Interpreter-mediated Doctor-Patient Communication
The Performance of non-trained Community Interpreters

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Abstract

In German hospitals family members, friends or staff members usually serve as interpreters in order to make verbal interaction between doctor and patient possible. In this paper I will refer to the question how these non-trained community interpreters reproduce the speaker's discourse. My aim is to show that some of the characteristic features in their speech actions derive from the 'fuzzy' status these persons have. As interpreters, they act in a "supportive function" (Bührig and Rehbein 1996), while as staff members or relatives, they have a specific relationship to the institution or the clients. The linguistic analysis will be based upon examples taken from transcribed audio recordings of authentic discourse. It will be shown that the interpreters have serious problems to restrict themselves to the interpreting task.

Community Interpreting in medical Institutions - The German Situation

In a recent article published by the "New York Times", Fein (1997) describes how medical institutions in New York City handle the language barrier. The article shows clearly that not all of these institutions have even recognized the problem and that those who have face serious problems in finding a solution that corresponds on the one hand to their needs and on the other to their possibilities. Furthermore, it is stated that New York is "behind the rest of the country in providing consistent, quality interpretation in health care facilities". With regard to Germany, one can say that this statement holds true for the country as a whole.

Immigration to Germany started in the sixties and seventies, when so-called "Guestworkers" came to satisfy the demand for workers in the growing industries of that time. Most of these immigrants came from Southern Europe and Turkey. Although neither the German authorities, nor most of the immigrants expected that they would stay their whole lifetime, they did indeed wind up staying in Germany. The immigrants raised their families, their children went to school, other family members followed the first pioneers so that, nowadays, 7 million, respectively about 9% of the population in Germany do not speak German as their first language. Speaking German as a second language, of course, does not necessarily imply that someone faces notable difficulties with the language barrier, but nevertheless many immigrants of the first generation - that is, people who came to Germany when they have already reached their mid-twenties or thirties - have acquired German only to a certain extend, whereas their cildren have acquired it sometimes even better than their mother tongue.

Most of the immigrants are not German citizens. This leads to the fact that they have only limited access to some social and political institutions. An exception is social services, because at least "long-established guestworkers are eligible for the same contributory social services, including medical care, available to all Germans through their employers" (McGroarty 1996: 868). Mc

Groarty in her article further confirms that the practice of relying on bilingual friends and family members as interpreters is quite common in cities with large immigrant populations.

In fact, we find two large groups of persons who serve as interpreters in health care settings: family members or friends of the patient (often young people), and bilingual staff members.
The use of interpreters to facilitate doctor-patient-communication does not necessarily imply that the patients do not understand German at all, but when they come to a hospital, their language dominance is often not sufficient to fully participate in this particular type of institutional discourse, where special types of knowledge and vocabulary are needed. Thus, community interpreting in German health care facilities deals with a language barrier that may be semipermeable, and the relationship between the primary interlocutors and the interpreter goes in many cases beyond the interpreting task.

The supportive Function of Interpreting

Interpreting, understood as the transfer of speech actions from a source language A to a target language B, occurs in certain constellations, where primary interlocutors want to interact with each other but do not share a common language. Here, the interpreter is engaged to make communication possible. His or her main task is to make speech actions of the speaker accessible to the listener in the target language. The role of the interpreter is thus similar to that of a messenger who informs a listener about speech actions performed by an absent speaker (see Ehlich, 1983: 30 for this concept of "messenger"). From the point of view of Functional Pragmatics (Rehbein 1977, Ehlich 1991), which I will adopt here, interpreting is a supportive activity, which consists mainly in reproducing speech actions of others (Bührig and Rehbein 1996). Similar to this, Knapp-Potthoff (1987) calls it a "speaking-for-others activity" and Qian (1994) emphasizes that interpreters, who for example answer a question by themselves without the previous interpreting to the adressee are, as interpreters, "off the track". Furthermore, Qian states (ibd.: 218) "a professional interpreter, however, would supress such instincts or impulses to interact with the participants of an communicative event",.
In this view of interpreting it seems to be a contradiction that many other scholars highlight the interactive role of the interpreter, perceiving the task as a "member's activity, (...) introduced, organized and handled by members of bilingual or multilingual participant constellations" (Müller 1989: 713). Knapp-Potthoff (1992) shows that dialogue interpreters become very active in adapting the speakers discourse to the listener, for example by omitting rudeness. Knapp-Potthoff (1987) presents categories of how interpreters process the propositional content of utterances of the source language in the target language by, for example, "condensing" or "expanding" it. Wadensjö (1992: 6) critizises the mechanic notion of interpreting as an activity where the interpreter lacks "any opportunity to introduce her own ideas" and emphazises that dialogue interpreters assume an important role for the organization of the whole communicative event.
Along the same line, some works following the paradigm of conversation analysis focus on the responsability of the interpreter for turn-taking (Roy 1993, 1997) or the negotiation of ambiguities (Apfelbaum 1995).
The fact that "just interpreting" (Niska 1995) sometimes is not enough to keep the interaction going and to enable the listener to understand the speaker has led users and providers of community interpreting services to a formulation of guidelines like the ones cited in Roberts (1997), in which community interpreters are requested to "fill in background information", "explain cultural differences" or "steer away from actions that may be culturally inappropriate".
These findings and observations give reason to assume that what we call interpreting is - at least in some constellations - a set of different activities, including "speaking-for-others" in the supportive sense as well as interactive procedures as the ones mentioned above. The basic opinion of this article is that we have to distinguish between actions carried out to support the interaction of the primary

interlocutors, such as reproducing speech actions in the target language or the organization of turn-taking, and - on the other - actions carried out by the interpreter assuming the role of a primary interlocutor. I will call actions of this category "Primary Interlocutor Actions" or PIAs.
The difference between PIAs and supportive actions is not, that by performing PIAs, the interpreter becomes active, while by performing supportive actions he or she is only a passive "translation machine" (Wadensjö 1992: 70). Reproducing or rendering speech actions of others is a fairly creative activity, as well as the maintenance of the interaction as a whole through "co-ordinating" or "gatekeeping" activities (Wadensjö ibd.: 69).
The point is that by answering a question adressed to someone else, or explaining cultural differences, or commenting on what another interlocutor has said, the interpreter assumes a role which is quite different from the role of a person which participates in the interaction to bridge the language barrier. The interpreters perception, reception and language processing is determined by the interpreting task, while primary interlocutors process discourse to achieve communicative goals. Note that, for example, "understanding" is quite a different mental process for interpreters or primary interlocutors: While the interpreter processes what has been said by the speaker to reproduce it in the other language, the listener processes the reproduced speech actions to participate in an ongoing interaction. If the doctor calls the patient to take off his clothes, the interpreter will not take off his clothes, but say rather "Please, take off your clothes!" in the patient's language, and the patient will take off his (the patient's) clothes.
Although "Primary Interlocutor Actions" performed by the interpreter are often functionally adequate for the interaction, they are also risky because they draw away the interpreter from the interpreting task. The more he or she gets involved in the interaction, the less it is clear which role he or she has assumed while speaking on the other side of the language barrier (for an example see Knapp and Knapp-Potthoff 1986). A trained dialogue interpreter may be aware of this and integrate the PIAs consciously into the interaction. In the next section I will present quantitative and qualitative aspects of two interactions with participation of non-trained community interpreters in order to show that these persons switch quite unconsciously between both activities.

Two Constellations

In the following, I discuss two authentic interactions between Portuguese patients and German doctors mediated by family members of the patients. Calling these interpreters "non-trained" does not mean that they did a bad job. It just means that they were not trained for it.
In the first case, a 55-year old women with an aching stomach is informed about the doctors plan to realize a certain type of diagnosis for the second time which includes a gastroscopy. The aim of the diagnosis is to find out whether she still has gallstones in her bile ducts or not. The patient has been living in Germany for more than 20 years and some of the staff members of the hospital think that she would be able to understand everything. Nevertheless her 17-year old daughter is there and acts as an interpreter during some parts. The whole discussion takes 11 minutes.
In the second case, another information talk is mediated by an uncle of a 40-year old women who came to Germany only for a family visit. She does not speak or understand any German. When she came to the hospital, the first diagnosis was appendicitis and the abdominal wall was opened to perform an appendectomy. Then it was noted that it was not an appendicits, but rather an inflammation of the ovary and the intestines. Later, a colonoscopy was performed to find out if the patient's intestines were still inflamed. In the interaction, a doctor informs the patient about this colonoscopy. This conversation takes 18 minutes.
Both interactions are obligatory for legal reasons. The doctors have to inform the patients about what is planned, why it is necessary and how it will be performed. Afterwards, each patient receives an information sheet which contains more or less the same information in written form. The patient has to sign the information sheet to declare his or her consent.

Quantitative Aspects

First I will present some countable features of both interactions. The methodological status of the following figures is not analytic, but rather illustrative. With that I would like to illustrate the proportion of each participant's contribution to the conversations. One way to illustrate this is to check the amount of words used by each participant. Normally, one could expect that the interpreter uses more or less the same amount of words as the primary interlocutors together.
Figure 1 below shows that this does not happen in these interactions.

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Insert Figure 1 about here

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In Interaction I, the doctor speaks three times more than the interpreter and the patient together. Even if we consider that the interpreter has "condensed" or somehow reduced the number of words necessary to express what the doctor has said, she obviously has not interpreted every turn the doctor has carried out.
In Interaction II the contrary occurs: The interpreter speaks about three times more than the patient and the doctor. Even if we consider that the interpreter has "expanded" or sometimes even explained parts of the source discourse, it is probably not the case that all his contributions serve the purpose of enabling the listener to understand what the speaker has said.
The differences found on this rather superficial level can be illustrated more detailed by comparing the number of words per turn used by the primary interlocutors and the interpreter. An example for this is given in the following Figures 2 and 3, where the contributions of the doctor and the interpreter of Interaction II are presented.

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Insert Figure 2 about here

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The doctor produces 53 turns with an average amount of 10 words per turn. Only a few turns contain more than 20 words. In contrast to this, the interpreter performs some long, monologue like turns. They often contain more than 40 word each (see Figure 3 below).

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Insert Figure 3 about here

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Because the patient speaks much less than the doctor this observation cannot be explained by her performance. So where do all the words performed by the interpreter come from?
It goes without saying that counting the words or turns is not a good method to investigate interpreted discourse, if it is a method at all. Not all ofthe linguistic material in a turn is relevant for the interpreter and so these figures are quite biased. Nevertheless, it could have been shown that interpreting is most probably not the only activity carried out by the interpreters in both interactions.
A close look at the languages used by the interpreters gives some more informations about the nature of their contributions (Figures 4 and 5).

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Insert Figure 4 about here

This figure shows that the interpreter of Interaction I produces more turns in German than in Portuguese. This is no result of the fact that her mother contributes so much to the interaction in Portuguese: In the whole conversation her mother verbalizes only 6 words in Portuguese. When the mother talks to the doctor, she tries to speak German. For an interpreter there would be no necessity to speak German, but that is exactly what the daughter does.
Figure 5 shows that in Interaction II the use of languages by the interpreter is more balanced.

Insert Figure 5 about here

The more balanced use of German and Portuguese can be explained by the fact that the primary interlocutors do not understand each other at all. They have to rely on the interpreter. Considering that in information talks usually the doctor talks more than the patient, it is remarkable that the interpreter performs a lot more turns in German than it would be necessary. Again, one can presume that interpreting the turns of the primary interlocutors is not his only concern.
The surface-related observations presented in this section are by no means sufficient to evaluate the work of the interpreters or to conclude whether the communicative goals of the interactions were attained or not. They just indicate that the normal format of mediators' discourse structure, in which the interpreter gets every second turn to interpret alternately the primary interlocutors (Knapp and Knapp-Potthoff (1985: 457), is an abstraction. In the next section, I will present a qualitative profile of the interpreters activities by distinguishing between actions carried out to support to the primary interlocutors and actions which have the quality of "Primary Interlocutor Actions".

Qualitative Aspects

As I have showed in the preceeding sections, both interactions are quite different with regard to the degree of permeability of the language barrier and the quantitiy of participation on side of the interpreters. While in Interaction I the daughter interprets only chosen parts of the doctors discourse for her mother, the interpreter in Interaction II speaks more than the doctor and the patient together and moreover switches in both directions. Figure 6 below shows which one of the interpreters' turns in Interaction I contain "Interpreter Actions" (IA), "Primary Interlocutor Actions" (PIA) or a mixture of both. The latter category has been chosen to account for turns which are composed by utterances of both the first and the second category. An example for this is turn No. 4 in Interaction I, where the daughter starts to reproduce the preceeding turn of the doctor, then stops, aborts the Portuguese utterance, hesitates and puts a question in German to the doctor:

(1)
Turn No. 4 / Interaction I:
Tá nos intestinos o ... • • • *Also das is nich normal geworden?*
Its in the intestines the... • • • So this didn`t normalize?

Insert Figure 6 about here

A comparison of Figure 6 and Figure 4 shows that the actional quality of the interpreter's turns always corresponds with the use of the respective language: Whenever the interpreter speaks Portuguese, the turn is adressed to her mother and the actional quality is "Interpreter Action", that is, reproducing what the doctor has said, or parts of it. Whenever she speaks German her contributions are adressed to the doctor and they have all the quality of "Primary Interlocutor Actions". The figure thus visualizes that the daughter participates in some parts of the interaction as a primary interlocutor. Most of her PIAs are questions and comments on what the doctor has said about the gastroscopy which is scheduled for one of the next days.
An example for this is Turn No. 12. The doctor has previuosly explained, that for the gastroscopy the patient is anesthetized and has to swallow a kind of tube. Without interpreting this to the mother the daughter asks:

(2)
Interaction I / Turn No. 12, Interpreter:

Bekommt sie das mit, mit dem runterschlucken?
Will she notice that, the swallowing?

It seems obvious that utterances like this have nothing to do with the interpreting task, but rather with the preocupations of a daughter whose mother is in a hospital. It might be interesting to know that after the conversation the daughter told me, she would later talk with her mother about the gastroscopy in detail. We can conclude that she puts a lot of questions in order to be able to explain the whole course to her mother when the doctor is away. Nevertheless, turn No. 12 is a "Primary Interlocutor Action" because within this turn, the daughter puts a question which the mother maybe would like to put. The daughter asks instead of the mother.

Interaction II is a little bit more complex. The actional quality of the interpreters' turns does not correspond to the use of German or Portuguese. A comparison of figures 5 and 7 shows that the interpreter performs PIAs in both languages. Note that his turns 41 - 47 are not just PIAs, but fairly long (No. 43 goes up to 124 words per turn). In these turns he informs the doctor about former illnesses of the patient. Meanwhile, the patient herself is 'off the track' because she cannot understand what both men are talking about.

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Insert Figure 7 about here

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The same happens the other way around in Turns No. 25 - 28. The Interpreter first exagerates problems the doctor has mentioned and then he has to calm down the patient because of his own misleading reproduction of what the doctor has said. In this case, it is the doctor who has no idea of what goes on on the other side of the language barrier.
In Interaction II the mixed turns are of special interest because in some of them the interpreter tries to mediate between the institutional discourse of the doctor and the layperson-like discourse of the patient. The turn No. 10, for example, is preceeded by a sequence in which the doctor calls the patient to drink saltwater to get the excrements out of the intestines. The patient answers that she has already drunken two liters, thus putting in question the doctor's order. The doctor does not care about this reply and continues with an explanation why she has to drink the saltwater. The interpreter then adds an attempt to react on the former reply of the patient to the doctors' words:

(3)

Turn No. 10/ Interaction II, Interpreter:
Mas se tiver ainda muitas sujidades no intestino eles depois não conseguem ver nada. Para que? Enf/ tem que ser mesmo.
But if there is still much dirt in the intestines they later cannot see anything. So that? Well, it really has to be.

In this turn the utterances *"Para que ..."* (»So that...«) and *"Enf/ tem que ser mesmo"* (»Well, it really has to be«) are PIAs. The latter refers to the necessity of drinking saltwater which the patient has put in question by replying that she has already drunken two liters, which the doctor has ignored. The uncle now appeals to the patient to believe him (not the doctor) that she really has to drink more of the recommended saltwater. The attempt to adapt the professional discourse of the doctor to the knowledge of the layperson is discussed more detailed in Bührig and Meyer (1998).

Conclusions

The qualitative analysis of both interactions shows that the family members act only partially as interpreters. For them it is quite natural to leave the interpreting task aside. They introduce a lot of own opinions and statements in the conversation and do not restrict these interventions to cases where the mutual understanding of the primary interlocutors is endangered. While in Interaction I the actional quality of each turn is obvious for the participants because of the semipermeability of the language barrier, the participants in Interaction II cannot control the actional quality of the interpreter's turns. The interpreter in Interaction I extracts and interprets those issues which she finds relevant for her mother to know and of which it is not clear if her mother has understood them sufficiently. Her speech actions carried out as a primary interlocutor often start with a question of hers which she discusses with the doctor. This allows her to store a lot of information in her memory to explain these details later to her mother.
The attitude of the interpreter in Interaction II is more complex because he acts on both sides of the language barrier both as an interpreter and as an interlocutor. A general feature of his performance is that he tries to adapt the contributions both of the doctor and of the patient to the actual speech situation, to make them (according to his opinion) more adequate. When, for example, the doctor asks the patient about previous diseases and she neglects these questions, the interpreter starts to give the doctor a survey on the patients' previous diseases and her story of life, without any regard to the relevance of these information.
Characteristic for both interactions is that the interpreters act much more frequently as a third party as it seem to be the case with the experienced dialogue interpreters investigated by Wadensjö (1992). "Mediating" in the sense of explaining cultural concepts or commenting on the performance of the other interlocutors does not occur. "Co-ordinating" activities are restricted to turn-taking and occur only in Interaction II. Note that these observations also seem to hold for interactions where nurses act as interpreters, but yet we have not analyzed these data in detail.

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