friends or relatives of patients, nurses, attendants or anyone around acted as interpreters in approximately 16%-20% of all consultations. More often, doctors and patients used various strategies such as stock phrases, sign-language and code-switching to exchange meaning when faced with the language barrier.

Interpreters often lacked proficiency in the patient's or the doctor's language as well as familiarity with medical terminology. In some consultations, more than one interpreter was involved e.g. where the patient's relative or friend could speak neither English nor Malay. Word-for-word interpretations of what was said were rare. Launer's method of categorising interpretations as `legitimate' or `illegitimate' will be used (Launer 1978). Extracts of transcripts are used below to illustrate (a) legitimate deviations and (b) illegitimate deviations in single- and multiple-interpreter consultations.

(a) Legitimate Deviations

Single-Interpreter Bilingual Consultations

Data 1

Note: The transcript notation system used is a simplified version of Schenkein's (Schenkein 1978:xi-xvi). Overlapping utterances are marked with a single left-hand bracket at the point when overlapping begins. Single parenthesis which are empty indicate that no hearing could be achieved. Intervals are timed in seconds and inserted in parentheses.

/ / indicates talk in Cantonese
{ } nurse's interpretation
B indicates talk in English

Dr	**She can lose weight a little bit also because I think she can be a little overweight.**
Interpr	{ /Yee san gew nay gam sik. Um moy um moy sik gum daw/ }
	THE DOCTOR ASKS YOU TO REDUCE YOUR FOOD INTAKE. NOT TO NOT TO EAT SO MUCH

(b) Illegitimate Deviations

Single-Interpreter Multilingual Consultations

Data 2

< > indicates talk in Malay
[ ] indicates talk in Indonesian
{ } nurse's interpretation
B indicates talk in English

Pt	[Saya tak bisa tidur] *I CAN'T SLEEP*
Dr	**Can you speak English?**
Pt	ah
Dr	**Cannot?**
Nurse	**Cannotlah**
Dr	<Sekit sekit?> *A LITTLE?*
Pt	(3) ( )
Dr	<Boleh?> *CAN?*
Pt	[Boleh tapi tak berapa ( )] *CAN BUT NOT SO* ( )

Dr	**OK tell me what is your problem**	
Pt	[Ah ini, saya tak bisa (1) tidurlah]	*AH THIS, I CAN'T SLEEP*
Dr	**You're listening?**	
Nurse	**Yes**	
Pt	[Saya tak bisa tidur ( ) lepas itu yang saya rasakan disini seperti ditesuk-tesuk jarum. Lepas itu sampai disini (1) lepas itu sampai sebelah ini lah, belakang ini. Lepas itu dia lari sampai keleherlah, keleher.]	
	I CAN'T SLEEP ( ) THEN I FEEL HERE LIKE NEEDLES PRICKING. THEN UNTIL HERE (1) THEN UNTIL THIS SIDE,AT THE BACK HERE. THEN IT GOES TO THE NECK, THE NECK.	
Nurse	{She complain head pain, and then, and then, feel like needle prick. And then feel like wah the eye want to come out and feel here}	

The patient's first utterance was probably not understood by the doctor. The four ensuing exchanges were solely directed towards finding a mutually-intelligible language in which patient and doctor could exchange information following which the nurse was assigned the role of interpreter.

Her complaint of not being able to sleep `[Saya tak bisa tidur]' uttered three times was not translated for the doctor. In fact, neither the nurse who was not very proficient in English nor the doctor appeared to understand fully what the patient was saying in Indonesian. Although Malay and Indonesian are similar, some words differ in meaning. For example, `[bisa]' means `venom' in Malay. The patient's verbal account of insomnia, the sensation of needle pricks and its spread up to the neck was interpreted for the doctor as head pain, needle pricks and a feeling that her eye was `coming out'.

It was obvious from listening to the audiotapes that the utterances were accompanied by nonverbal language. Nevertheless, much of what the patient said was not interpreted correctly for the doctor; on the other hand some things imputed to have been said by the patient were in fact never uttered. The tendency to distort what is said by the patient and to omit important medical information was noted by Launer in his study of Hausa-speaking interpreters (Launer 1978):

Data 3

Pt	It's my ear, that's hurting me. It's blocked and I can't hear with it. The head and neck are hurting and I've got a fever.
Interpr	She says she's suffering from ear pain and headache.

In the following excerpted transcript below, the 51-year old diabetic patient was proficient only in Hokkien. Her husband was proficient in Mandarin but since the doctor, an Indian, spoke neither language, a student was asked to interpret for the patient's husband (Pt's H). The student was not very proficient in English.

Multiple-Interpreter Multilingual Consultations

Data 4

< >	indicates talk in Mandarin
[ ]	indicates talk in Hokkien Spoken by Patient & Pt's Husband
/ /	indicates talk in Cantonese Spoken by Interpreter

{ } interpretation by student / Patient's Husband
B indicates talk in English

Pt's H <Ta shua ta de erdua guagua jiao `piu piu piu'> SHE SAID SHE *ALWAYS HEARS A NOISE LIKE `PIU PIU PIU' INSIDE IN HER EAR*

Interpr **Doctor, this aunty says she always heard a sound, heard the sound**

Dr **Yes**

Interpr **And its non-stop, the sound**

Dr **A ringing sound, is it?**

Interpr **Ah, yes, ringing sound**

Pt's H <Hui paolaipaoqu de shengyin, youshi nali, youshi zheli> *THE SOUND CAN MOVE HERE AND THERE, SOMETIMES THERE, SOMETIMES HERE*

Pt <Shi zhi you, shi zhi li > *IT'S PRESENT HERE, IT'S HERE*

Pt's H <Ah, shi zhi you, shi (zhi li> *YES, IT'S PRESENT HERE, IT'S HERE* (

Interpr (**and the sound always move, some is in the head, some is in the body, and it runs, the sound**

(5)

Dr **Always or sometimes?**

Interpr <Shi chang shi zhe yang?> {Always or sometimes?}

Pt's H <Shi chang you, xian zai bu zhi (dao, wen a hao

Interpr (**always**

Pt's H le (ma *ALWAYS, NOW I DON'T KNOW. ASK HER IF ITS* (*GONE*

Pt ([Sum bu hao, sum hao `piu piu'] *SOMETIMES ITS GONE, SOMETIMES THERE THE `PIU PIU' SOUND*

Interpr **Some some sometimes, sometimes**

Pt's H <Shi chang, shi chang ta xihuan yaojian jiu jiao> *ALWAYS, ALWAYS WHEN IT LIKES IT COMES*

Dr **One ear or both ears?**

Interpr <You yi ge erduo ting dao haishi liang ge erduo ting dao?> {One ear or both ears?}

Pt <Yi ge, (yi ge > *ONE EAR, ONE EAR*

Interpr (<Yi ge erduo ba le? Na yi ge erduo?> *JUST ONE EAR? WHICH EAR?*

(1)

Er one ear only

Dr **Which ear?**

Pt's H [Ji koh zhe ge er tia ou] *CAN YOU HEAR WITH THIS?*

Pt [Zhe goh tia ou] *CAN HEAR WITH THIS*

Pt's H Ha?

Pt [Ji ge tia ou, tia ou] *I CAN HEAR WITH THIS, I CAN*

Pt's H < Zhi bianlah, zhi bian > *THIS SIDE, THIS SIDE*

Dr **How long has she been having this?**

Interpr / Yow gay nou ze? / <You ji jiu liao ting dao?> *FOR HOW LONG? HOW LONG HAS THE SOUND BEEN THERE?*

Pt's H <San nian, san nian duo le> *THREE YEARS, MORE THAN*

	THREE YEARS
Pt	<San nian> *THREE YEARS*
Pt's H	< San nian > *THREE YEARS*
Interpr	**Three years**

The doctor's questions regarding the description, frequency, location and duration of the patient's ear problem were uttered in a complex multi-speaker simultaneous-talk conversation involving no less than 25 speaker turns. Of the doctor's five questions embedded in the 25 turns, only three were interpreted verbally:

Dr.Question 1:	**A ringing sound, is it?**
	(not interpreted for patient)
Interpreter	**Ah, yes, ringing sound**
Dr.Question 2:	**Always or sometimes?**
	(after 2 intervening turns)
Interpreter	**Always**
	(after another 2 intervening turns)
Interpreter	**SOME SOME SOMETIMES, SOMETIMES**
Dr.Question 3:	**One ear or both ears?**
	(after 3 intervening turns)
Interpreter	**Er one ear only**
Dr.Question 4:	**Which ear?**
	(no interpretation is given)
Dr.Question 5:	**How long has she been having this*?***
	(after 4 intervening turns)
Interpreter	**Three years.**

A closer examination of the tapescript focusing on the doctor's questions reveals further omissions and distortions in the interpretations dealing with description and frequency of the complaint. The nature of the sound was described as `piu piu piu' but the interpreter accepted the doctor's suggestion that it was a `ringing sound' without checking with the patient / patient's husband. As for frequency, after saying that the ringing sound occured `always', the interpreter added on that the sound was `non-stop'

Moreover, the interpreter failed to alert the doctor to the ambivalant answers of the patient's husband regarding the frequency of the sound, as he vacillated from *`ALWAYS ..' to `SOMETIMES ..'* and finally to *`ALWAYS, ALWAYS ..'*.

Instead of providing the doctor with the interpretation of the patient's answer that one ear was affected, she then took it upon herself after checking to initate a question on a new topic `*WHICH EAR*?' within the same turn. This was done without the knowledge of the doctor, outpacing the doctor by a turn.

Next, following the doctor's question *`WHICH EAR?'* which was neither interpreted nor answered as a separate question, the patient's husband took it upon himself to ask his wife which ear she could hear with thus triggering a change of topic.

Discussion

The Discourse of History-taking

Interactive discourse is characterized by basic norms such as temporal and sequential constraints (Frankel 1984) and these are violated repeatedly in Data 4. The interpreter has to cope with the pressure of processing what is being said to her by several speakers as well as provide interpretations. Questions, answers and interpretations on different topics do not appear in a linear manner. The speakers addressed their interlocutors in different languages, sometimes interrupting one another. For example, in the above excerpt the interpreter interrupted the patient's husband twice.

History-taking is characterized by simultaneous talk and interruptions. Shifts in topic occur sometimes without the doctor's knowledge. As a result, the coherence of the discourse and the accuracy and completeness of information the doctor is attempting to gather is compromised. Even where only one interpreter is involved, medical information can be lost through the interpreter summarizing the patient's answers as in the following excerpted transcript from Launer's 1978 study:

Data 5

Interpr	Do you pass water normally?
Pt	Yes, I pass water normally
Interpr	Is there any pain?
Pt	No, there is no pain.
Interpr	Is there blood in the urine?
Pt	No, there is no blood.
Interpr	His urine's normal

As in Data 4 the doctor is left on the periphery of the discourse while the interpreter took it upon himself to initiate questioning the patient and to decide what warrants mention. Apart from initiating questions and changing topics, non-professional interpreters have been observed to reprimand patients (Launer 1978, Fredericks 1997).

Notwithstanding the simultaneous talk, interruptions, and the many turns intervening between his own utterances and those of the other parties, the doctor has to impose a logic, coherence and cohesion on what is uttered even where it may not exist, and steer discourse towards his own information-seeking objectives.

The control of discourse, decision-making and information-sharing no longer remains the sole prerogative of doctors as interpreters in fact possess the licence to interrupt, initiate questions, change topics as well as reprimand patients. There appears to be an assumption of some implicit delegation of responsibility by the doctor for the patient as interpreters freely manipulate and process vital information. (Diaz-Duque 1989, Launer 1978).

The doctor's objective to gather information verbally on the signs and symptoms of the patient's illness is subject to the vagaries of the interpreter's performance. Forced to depend on the interpreter, he may be unaware of distortions, omissions, condensation of messages and of

interpreter-invented fabrications. On the other hand, interpreters may deliberately withhold information gathered from the patient. For example, the medical orderlies in Launer's study who were interpreting `would occasionally irritate the doctor (later) in the consultation by revealing that he knew the answers to a dozen questions which he had asked but not translated.' (Launer 1978:935).

The presence of a third party in what is a ritually-governed dyadic interaction characterized by confidentiality can also militate against the doctor's aim to foster a close relationship with the patient. A patient's natural reluctance to verbalize psychosocial problems or to reveal information on private or sensitive matters such as that pertaining to reproduction (Haffner 1992) is further reinforced by the communication barrier caused by the absence of a shared language.

It was mentioned earlier that apart from using interpreters, clinicians and patients used various strategies when faced with the language barrier such as sign-language, stock phrases, or code-switching. Data 4 provides some examples of code-switching. Codeswitching is defined as the use of more than one language in the course of a single communicative episode (Heller 1988). Where the language used could not serve the speaker's communicative needs or when it is clear the message is not understood, interlocutors switched languages to overcome the difficulty. This occurred between as well as within speaker turns. For example, the interpreter switched from Cantonese to Mandarin in repeating the question {FOR HOW LONG/ HOW LONG HAS THE SOUND BEEN THERE?} to the patient's husband.

Communication and Consultation Outcome

The above illustrates some of the more obvious problems in non-professional interpreting. Sometimes interpreters lacked proficiency in English as well as the patient's language. Although language is one of the four main input variables to communication in the consultation (Fig. 1), it plays a pivotal role in diagnosis, treatment and patient outcomes.

The data was used to illustrate how the normal pace of verbal interaction can be disrupted and the contents of utterances distorted through the intervention of non-professional interpreters. As a result, messages were only partially understood or sometimes miscommunicated. Neither doctor nor patient may be aware of the distortions and omissions.

The language barrier may affect a patient's desire to ask questions or talk to the doctor about his problems and concerns. He may not receive information on his illness nor the medication and advice given by the doctor.

Conclusions

It was mentioned earlier that not much research has been done looking at the variable of language in the medical consultation and at the discourse of interpreter-mediated consultations. The problem of doctors not being able to speak the patient's language will remain in multiethnic societies like Malaysia. In countries such as Canada, the United States and Australia which have large immigration populations, doctors will also find that they are sometimes unable to communicate verbally with their immigrant patients.

This paper has highlighted some of the common problems in using non-professional interpreters in a primary care setting which does not have interpreter services. This situation is not unique nor uncommon. For example, Rader (1988) reported that where other forms of `interpreter' services were lacking for dealing with patients, nurses and physicians were tied up doing 50% of the interpretations in a Californian Medical Center.

Providing professional interpreter services is not always an attainable goal given limited resources and the variety of languages spoken in some patient populations. On the other hand, as an input variable to the consultation language plays an important role in the process of doctor-patient communication which in turn will have an effect on patient outcomes. There is a need to study the relationship between language and patient outcome where doctor and patient are unable to communicate in a common language. This should be done within a model of Doctor-Patient communication which takes into account the variable of language.

References

Buchwald, D., Panwala, S. and Hooton, T.M. 1992."Use Of Traditional Health Practices By Southeast Asian Refugees In A Primary Care Clinic", *The Western Journal of Medicine*, (156):507-511.

Diaz-Duque, O.F. 1989 "Communication Barriers in Medical Settings: Hispanics In the United States' Int'l J. Soc. Lang, (79): 93-102

Eisenbruch, M. 1989. "Medical Education For A Multicultural Society" *The Medical Journal of Australia*, Nov 20 (151):574-580.

Frankel R.M. 1984 "From Sentence to Sequence: understanding the Medical Encounter Through Microinteractional Analysis", *Discourse Processes* (7):135-170.

Fredericks, C. 1997 "Doctor-Patient Communication and Cognitive Outcome: An

Empirical Study", PhD Thesis, University of Malaya.

Giles, H. & Coupland, N. 1991. *Language: Contexts And Consequences*, Open University Press.

Haffner, L. 1992. "Cross-Cultural Medicine A Decade Later" *Western Journal of Medicine*, Sept No.3, 157:255-259.

Heller, M. (ed) 1988. *Codeswitching*. Mouton de Gruyter, Berlin.

Launer, J. 1978. "Taking Medical Histories Through Interpreters", *British Medical Journal*, (30):934-935.

Mishler, E.G. 1984. *The Discourse Of Medicine: Dialectics Of Medical Interviews*, Ablex Publishing Corpn, Norwood.

Ong L.M.L., de Haes J.C.J.M., Hoos A.M. and Lammes F.B. 1995 "Doctor-Patient Communication: A Review of the Literature". *Social Science & Medicine*, Vol. 40, (7):903-918

Pauwels, A. 1990. "Health Professionals' Perceptions Of Communication Difficulties in Cross-Cultural Contexts" *ARAL Series S*, No.7:93-111.

Pendleton, D. and Bochner, S. 1980. "The Communication of Medical Information In General Practice Consultations as a Function Of Patients' Social Class". *Social Science & Medicine*, Vol.14A:669-673.

Pendleton, D. 1983. "Doctor-Patient Communication. A Review" in Pendleton & Hasler (eds.) *Doctor-Patient Communication*, London: Acadermic press.

Quesada, G.M.. 1976. "Language and Communication Barriers For Health Delivery To A Minority Group", *Social Science & Medicine*, 10:323-357.

Rader, G.S. 1988. "Management Decisions: Do We Really Need Interpreters?" *Nursing Management* (19):46-48.

Schenkein, J. (ed.) 1978. *Studies In The Organization Of Conversational Interaction*, Academic Press, New York.

Shuy, R.W. 1976. "The Medical Interview: Problems In Communication", *Primary Care*, (3):365-385.

Worley, L. and Elder, C. 1990. "*Miscommunication In The Medical Encounter: A Function Of Language Or Social Roles?"* Melbourne Papers in Applied Linguistics, (2) No.1.

Waitzkin, H. and Stoekle, J.D. 1972. "*The Communication Of Information about Illness'* Adv.Psychosom.Med., (8):180-215.

Table 1

LANGUAGE BACKGROUNDS OF PATIENTS AND DOCTORS AND LANGUAGES USED DURING CONSULTATION

	Language Dr most proficient in	Language spoken by patient at home	Language used during Consultation
	%	%	%
Malay	**63**	**43**	**70**
Tamil	**20**	**24**	**5**
Cantonese	**0**	**11**	**0**
English	**17**	**2**	**25**
Other Ls*	**0**	**20**	**0**

* These include the dialects and languages spoken by the various ethnic groups in Malaysia as well as the language of non-nationals

(a) Legitimate Deviations

Single-Interpreter Bilingual Consultations

Data 1

/ / indicates talk in Cantonese
{ } nurse's interpretation
B indicates talk in English

Dr **She can lose weight a little bit also because I think she can be a little overweight.**

Interpr { /Yee san gew nay gam sik. Um moy um moy sik gum daw/ }
THE DOCTOR ASKS YOU TO REDUCE YOUR FOOD INTAKE.
NOT TO NOT TO EAT SO MUCH

(b) Illegitimate Deviations

Single-Interpreter Multilingual Consultations

Data 2

< > indicates talk in Malay
[ ] indicates talk in Indonesian
B indicates talk in English

Pt	[Saya tak bisa tidur] *I CAN'T SLEEP*
Dr	**Can you speak English?**
Pt	ah
Dr	**Cannot?**
Nurse	**Cannotlah**
Dr	<Sekit sekit?> *A LITTLE?*
Pt	(3) ( )
Dr	<Boleh?> *CAN?*
Pt	[Boleh tapi tak berapa ( )] *CAN BUT NOT SO* ( )
Dr	**OK tell me what is your problem**
Pt	[Ah ini, saya tak bisa (1) tidurlah] *AH THIS, I CAN'T SLEEP*
Dr	**You're listening?**
Nurse	**Yes**
Pt	[Saya tak bisa tidur ( ) lepas itu yang saya rasakan disini seperti ditesuk-tesuk jarum. Lepas itu sampai disini (1) lepas itu sampai sebelah ini lah, belakang ini. Lepas itu dia lari sampai keleherlah, keleher.] *I CAN'T SLEEP ( ) THEN I FEEL HERE LIKE NEEDLES PRICKING. THEN UNTIL HERE (1) THEN UNTIL THIS SIDE,AT THE BACK HERE. THEN IT GOES TO THE NECK, THE NECK.*
Nurse	**{She complain head pain, and then, and then, feel like needle prick. And then feel like wah the eye want to come out and feel here}**

Data 3

Pt	It's my ear, that's hurting me. It's blocked and I can't hear with it. The head and neck are hurting and I've got a fever.

Interpr She says she's suffering from ear pain and headache.

Launer 1978

Data 4

< >	indicates talk in Mandarin
[ ]	indicates talk in Hokkien Spoken by Patient & Pt's Husband
/ /	indicates talk in Cantonese Spoken by Interpreter
{ }	interpretation by student / Patient's Husband
B	indicates talk in English

Pt's H <Ta shua ta de erdua guagua jiao `piu piu piu'> SHE SAID SHE *ALWAYS HEARS A NOISE LIKE `PIU PIU PIU' INSIDE IN HER EAR*

Interpr **Doctor, this aunty says she always heard a sound, heard the sound**

Dr **Yes**

Interpr **And its non-stop, the sound**

Dr **A ringing sound, is it?**

Interpr **Ah, yes, ringing sound**

Pt's H <Hui paolaipaoqu de shengyin, youshi nali, youshi zheli> *THE SOUND CAN MOVE HERE AND THERE, SOMETIMES THERE, SOMETIMES HERE*

Pt <Shi zhi you, shi zhi li > *IT'S PRESENT HERE, IT'S HERE*

Pt's H <Ah, shi zhi you, shi (zhi li> *YES, IT'S PRESENT HERE, IT'S HERE* (

Interpr (**and the sound always move, some is in the head, some is in the body, and it runs, the sound**

(5)

Dr **Always or sometimes?**

Interpr <Shi chang shi zhe yang?> {Always or sometimes?}

Pt's H <Shi chang you, xian zai bu zhi (dao, wen a hao

Interpr (**always**

Pt's H le (ma *ALWAYS, NOW I DON'T KNOW. ASK HER IF ITS* (*GONE*

Pt ([Sum bu hao, sum hao `piu piu'] *SOMETIMES ITS GONE, SOMETIMES THERE THE `PIU PIU' SOUND*

Interpr **Some some sometimes, sometimes**

Pt's H <Shi chang, shi chang ta xihuan yaojian jiu jiao> *ALWAYS, ALWAYS WHEN IT LIKES IT COMES*

Dr **One ear or both ears?**

Interpr <You yi ge erduo ting dao haishi liang ge erduo ting dao?> {One ear or both ears?}

Pt <Yi ge, (yi ge > *ONE EAR, ONE EAR*

Interpr (<Yi ge erduo ba le? Na yi ge erduo?> *JUST ONE EAR? WHICH EAR?*

(1)

Er one ear only

Dr **Which ear?**

Pt's H [Ji koh zhe ge er tia ou] *CAN YOU HEAR WITH THIS?*

Pt [Zhe goh tia ou] *CAN HEAR WITH THIS*

Pt's H Ha?

Pt [Ji ge tia ou, tia ou] *I CAN HEAR WITH THIS, I CAN*

Pt's H < Zhi bianlah, zhi bian > *THIS SIDE, THIS SIDE*

Dr **How long has she been having this?**

Interpr / Yow gay nou ze? / <You ji jiu liao ting dao?> *FOR HOW LONG? HOW LONG HAS THE SOUND BEEN THERE?*

Pt's H <San nian, san nian duo le> *THREE YEARS, MORE THAN THREE YEARS*

Pt <San nian> *THREE YEARS*

Pt's H < San nian > *THREE YEARS*

Interpr **Three years**

Dr.Question 1: **A ringing sound, is it?**

(not interpreted for patient)

Interpreter **Ah, yes, ringing sound**

Dr.Question 2: **Always or sometimes?**

(after 2 intervening turns)

Interpreter **Always**

(after another 2 intervening turns)

Interpreter **SOME SOME SOMETIMES, SOMETIMES**

Dr.Question 3: **One ear or both ears?**

(after 3 intervening turns)

Interpreter **Er one ear only**

Dr.Question 4: **Which ear?**

(no interpretation is given)

Dr.Question 5: **How long has she been having this*?***

(after 4 intervening turns)

Interpreter	**Three years.**

Data 5

Interpr	Do you pass water normally?
Pt	Yes, I pass water normally
Interpr	Is there any pain?
Pt	No, there is no pain.
Interpr	Is there blood in the urine?
Pt	No, there is no blood.
Interpr	**His urine's normal**

Launer 1978