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Interruptions and resistance: A comparison of medical consultations with family and trained interpreters

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ABSTRACT

While working with trained interpreters in health care is strongly recommended, few studies have looked at the subtle differences in communication processes between trained and "ad hoc" interpreters, such as adult family members. Using Habermas' Communicative Action Theory (CAT) which distinguishes between the Lifeworld (contextually grounded experiences) and the System (decontextualized rules), we analysed 16 family practice consultations with interpreters, 10 with a trained interpreter and 6 with a family member. We found clear differences in communication patterns between consultations with a trained interpreter and consultations with a family member as interpreter. In both cases the Lifeworld is frequently interrupted and the outcomes are similar: the Lifeworld is rarely heard and acknowledged by the physician. Physicians interrupt the Voice of the Lifeworld significantly more with a trained interpreter than with a family member. Family members and trained interpreters also interrupt the Voice of the Lifeworld just as much. However, these interruptions differ in their functions (both physicians and interpreters interrupt to keep the interview on track to meet the biomedical goals; family interpreters interrupt to control the agenda). We have identified patients' resistance when physicians ignore their Lifeworld, but this resistance is usually only transmitted by professional interpreters (and not by family interpreters). We identified specific risks of working with family interpreters: imposing their own agenda (vs. the patient's one) and controlling the consultation process. Even if the collaboration with trained interpreters becomes more widespread, work with "ad hoc" interpreters will continue to occur. Therefore, institutions should provide training and organizational support to help physicians and patients to achieve communication in all situations.

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Introduction

Language barriers are frequently present in health care in developed countries. In the US over 24 million residents are unable to speak English fluently, with over 55 million residents speaking a language other than English (U.S. Census Bureau, 2000). In England, there are an estimated 2,520,885 general practice visits per year where interpreting services might be required (Gill, Shankar, Quirke, & Freemantle, 2009). In Canada, where our work took place, 520,000 people (1.7% of the population) cannot speak either of the official languages (English and French) at all (Statistics Canada, 2007).

* Corresponding author. Tel.: +1 418 656 2131. E-mail address: yvan.leanza@psy.ulaval.ca (Y. Leanza). Interpreting in institutional settings for service providers and individual clients who do not speak the same language is fundamentally different from conference interpreting as the interpreter is inside, not outside the interaction. Because the interpreter may share the patient's culture and is also part of the medical system (Robb & Greenhalgh, 2006), she can serve as a bridge between the two cultures. The presence of an interpreter can provide access to the patient's culture and experiences and promote a bond of trust between the professional and his/her client (Raval & Smith, 2003). Some professionals are concerned about the quality (exactness and completeness) of translations (e.g. Robb & Greenhalgh, 2006) and report negative feelings associated with working with interpreters, such as loss of control (Greenhalgh, Robb, & Scambler, 2006; Leanza, 2005), and exclusion from the conversation (Hatton & Webb, 1993; Leanza, 2005).

The quality of work of interpreters is frequently assessed in terms of translation errors. Trained interpreters make fewer errors



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than their untrained counterparts (Karliner, Jacobs, Hm Chen, & Mutha, 2007) and as such are considered more reliable. This reinforces the image of the interpreter not participating in the interaction but merely relaying information from patient to physician and vice-versa, the famous "conduit" metaphor. It also supports a simplistic dichotomy between trained and "ad hoc" interpreters.

There are, however, two reasons to understand the specificities of the work of all sorts of interpreters. First, health care may benefit from interpreters who play roles other than translation in the clinical conversation such as cultural informant and culture broker (Leanza, 2005). Judgements of the quality of this work should not be based on the accuracy of translation (Pöchhacker, 2004). Second, many clinical consultations occur without trained interpreters. The existing literature does not differentiate between the many different kinds of 'ad hoc' interpreters although the strengths and weaknesses of adult close family members, minor children, health care staff, institution non-professional employees, strangers in the waiting room and volunteers from community organisations vary enormously (Hsieh, 2006; Rosenberg, Leanza, & Seller, 2007).

Habermas and patient-health professional relationships

The Communicative Action Theory (CAT) of the German philosopher and critical sociologist Jürgen Habermas (1987) inspired the way we framed our analysis of family practice consultations. CAT's first assumption is the opposition of the Lifeworld and the System. The Lifeworld is expressed through the Voice of Lifeworld (VoL) (Mishler, 1984). A voice is 'the realization in speech of underlying normative orders' (p. 103). Communication in the Lifeworld is oriented toward understanding and consensus through negotiation (communicative action). The timing of events and their significance are dependent on the patient's biographical situation and his position in the social world. In contrast, communication in the System (the Voice of Medicine, VoM, Mishler, 1984) is goal-oriented, subject to scientific and technocratic institutions' interests and aims at success (strategic action). The meaning of events is provided through abstract rules that serve to decontextualize events, to remove them from particular personal and social contexts. When the Voice of the System takes over the VoL, the Lifeworld is said to be colonized. This present study deals with strategic action since interrupting the VoL aims at controlling or silencing it and does not allow participants to build meaning within the Lifeworld.

Mishler (1984) demonstrated how the VoM systematically seeks to dominate the VoL, and usually succeeds. The physician's power to focus on his own agenda is made visible through his interruptions of the patient's Lifeworld. Barry, Stevenson, Britten, Barber, and Bradley (2001) identified four patterns of communication (see Table 1), two of them are interruptions of the Lifeworld. Leanza (2004) identified a third interruption pattern and placed the three interruption patterns along a continuum of degrees of physician control. The Lifeworld can be ignored (LI), blocked (LB) or recognized (LRec). The LI pattern is the strongest: the Lifeworld seems to simply not exist. In the LB pattern, the Lifeworld is minimally acknowledged (so it exists), but its worth and uniqueness are not validated. The LRec pattern is the most gentle: the acknowledgement is more detailed than in the LB pattern and it is more personalized. It can sometimes be a sign of empathy, but it remains an interruption since the VoM follows immediately. Barry et al. (2001) observe that where the VoL is used and acknowledged, physicians and patients are more satisfied, and care is more humane.

The aim of the present research was to use the Habermasian perspective to analyse video recordings of actual consultations in

Table 1

Patterns of communication from Barry et al. (2001) and Leanza (2004).

Name (Abbreviation)		Description
Strictly Medicine (SM)		Physicians and patients speak exclusively in the Voice of Medicine
Lifeworld Ignored (LI)	an control →ı	"[] the patients talked either exclusively or for a large amount of the consultation in the voice of the Lifeworld. However, the doctors completely ignored this and conducted the whole of their communication in the voice of medicine" (Barry et al., 2001, p. 494-495).
Lifeworld Blocked (LB)	gree of physici	"These appear similar to those consultations where Mishler reports seeing glimpses of the Lifeworld. These glimpses were immediately suppressed as a result of the doctor using the structural sequence of question control []" (Barry et al., 2001, p. 494).
Lifeworld Recognized (LRec)	i+ De	The Lifeworld is briefly acknowledged, sometimes even with some empathy, but the Voice of Medicine reappears quickly (Leanza, 2004).
Mutual Lifeworld (ML)		Physicians and patients dominantly spoke in the voice of the Lifeworld.

primary care involving three participants: a family physician, a patient and a trained interpreter or a bilingual adult family member. Contrary to most of the research on interpreting which focuses on discourse about working with interpreters, this paper deals with what actually happens in the consultations.

Methodology

Participants, ethics and materials

Physicians of two clinics (A and B) in Montreal were asked to identify patients who usually come with an interpreter (professional or family member) in their agenda for a period of 8 months (from June 2004 to January 2005). All identified patients were telephoned by an interpreter to briefly explain the project before the day of the consultation and were asked to come 30 min earlier than their appointment with the physician for detailed explanation of the research and consent. Twenty-two patients agreed to participate. All 5 patient-interpreter pairs introduced to the project by their physicians accepted. None of 5 patients approached by a professional interpreter they did not know agreed to participate. We therefore asked interpreters known to the patients to explain the study to patients. All 17 patients approached about the study by an interpreter they knew consented to participate. The telephone call to those who used a professional interpreter was made by this interpreter. For those who used a family interpreter. the telephone call was made by the research associate who spoke to the family interpreter.

Before the appointment, the research associate explained the project to the patient through the interpreter. We enrolled participants when both the patient and the interpreter consented. The protocol was approved by the Institutional Review Boards of McGill University Faculty of Medicine and all of the participating clinics.

Clinics were chosen because they serve many immigrants. At clinic A, 27% of adult patients reported being unable to speak English or French well enough to talk with their doctor; at clinic B the prevalence was 49% (Rosenberg, 2008).

Out of the 22 recorded consultations, 12 were with a trained interpreter from the Montreal interregional interpreters bank (a government program) who had undergone 45 h of training and passed formal linguistic competence testing. The 10 "ad hoc" interpreters (family members) were brought in by the patient. Because of technical problems with some recordings, for this analysis we retained 16 consultations, 10 with a trained interpreter (see Table 2 for details). The 6 excluded consultations were as varied in the languages involved and the nature of the medical conditions addressed as the 16 analysed.

Physicians were mainly female (N = 12) as were patients (N = 13) and interpreters (N = 12). The 4 male interpreters were all family members (son-in-law, husband, brother and son). This dominance is concordant with other observations of the feminisation of interpreting practices (Pöchhacker, 2004). There were 5 patients' languages, the most spoken being Punjabi (N = 9), followed by Bengali (N = 2), Vietnamese (N = 2), Tamil (N = 2) and Dari (N = 1). Punjabi is the language of all but one professionally interpreted consultation (case 11). These languages, except for Dari, were among the 10 most requested languages for interpretations in the Montréal area during that period (Agence de la santé et des services sociaux de Montréal, 2005), likely because members of these language communities represent the most recent arrivals in Montreal.

Table 2

Case	e Sex		Interpreter's	Problems	Language	
	MD	Patient	Interpreter	relationship to patient	addressed	
1	F	F	F		Back pain Sociopolitical Problems	Punjabi
3	F	F	F		Depression Social problems	Punjabi
4	F	F	F		Limb & Neck Pains Diabetes	Punjabi
5	F	F	F		Headache Limb Pain Sociopolitical Problems	Punjabi
6	F	F	F		Pregnancy	Punjabi
7	F	Μ	F		Back pain Sociopolitical Problems	Punjabi
9	F	F	F		Headache Sociopolitical Problems	Punjabi
10	М	М	F		Limb Pain Sociopolitical Problems	Punjabi
11	М	F	F		Insomnia Depression Cough	Vietnamese
12	F	F	F		Shoulder pain Headaches Sociopolitical Problems	Punjabi
2	F	F	Μ	Son-in-law	Diabetes Angina Hypertension Osteopenia Headaches	Bengali
14	F	F	F	Daughter	Heart failure Chronic Lung Disease Skin rash	Vietnamese
16	М	F	М	Husband	Pregnancy	Tamil
17	Μ	F	F	Daughter	Diabetes Hypertension Limb pain	Tamil
20	F	F	М	Brother	Wrist work injury	Bengali
21	F	М	М	Son	Angina Urinary problems Constipation	Dari

A professional interpreter not involved in the consultations listened to the recordings and translated the non-English or French parts in the presence of the research associate who pressed for accuracy and asked for clarification when meaning was not clear to her. Then, the entire clinical consultations were transcribed in French or English.

Coding procedure

Each utterance was coded separately by two people (IB for the whole data set and two research assistants, who each took half of the consultations). All were trained by YL. Each utterance i.e. a meaningful unit (which can be as short as a few words in a sentence and as long as a full speech turn), was coded as the VoM (M) or the VoL (L). A mean of 1.5% of utterances of each consultation could be both voices and were coded as such. The VoM is characterized by (1) a specialized/expert language (jargon); (2) questions or interventions on context free facts or symptoms, possibly measured and quantified; (3) questions or interventions which exclude family and socio-cultural contexts and affective elements. Characteristics of the VoL are designated in opposition of those of the VoM: (1) a lay language; (2) questions or interventions which include contextualized facts, historically situated, accompanied by affective comments (Leanza, 2004). The first coding reached about 90% agreement. All the divergent coded utterances were discussed by research assistants with YL and ER in order to reach consensus.

Analysis procedure

We next looked for communication patterns, especially the interruptions of the VoL, as constructed from Barry et al. (2001) and Leanza (2004). The physician, the interpreter or the patient could interrupt. Unlike Barry et al. (2001) who, after coding, characterized the whole consultation with a single communication pattern, we examined all the communication patterns within the same consultation, in order to observe the course of communication throughout the consultation.

A large proportion of each interview was conducted exclusively in the VoM (SM). We did not analyse these portions of the interviews. We were interested in what happens when the VoL appears. Therefore, we looked for its appearance, coding who initiated it, whether it was interrupted, how it was interrupted (blocked, ignored or recognized) and by whom. IB and YL began the analysis together in order to discuss the appearing schemas. Then IB analysed the whole data set and met with YL and ER to discuss every ambiguity with analysis.

Results

Overview

In the 16 consultations, we observed 212 communication events involving the VoL (103 Interruptions and 109 Mutual Lifeworld patterns).

As gender is an important variable in patient—physician interactions, we ran Student's *t* tests on Interruptions and ML patterns frequencies to verify whether there were significant differences between "all female" consultations (N = 8) vs. the presence of at least one male (the patient, the interpreter or the physician, N = 8). No significant differences appeared.

Table 3 presents the mean frequencies by consultation for each communication pattern according to the type of interpreter. Physicians interrupt the VoL 19.2 times more often when a trained

Table 3

Mean frequencies of Lifeworld interruptions by consultation and by status of interpreters and Student's *t* test associated.

Interruptions ^a	Interpreters' status				Student's t
	Trained		Family		
	N	Mean	N	Mean	
By physicians					
LI	28	2.80	1	0.17	
LB	25	2.50	1	0.17	
LRec	11	1.10	0	0.00	
Total interrupt./physicians	64	6.40	2	0.33	<.001
By interpreters					
LI	8	0.80	14	2.33	
LB	4	0.40	4	0.67	
LRec	0	0.00	3	0.50	
Total interrupt./interpreters	12	1.20	21	3.50	NS
Without interruptions					
Mutual Lifeworld	59	5.90	50	8.33	NS

^a Note: We excluded patients' interruptions. Patients interrupted the VoL very rarely: we observed it four times, for three different patients. Only one of these patients was with a trained interpreter and interrupted communication twice.

interpreter is present in the consultation than when a family member interprets (p < .001). Family members and trained interpreters both interrupt the Lifeworld, but do not significantly differ in their amount of interruptions. ML patterns appear quantitatively the same whatever the type of the interpreter. The apparent difference in mean frequencies for ML is due to an extreme value (25) for case 20. The median frequency of ML events in consultations with a trained interpreter is 5 and 5.5 with a family interpreter.

Communication with and through trained interpreters

We now turn to a detailed qualitative analysis of communication patterns to provide some insight into what actually happens when the VoL is interrupted.

Physicians interrupting

Physicians use all three kinds of interruptions (LRec, LB and LI). The use of the LRec pattern has the effect of achieving closure, contrary to the two other patterns. In excerpt 1, the interpreter plays the role of a cultural informant, adding comments to help the physician understand the patient's Lifeworld (see Leanza, 2005 for more details on interpreters' roles). The clinician asserts her understanding and then follows with the VoM, which is typical of LRec pattern. In contrast to the patient in Case 3 whose Lifeworld is blocked (see below), this patient does not reiterate this complaint later.

Excerpt 1 (Case 7)

134. 135.	PT: When I get up in the morning I am broken. I am tired. INT: He feels tired in the morning when he wakes up, like the body is like tired, or like the expression is like that the body is broken. Tired.	M-L M-L
136. 137. 138.	MD: 1 understand. INT: 1 understand that. MD: During the daytime, when you are not sleeping does it happen sometimes that you kind of see flashbacks of some of the difficult times that you had in India. Almost like a film coming in	L (LRec) L M
	front of your eyes, like movies?	

Note: Italics are for utterances that have been translated for the research purposes. L = VoL; M = VoM; M-L = both the voices of the Lifeworld and Medicine are expressed in this statement. Between parentheses is the illustrated pattern: here, LRec stands for Lifeworld Recognized.

The VoL may contain information essential to the achievement of good health results. For example, it can inform physicians about realities that interfere with the medical agenda (e.g. an explanation of why one does not want to take a specific medicine, Case 6; or a patient saying she often forgets to take her medicine, Case 11). It can also refer to personal hypotheses on the source of disease. The Case 9 patient thinks that her headaches are related to gas going into her head. Ignoring this kind of information has consequences for the communication dynamic.

Excerpt	2	(Case	9)
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Note: LI = Lifeworld ignored.

In excerpt 2 the physician rapidly directs the matter to giving tips to manage gas, in the way she understands gas (located in the belly and mainly caused by nutrition and digestion), totally ignoring the link between gas and headaches. Her lay theory not being heard, the patient raises the question five more times during the consultation.

In the next example, the physician makes an unsuccessful attempt to build meaning with the patient's experience ("body lifeless" transformed into "passing out").

Excerpt 3 (Case 3)

184.	MD: So, does she have any questions for me?	M-L
185.	INT: Do you want to ask a question?	M-L
186.	PT: The only thing is that when I'm sitting and	L
	I feel I'm lifeless, as I was sitting outside, and	
	I felt [could not make out last word].	
187.	INT: She's saying that sometimes it happens	L
	that she's sitting and she feels that she has no	
	strength, no energy like lifeless, the body's lifeless.	
	And it happened to her in the waiting room she	
	told me and she's telling me to tell you the way	
	it happened in the waiting room. Sometimes	
	she sees people like blurry, blurry. She can't see clear.	
188.	MD: Does she feel like she's going to pass out?	M(LB)
189.	INT: Do you feel you're going to be unconscious?	Μ
190.	PT: I feel like a statue sometimes, I feel like I have no life.	L
	I feel like a statue.	
191.	INT: She's saying. She didn't say anything clearly about that.	L
	She's saying not like passing out but she feels	
	there is no strength, no life inside. She's like a spectre.	
192.	MD: Ok. How long has that been going on?	M (LB)

Note: LB = Lifeworld Blocked.

When the patient returns to the VoL a second time (line 190), the physician blocks the VoL by asking a quantitative question ("how long?", line 192). The consequence of the LB is that it remains unclear what it is to be like a statue, a spectre or to feel lifeless. A sign that the Lifeworld is not heard is the repetition the patient makes of her symptoms later in the interview.

In some cases, it can be crucial for physicians to block the VoL in order to get essential information and to achieve diagnostic and therapeutic goals. In the following excerpt the physician checks the suicidal risk. The interpreter recounts the context but not the patient's suicidal thoughts. The physician then goes straight to the point, blocking the VoL:

Excerpt 4 (Case 7)

197.	INT: It's not the age. He's saying he just came	L
	this is not his age to go to another country and go	
	through all the difficulties again just to save	
	for his security and for the security of his children.	
198.	MD: Ok. So, the ideas of killing yourself?	M (LB)

Trained interpreters interrupting

Trained interpreters of our sample never use the LRec pattern, but we observe them using the LB and LI ones.

Interruptions can be the consequence of inaccurate or incomplete translations. For instance, when the Case 10 physician asks many questions at once, it results in confusion and LB by the interpreter. Blocking the Lifeworld may also be a shortcut toward a more efficient communication. For instance, a patient talks about "an orange pill" which is translated as "ibuprofen" by the interpreter (Case 9).

Interpreters' interruptions may have the effect of keeping the biomedical discourse coherent as in the following excerpt. The patient does not directly answer the question and gives other information. The interpreter chooses to partly translate the patient's utterance.

Excerpt 5 (Case 5)

97.	MD: [The pain happens] More often in cold weather, right?	М
98.	INT: Does it happen to you when it is very cold?	М
99.	PT: Even when I am in the house, and it started. I just	L
	massage my leg. I feel like I want somebody to give me a massage.	
100.	INT: Yes, she's more concerned it's right here. She says	M (LB)
	it happens in the cold and at home too.	
101.	MD: Ok.	М

Ignoring the Lifeworld may censor a part of the discourse that is not comprehensible or manageable by biomedicine. Case 9 patient reports conceptions about how oil and milk might "reduce the dryness inside". Initially, the interpreter translates everything the patient says (line 221), but the physician ignores it (line 234). Then the interpreter chooses not to translate this information anymore even when the patient repeats it (line 236–239).

Trained interpreters interrupt patients' Lifeworlds a lot less than physicians do. Thus, they usually allow circulation of information. When they interrupt, it can be a way to keep the discourse coherent, to censor a part of the discourse that is not comprehensible or manageable by biomedicine or to ignore a reality that has been previously ignored by the physician. A translation error may have the same effect as an interruption. Physicians choose to interrupt the Lifeworld to get straight to the information they (think they) need. We observe that these interruptions lead to repetition of the portions of the VoL that were not heard and to unsuccessful meaning building. However, physicians interrupt the VoL in order to get the appropriate information in serious, indeed life-threatening situations.

Communication with and through family members as interpreters

Physicians interrupting

Physicians rarely interrupt in the presence of a family interpreter. One LI, and one LRec pattern were found. In comparison, 28 LI, 25 LB and 11 LRec interruptions by physicians were found in the presence of professional interpreters.

These interruptions are rather gentle (a trivial value judgement over a physiotherapist in Case 20 and a demonstration of empathy – "that's very unfortunate" – in Case 21). In both instances, the Lifeworld does not seem to require an answer and does not come back.

Family interpreters interrupting

All three interrupting patterns are used by family interpreters, with a predilection for the LI: the Lifeworld was ignored 14 times by family interpreters, blocked four times and the LRec pattern was used three times.

We found an unexpected pattern with family interpreters: LRec with a Lifeworld uttered by the physician. Case 14 physician gives a personal opinion; another asks a question about the sex of the baby coming (Case 16). In both instances, interpreters respond to the VoL, do not translate to the patient and afterwards go on with a biomedical matter. In another instance (Case 17), a physician tells a joke which is not translated to the patient.

As for trained interpreters, blocking the Lifeworld may be a shortcut toward a more efficient communication: case 14 interpreter translated "yellow pill" as "Metamucil".

The LI pattern appears in two situations. First when the patient's statements go beyond the expectations of a biomedical agenda. It is seen when patients give additional contextual details or information that is not quantitative (e.g. perception of time passed grounded in events instead of number of years; talking about the children when only their number was asked, Case 18). These details are not transmitted to the physician. Second the LI pattern appears when the interpreter seems to disagree with the patient's views.

Excerpt 6 (Case 21)

199.	INT: Fruit is good but it's better to take (unclear) like dates, prunes.	М
200.	PT: I don't like.	L
201.	PT: [to the physician] Will you give the medicine?	Μ
202.	INT: It's better to take dates and prunes.	Μ
203.	MD: He doesn't look convinced. [MD laughing slightly].	L
204.	INT: No, he agrees.	L (LI)

In addition to not translating the patient's preference (LI), the interpreter (patient's son) lies about his father disagreement. The patient is therefore silenced. He later tries to join the conversation in asking "What is the doctor talking about?"(line 309). This final attempt is ignored by the interpreter. This is the last time the patient says anything during the consultation.

In Case 20 the patient has a wrist injury and she was fired because she could not meet the productivity quotas. The physician wants to send her to a social worker to help her eventually find a new job, something the patient's brother (interpreter) does not translate. The physician goes out of the consultation room for a few minutes. The patient asks her brother a few questions about her treatment and when she can go back to work. He states that he does not know the answers. He could ask the physician but he does not when the physician comes back. In this case the patient's VoL is simply ignored.

Family interpreters interrupt the VoL coming either from the physician or the patient. Interrupting patients' VoL can allow avoidance of statements that go beyond the expectations of a biomedical agenda and be a means of controlling the patients' decisions. When they interrupt physicians' VoL they exclude the patient from a meaningful interaction. In all cases, family interpreters act as main interlocutors. The major consequence of this behaviour is to exclude patients from the consultations.

Patients' resistance

It would be incomplete to present only interruptions of the VoL. In many instances, patients actively seek to be heard or refuse to answer physicians' questions in a way that would typically fit the biomedical mould. A new communication pattern emerges from our analyses: the Lifeworld Resistance (LRes). We define it as a set of communicational events that occur in order to limit or cancel the effects of the colonization of the Lifeworld. The main form of resistance is the repetition of the VoL as we have already shown (excerpts 2 and 3). Resistance can also be an outcome of premature closure by the physician who assumes he or she has understood the meaning of the patients' descriptions of symptoms. In these cases, patients repeat their symptoms many times (e.g. "I'm feeling like a spectre", Case 3; "My baby looks weak", Case 12; etc.) with the hope of being heard in the end.

In two cases (9 and 11), treatments are planned but do not seem to meet clients' expectations. Neither patient gets her personal hypothesis truly heard. Case 9 patient who believes her headaches are related to gas going into her head keeps repeating her theory until the physician says "Well, I explained what I know for gas problems." (line 401). From that moment, when limits are made explicit, the discussion takes another direction as this patient knows her need will not be fulfilled in this consultation.

Escalation of the VoL is the second form of resistance.

Excerpt 8 (Case 4)

110. PT: I used to walk a lot, and my sugar was in control. But now I can't walk because of my pain, and my sugar is not in control. Seven, four. From the time I stopped walking, my diabetes is nine eleven ten.	IntegML
111. I am scared of taking insulin, because I am so scared	L
if I take it that I might die. The doctor should only help me.	
So if these tablets can help me for my pain, and I'm going to	
start walking again, and that might help with my diabetes.	
Insulin, I'm very scared of. There's somebody who is taking insulin,	
and her whole hands and feet have so much rash that	
she cannot go out, and I think it is because of the taking the insulin.	
And she can't go do anything. So I'm scared of taking insulin.	
Another neighbour who is taking insulin had more problems.	
Five, six, seven	
[In the following lines, the patient and her husband continue	
giving more arguments against insulin]	



This patient's theory (line 110) implies a solution: reducing the pain to be able to exercise, and then, the sugars will be controlled. This theory is not acknowledged and therefore not refuted nor validated. The patient escalates her accounts of her fear of insulin until the doctor interrupts her quite authoritatively ("We won't try to convince her anymore today", line 149).

A third way to resist colonization of the Lifeworld is to not answer yes or no to a closed question (Case 3) or by giving more context than requested by the physician (Case 9). It can also be clearly stating dissatisfaction: "Again, I meet you people. I hear good things and I feel good. But my problem is not solved." (Case 3, line 242).

Resistance does not come only with combative assertions from patients. Patients sometimes reveal their need to protect the relationship at the same time they resist ("I'm not ... what I'm saying is, I didn't mean to say ...I mean to say that people *do* take care of patients [...] but he did not really take care of me." (Case 1, line 122); "Please tell the doctor that I don't want to fight with you, I don't want to get mad at you. Doctors are very kind to me. They love me a lot. They say we are going to save your life." (Case 4, line 143).

Our data suggest that only trained interpreters transmit patients' resistance. Family members do not do so. We also see that interpreters very rarely take the initiative to resist the VoM. In the consultations studied, only one interpreter takes the advocate role to repeat to the physician that the patient has to see a woman gynaecologist (Case 4).

Discussion

The study has some limits. First, the quality of the translation we obtained in order to have access to the full content of the consultations was not checked by a second translator. However, we employed trained interpreters who were repeatedly reminded to translate all utterances and to do so as accurately as possible by the research associate who sat with them as they worked. Acknowledging this limit, we observed no major translation errors, whatever the type of interpreter. This result is an argument in favour of differentiating between types of "ad hoc" interpreters. According to this study, adult family interpreters might be considered, at a linguistic level, as reliable as trained interpreters. As we've seen (and we'll discuss later) at other level of analysis, this statement might be challenged.

Second, given the small number of languages and cultures of our participants, it is possible that our results are influenced by linguistic and cultural challenges specific to our participants, as others have found (Free, Green, Bhavnani, & Newman, 2003). All but one professional interpreter and none of the family interpreters spoke Punjabi. It is possible that the differences observed between the two groups are related to this language difference. However, 4 of the 6 encounters with family interpreters involved members of similar cultural communities: they were also from South Asia (Bangladesh and Sri Lanka); they arrived in Montreal within the past 5–7 years and the Tamil speakers, like the Punjabi speakers, were escaping political violence. Other studies would be needed to shed light on this issue.

Third, the small number of family interpreted consultations makes our conclusions about consultations interpreted by family members more tentative than those about consultations interpreted by trained interpreters.

The fourth limit may be the most important. It concerns the gender issue. Again our statistics on Interruptions and Mutual Lifeworld patterns show no differences between "all female" consultations vs. the presence of at least one male in the consultation. However, 4 out of 6 family interpreters are male and 3 of them do interpret for a female relative. Hierarchical relationships between male and female, culturally organized, certainly influence the way communication occurs in such consultations. Case 20, the brother interpreting for his sister with a wrist injury, is an example of how communication can be strategically manipulated in order to achieve the interlocutor's interests (here the brother). One hypothesis is that the manipulation we observed is the result of the hierarchical relationship between male and female, in particular the eldest brother/sister relationship, in their community. One would need to test this hypothesis in systematic observations of family interpreted consultations comparing male and female interpreters with male and female patients and involving different linguistic/ethnic groups.

Notwithstanding these limits, we have found clear differences in communication patterns between consultations with a trained interpreter and consultations with a family member as interpreter. In both cases the Lifeworld is frequently interrupted. However, these interruptions differ in their source (physician vs. interpreter) and in their functions (both physicians and interpreters interrupt to keep the interview on track to meet the biomedical goals; some family interpreters also interrupt to control the agenda).

Strategic action, i.e. patterns of communication oriented toward achieving goals without negotiation, is employed not only by physicians but also by family interpreters, but rarely by trained interpreters. This seems contradictory to what others have found. Greenhalgh et al. (2006) concluded that family interpreters in the UK, who were generally trusted and shared the patient's Lifeworld, shifted the power balance in the patient's favour. Green, Free, Bhavnani, and Newman (2005) showed young people (10–18 years old) interpreting for their relatives in the UK health institutions tended to see this activity as a social responsibility and were not "just translating" but mediating and sometimes advocating for their relatives. Based on these findings, we might have expected family interpreters to advocate for the patients, claiming the validity of the Lifeworld. It was not the case. Three factors might explain the difference. First, the studies mentioned are based on physician and interpreter reports, not on analysis of actual interpreted consultations. There is always a gap between what is said and what is done. Other studies of actual communication showed trained interpreters mainly adopted System roles, i.e. keeping the consultation in the biomedical domain (Davidson, 2000; Leanza, 2004). In this regard our results are not surprising. Second, the work of Green et al. (2005) focused on pre-teens, adolescents and young adults. In our research the family interpreters are all adults. Their motivations and intentions are certainly different from those of young people in the process of building/asserting their identity and exerting their loyalty toward family in a System perceived as discriminating. Third, this paper presents an analysis of part of the consultations only: the interruptions. More than half of the communication events we observed are Mutual Lifeworld (ML) exchanges. We have also analysed ML looking at the process of meaning building in the consultation with the two types of interpreters (Boivin, Leanza, & Rosenberg, 2009). Results show family interpreters do indeed help to build meaning, using communicative action and adding crucial contextual information in the communication. Trained interpreters are more unobtrusive and do not participate much in meaning building.

From our observations and analyses trained interpreters transmit virtually everything that is said, including patients' resistance to the VoM. However, they cease to translate the VoL when it already has been ignored or blocked by the physician. Only one of them insisted on the VoL when it was not heard by the physician. In sum, trained interpreters mainly reinforce the status quo, avoiding changing the power dynamic. They tend to reinforce the VoM by controlling communication according to the System's (biomedical) agenda. This behaviour may be understood to be a result of attempts by trained interpreters to maintain "neutrality", a strong principle of community interpreting ethical codes (Bancroft, 2005) in spite of the view of many researchers that this principle is unattainable and probably undesirable (Pöchhacker, 2004; Wadensjö, 1998). Attempts to maintain neutrality also prevent interpreters from playing community agent roles (e.g. cultural mediator or advocate) or using communicative action. This behaviour may be reinforced by the numerous interruptions of the VoL by the physician when a trained interpreter is present.

We propose two non-mutually exclusive interpretations for this result. First, being migrants themselves, interpreters may want to obtain recognition from the System (or the society at large). This quest will motivate them to be more oriented toward the System than their counterparts, as we suggested explaining similar behaviours from trained interpreters in another context (Leanza, 2005). Another way of formulating the same interpretation is to use Orbe's (1998) theory on intercultural communication. This author identified three goals of members of marginalized groups in their interactions with members of the dominant society: separation (avoidance of contact), accommodation, and assimilation. Accommodation requires individuals to insist that dominant structures incorporate the life experiences of marginalized groups. Assimilation involves attempts to eliminate cultural differences in order to fit in with dominant society. Our trained interpreters seem to have been trying to avoid accommodation by staying neutral to meet the System expectations.

The second explanation is that the interpreter is afraid to damage the relationship with the physician if he/she "fights" for the Lifeworld. The relationship with the physician is an important one: we do not want not to have a physician, not to receive health care. As Mishler (2005) mentioned, "[...] there is no doubt that patients

are dependent on physicians for care and treatment and have to find ways to ensure that they will neither be abandoned nor treated in harmful ways" (p. 440). Because the trained interpreter has better access to the biomedical world, he may know what is considered appropriate and what is not. He may feel accountable for protecting the quality of the relationship.

Physicians position themselves differently in the presence of family interpreters compared to trained interpreters. This observed difference is consistent with physicians' statements in our interviews with them. They see trained interpreters as conduits and family interpreters as partners (even if they also complained that the family interpreter answered for the patient, Rosenberg et al., 2007). However, physician behaviour may be heavily influenced by family interpreter behaviour. Physicians may not have needed to interrupt the VoL because family interpreters prevented them from hearing it. We have showed the VoL is filtered by interpreters themselves. Even if this trend is not statistically significant, qualitative analyses of interruption patterns allow us to identify concrete examples of specific risks of working with family interpreters: imposing their own agenda rather than the patient's one and controlling the consultation process. This is concordant with what family interpreters reported in their interviews: they often speak for themselves (Rosenberg, Seller, & Leanza, 2008). Moreover, they do not transmit patients' resistance to the VoM. These behaviours tend to exclude the patient from the interaction.

Part of the control family interpreters choose to exert might certainly be explained in the same way we interpreted trained interpreters' behaviours: the quest for recognition or assimilation and the fear of being rejected in this crucial relationship. But they do not only use strategic action to achieve institutional goals, they use interruptions of the VoL to achieve their own goals which may be contrary to patients' goals and even to patients' health. We observe that there is indeed a process of exclusion in the consultation, but contrary to what physicians feel (Hatton & Webb, 1993; Leanza, 2005) it is not directed toward them but toward the patient. This said, the physicians' feelings remain true and legitimate. This part of the control family interpreters exert might be interpreted as strategic action oriented toward achieving the goals of another System, not the biomedical one. This System would be the family or the patient's larger community. From the perspective of the patient, the family and the community can be considered a System in Habermas' sense, as family or the community may have a very restricting organisation, not allowing individuals to express their opinions. In such Systems appropriate individual behaviours will be determined by a person's characteristics and status (gender, age, education, profession...). Being from the family/community System, the family interpreter will orient the communication in order to fulfil this System's expectations. The trained interpreter is unlikely to try to further family/community System goals for several reasons: 1) she is less personally or emotionally involved, 2) she has a professional duty to be as neutral as possible (i.e. as we've seen not being influenced by any other System than the biomedical one) and 3) she may not be of the same culture, social class or community as the patient.

In our data, not only do we see patients' Lifeworlds, but also physicians'. Indeed, we detect between the lines physicians' emotions and worries affecting their way of communicating. Concern about life-threatening conditions and uneasiness in the face of differences in illness representations may cause interruptions of the patients' Lifeworld. Sometimes, these interruptions motivated by a physician's emotions may be used strategically (as in the suicide check). Sometimes they may prevent physicians from working effectively (not hearing or not taking into consideration valuable information coming from patients). Awareness of one's motivations and the effect of one's behaviour on the other participants in a professional consultation can improve the effectiveness of professional practice (Saint-Arnaud, 2003; Schön, 1983). As the physician's self is a therapeutic instrument (Balint, 1957), increased self-awareness could allow physicians to use their own Lifeworld (e.g. concerns, uneasiness) to benefit patients.

Finally it appears that it is almost impossible for an interpreter (or a physician) to remain outside of any System, whatever his status and training. The main consequence is that communication is frequently shaped to achieve one of the Systems' goals. The Lifeworld is infrequently heard and acknowledged by the physician, even if patients do use different communication strategies to resist colonization by the VoM. We are still far from what Mishler (2005) suggests: to consider patients' resistance as having considerable worth.

Conclusion

Like others, we have observed the primacy of the VoM over the VoL in consultations involving interpreters. Our analyses provide insight into the motivations for this behaviour specific to physicians, trained interpreters and family members. However, the physician has the major responsibility to ensure effective communication, including the expression and acknowledgement of the Lifeworld. In order to fulfil this responsibility he/she needs to develop an intercultural and interlinguistic sensitivity which can only be achieved if the biomedical hierarchy, health care institutions and the society at large recognize the importance of accessing health care in one's own language. Wider recognition will ensure policies and means to strengthen the physician-interpreter dvad by providing training (for interpreter and physician) as well as budgetary, scheduling and staffing adjustments to permit equal quality of care for all, independent of a patient's ability to speak the language(s) of the health care institution and staff (Leanza, 2008).

Part of this sensitivity should be, according to Hsieh (2010), to negotiate authority when appropriate, as an effective interpreted consultation is the result of "a coordinated achievement between the interpreters, providers, and patients" (p. 158):

[...] authority in bilingual health care should not be established through pre-existing categories or expertise but negotiated and coordinated during the interactive process, which would allow individuals to be adaptive to the issues emerged in the communicative process" (Hsieh, 2010, p. 158).

The type of interpreter will necessarily influence the interaction dynamic, and, as we've shown, influence how control is exerted in the consultation. Training in working with interpreters should, instead of diabolizing family members or other "ad hoc" interpreters, include differentiated approaches depending on the interpreter's relationship with the patient. These approaches might have as a basic principle the necessity of communicative action or negotiation. In order to build these different approaches it is necessary to study providers' discourses and also to do more research on actual communication in medical consultations with interpreters, taking into account characteristics including gender, age, kin relationship, language and ethnicity.

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