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# The patient's Lifeworld: Building meaningful clinical encounters between patients, physicians and interpreters

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## Abstract

*In this paper, our objectives are first to explore the different ways physicians and interpreters interact with patients' Lifeworld, and second, to describe and compare communication patterns in consultations with professional and those with family interpreters. We conducted analyses of transcriptions of 16 family practice consultations in Montreal in the presence of interpreters. Patterns of communication are delineated, grounded in Habermas' Communicative Action Theory and Mishler's operational concepts of Voice of Medicine and Voice of Lifeworld. Four communication patterns emerged: (1) strategically using Lifeworld data to achieve biomedical goals; (2) having an interest in the Lifeworld for itself; (3) integrating the Lifeworld with biomedicine; and (4) referring to another professional. Our results suggest physicians engage with patients' Lifeworld and may benefit from both types of interpreters' understanding of the patient's specific situations. A professional interpreter is likely to transmit the patient's Lifeworld utterances to the physician. A family member, on the other hand, may provide extra biomedical and Lifeworld information, but also prevent the patient's Lifeworld accounts from reaching the physician. Physicians' training should include advice on how to work with all types of interpreters and interpreters' training should include mediation competencies in order to enhance their ability to promote the processes of co-construction of meaning.*

*Keywords: Habermas' communicative action theory; intercultural medical encounters; medical interpreter; mixed method; physician–patient communication*

## 1. Introduction

Language barriers have been shown to be one of the most important factors explaining health disparities among migrants (Pottie *et al.* 2008). For example, they decrease patient satisfaction (Fernandez and Schenker 2010; Schenker *et al.* 2010) and the likelihood of patients receiving a follow up appointment (Sarver and Baker 2000), physician–patient agreement about the physician's recommendations (Clark *et al.* 2004), increase length of hospital stay and increase the number of medical errors (Divi *et al.* 2007). One way to improve access and quality of care is to work with an interpreter (Ngo-Metzger *et al.* 2003; Green *et al.* 2005; Ngo-Metzger *et al.* 2007). While professional interpreters are generally recommended (Jacobs *et al.* 2001; Karliner *et al.* 2007; Brua 2008; Fernandez and Schenker 2010), most interpreted encounters involve untrained interpreters, often the patient's relatives (Ginde *et al.* 2010). In the absence of institutionally provided professional resources, lay interpreters are employed (Brua 2008). Some patients are more satisfied with family members as interpreters (family interpreters) (Edwards *et al.* 1999); physicians seem to be comfortable with family interpreters (Ginde *et al.* 2010); and some authors do see benefits of family interpreters such as gaining knowledge about the patient's Lifeworld (Green *et al.* 2005; Morales and Hanson 2005; Greenhalgh *et al.* 2006; Rosenberg *et al.* 2007). In other words, '[*ad hoc* interpreters, including family members] represent an important resource in multi-linguistic healthcare that might, with adequate practitioner training and guidelines, help diminish utilization disparities and even improve clinical outcomes' (Brisset *et al.* 2013: 8). Thus, there is not only a need to study communication with professional interpreters but also with family interpreters

in order to elucidate some of the conditions required for more effective communication in both contexts and to formulate training guidelines accordingly.

Jürgen Habermas, a philosopher and critical sociologist, developed the Communicative Action Theory (CAT), which makes a distinction between the *System* – comprised of the economy and the state, and which is characterized by *strategic action* (oriented to efficiency and success) – and the *Lifeworld* – comprised of the private and public spheres, and which is characterized by *communicative action* (oriented to interpreting collectively a situation in order to freely agree on a consensual understanding and on the course of action) (Habermas 1984, 1987; Scambler 2001). In strategic action, the emphasis is on the means (influence, coercion, seduction) used to achieve aims that are not disclosed to the interlocutor. In communicative action, intentions appear from the manifest content of the utterances (these acts are self-sufficient) and the process aims at mutual understanding. Communicative acts may or may not succeed, depending on their capacity to result or not in a consensus. As communicative agreements are based on reasons and common convictions, they do not require coercion. When disagreements occur, interlocutors have the opportunity to criticize reasons (validity claims) and the power is located in the quality of argumentation, not in the person and his or her authority status (Habermas 1984).

Mishler (1984) applied Habermas' concepts to the medical encounter and made a distinction between the Voice of Medicine (VoM; technical, decontextualized scientific assumptions of medicine) and the Voice of the Lifeworld (VoL; contextual understanding of health issues). A voice is 'the realization in speech of underlying normative orders' (Mishler 1984: 103). Not only does the content define a voice, but also its form (i.e. context-free and technical jargon vs. contextualized and lay language). Dialogue is an ongoing negotiation of meaning and contextualization is necessary to make interactions coherent (Janzen and Shaffer 2008).When the VoM takes over the VoL through strategic action, the conditions for generating meaning are altered and the Lifeworld is said to be colonized.

In most consultations, communication follows the sequence: (1) physician asks a close-ended question; (2) patient answers; and (3) physician assesses and asks another question. Such systematized communication, described as 'unremarkable interviews' by Mishler, does not allow meaning creation from the patient's Lifeworld and the VoL is seen as disruptive of the VoM (Mishler 1984, 2005) or as 'noise' (Islam and Zyphur 2007). Consultations in which the VoL is interrupted are characterized by poor outcomes from the patient's perspective (Barry *et al.* 2001) and patients may express disagreement (Mortenson and Dyck 2006) or resistance in order to limit or cancel the effects of colonization of their Lifeworld (Leanza *et al.* 2010). The VoL can provide worthwhile alternative understandings (Williams and Poppay 2001; Mishler 2005; Hodge and Perkins 2007). Lay persons' knowledge contains an understanding of the complex interplay of biography, history, locality and the broader social divisions of class and gender (Williams and Poppay 2001). From this perspective, the biomedical agenda cannot (and should not) be cut off from the patient's Lifeworld (Greenhalgh *et al.* 2006).

Interpreters may understand, share, and have the power to reveal or conceal patients' Lifeworld. Professional interpreters are also part of the (medical) System. Their dual membership may facilitate building bridges between patients' and physicians' worldviews (Robb and Greenhalgh 2006). However, there are multiple sources of conflict for professional interpreters, some of which come from misunderstood roles on both sides (Hsieh 2006) and a lack of support from healthcare institutions to face these conflicts and other ethical dilemmas (Brisset *et al.* 2013). It appears that professional interpreters mainly act as 'neutral' translators and as health system agents, transmitting the dominant discourse, norms and values to the patient and therefore favouring the VoM (Wadensjö 1998; Davidson 2000; Leanza 2005; Robb and Greenhalgh 2006). Interpreters rarely play community agent roles where the minority norms and values (VoL) are presented as equally valid (Leanza 2005). Moreover, not all professional interpreters share or understand a patient's Lifeworld, given differences in their socioeconomic status or the simple fact that although they share the same language, they do not share the same culture. Drennan and Swartz (1999) warn us to not assume that interpreters know 'the culture' of the patients and are able to summarize patients' experiences in a straightforward manner for easy physician consumption. This assumption is based on a reductionist view of culture as the beliefs and customs of all people who share a language and country of origin.

This study is part of an exploratory mixed-method project which aimed to describe interpreted patient–physician interaction and compare patient–physician communication when professional and family interpreters are present. The project is qualitatively driven and some material (video recording of consultations)

was also quantitatively analyzed to complement the qualitative analysis. We have published qualitative analyses of physicians' and interpreters' views of these same consultations (Rosenberg *et al.* 2007; Rosenberg *et al.* 2008), quantitative analysis of the consultations' content (Rosenberg *et al.* 2011) and qualitative and quantitative analyses of interruptions of the VoL (Leanza *et al.* 2010). This paper focuses on communication patterns in which at least two people speak in the VoL without interrupting it. Our aim, with this paper, is to study the way meaning is generated from the VoL. First, we explore the different ways patients, physicians and interpreters interact with the VoL whether or not this voice is initiated by the patient. We identify four communication patterns. Second, we describe and compare communication patterns in consultations with professional and family interpreters.

## 2. Methods

### *2.1. Participants*

Physicians working in two primary care clinics in Montreal who consented to participate were asked to identify adult patients who usually come with an interpreter, either a professional or a family member, from June 2004 to January 2005. The research associate then sought the consent of the professional interpreters or the family interpreters who accompanied these patients. Consenting interpreters sought the consent of the patients. In all, 22 physician–interpreter–patient triads agreed to participate. Some physicians and professional interpreters interacted with more than one patient. There were 18 physicians, 16 interpreters and 22 patients in the study.

An interpreter telephoned all identified patients to briefly explain the project before the day of the consultation and asked them to come 30 minutes earlier than their appointment with the physician for a detailed explanation of the research. The research associate explained the project to the patient through the interpreter. All physicians, interpreters and patients gave written consent.

Of the 22 recorded consultations, 12 were with a professional interpreter from the Montreal interregional interpreters bank (a government program) who had undergone 45 hours of training, i.e. a university course about community interpreting, including interpreting techniques and knowledge about Quebec laws and institutions. They also passed formal linguistic competence testing in French and in the language(s) they interpret. The 10 family interpreters 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 1 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. The project was approved by the research ethics boards of the clinics and McGill University.

Professional interpreters not involved in the consultations translated the parts of the recordings that were not in English or French. The consultations were transcribed. No back-translation was performed. For this reason, micro-analyses (e.g. assessing the accuracy of translation or how a precise meaning is transformed) are not performed; neither are they the aim of this study.

### *2.2. Coding procedures*

We used content discourse analysis, i.e. we determined which underlying voice was expressed in the consultations' dialogues. Coding criteria are detailed in Table 2. These criteria and the coding procedure are drawn from Barry *et al.* (2001), further specified by Leanza (2004). Each utterance, 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 or the VoL. Each utterance was coded separately by two people trained by YL (IB for the whole data set and two research assistants, who coded half of the consultations each).

The first coding reached about 90% agreement. All the divergent coded utterances were discussed by research assistants with YL in order to reach consensus. Generally, ambiguities could be resolved by considering the formulation and the context surrounding an utterance. Where no specific voice could be identified, the utterance was coded as such (no Voice). It happened quite rarely (34 times out of 4654 coded utterances, i.e. 0.73%).

### *2.3. Analysis procedures*

Analyses were performed in two steps. First, we looked for the VoL, we noted who initiated it, what happened next (e.g. was it translated? did negotiation occur?), and how the Lifeworld exchange ended (e.g. who closed it? was consensus achieved?). After we went through the first few interviews, four communication patterns emerged. Three are characterized by the register in which meaning was built (i.e. meaningful for the Lifeworld, for the medical System, or for both); in the fourth no meaning was created. We then systematically marked these four patterns throughout the course of all the consultations. Second, we compared consultations with professional and family

Table 1. *Characteristics of the consultations*

| Case | Sex MD | Pat. | Inter. | Interpreter's relationship to patient | Problems addressed | Language |
|---|---|---|---|---|---|---|
| 1 | F | F | F | | Back pain<br>Sociopolitical problems | Punjabi |
| 2 | F | F | M | son-in-law | Angina<br>Diabetes<br>Headaches<br>Hypertension<br>Osteopenia | Bengali |
| 3 | F | F | F | | Depression<br>Social problems | Punjabi |
| 4 | F | F | F | | Diabetes<br>Limb & Neck Pains | Punjabi |
| 5 | F | F | F | | Headache<br>Limb Pain<br>Sociopolitical Problems | Punjabi |
| 6 | F | F | F | | Pregnancy | Punjabi |
| 7 | F | M | F | | Back pain<br>Sociopolitical Problems | Punjabi |
| 9 | F | F | F | | Headache<br>Sociopolitical Problems | Punjabi |
| 10 | M | M | F | | Limb Pain<br>Sociopolitical Problems | Punjabi |
| 11 | M | F | F | | Cough<br>Depression<br>Insomnia | Vietnamese |
| 12 | F | F | F | | Headaches<br>Shoulder pain<br>Sociopolitical Problems | Punjabi |
| 14 | F | F | F | daughter | Chronic Lung Disease<br>Heart failure<br>Skin rash | Vietnamese |
| 16 | M | F | M | husband | Pregnancy | Tamil |
| 17 | M | F | F | daughter | Diabetes<br>Hypertension<br>Limb pain | Tamil |
| 20 | F | F | M | brother | Wrist work injury | Bengali |
| 21 | F | M | M | son | Angina<br>Constipation<br>Urinary problems | Dari |

Note: this table was first published in Leanza *et al.* 2010

Table 2. *Criteria of the VoM and of the VoL*

| | |
|---|---|
| The VoM is characterized by | a specialized/expert language (jargon);<br>questions or interventions on context-free facts or symptoms, possibly measured and quantified;<br>questions or interventions which exclude family and socio-cultural contexts and affective elements. |
| Characteristics of the VoL are designed in opposition of those of the VoM by | a lay language;<br>questions or interventions which include contextualized facts, historically situated, accompanied by affective comments. |

interpreters to describe differences or similarities in the use of these communication patterns.

IB and YL began the analysis together in order to discuss the emerging categories. IB then analysed the whole data set and met with YL and ER to discuss every ambiguity. Difficulties in analysis were solved by looking at the context and the formulation of speech.

## 3. Results

In the 16 consultations, we observed 212 communication events involving the VoL (103 interruption patterns and 109 without interruption). We identified four ways of interacting with the patient's Lifeworld: (1) Lifeworld Rationalization (found 13 times in our corpus), i.e. using Lifeworld data to achieve biomedical goals; (2) Integration of Lifeworld and Medicine (39 times); (3) Mutual Lifeworld (39 times), i.e. having an interest in the Lifeworld for itself; and (4) referring to another professional (18 times) to address the patient's concerns (see Figure 1). We first describe three communication patterns (the fourth, referral to another System, is not discussed as it does not imply meaning-building) and then we differentiate them according to the types of interpreters (professional vs. family).

### *3.1. Lifeworld Rationalization [LRat]*

The LRat pattern was first described by Leanza (2004) in relation to paediatricians. It is a strategic incursion into patients' Lifeworld in order to obtain or present information crucial for the achievement of biomedical goals. In this pattern, information is extracted from the meaningful Lifeworld context and transformed in order to achieve a systemic goal (e.g. biomedical diagnosis). By virtue of the fact that the physician does not disclose his/her intention to the patient, LRat is characterized by strategic action. This pattern enables physicians to understand and perceive the patient's medical reality more complexly than close-ended questioning, grounding information in the patient's contexts. However, the meaning derived by the physician is not directly accessible to the patient, and the patient is excluded from any negotiation of meaning. Excerpt 1 illustrates this pattern. Note that, for all excerpts in the paper, italics indicate a translation from patient and interpreter language to English and that the illustrated pattern is between parentheses.

**Excerpt 1:** Case 3 (professional)

| | | | |
|---|---|---|---|
| 69. | MD: OK. What did she do during the day? | VoL | |
| 70. | INT: *What did you do the whole day?* | VoL | |
| 71. | PT: *I get up in the morning to go to school, then I go to get something if I need it, then I clean the house, and do small little work in the house.* | VoL | |
| 72. | INT: She goes to school in the morning... Sorry? | VoL | |
| 73. | PT: *Small little work in the house.* | VoL | |
| 74. | MD: School with your son or her own school? | VoL | |
| 75. | INT: No, her own school. She goes to her school and comes back at around 1h-1h30 and then if she has to buy something, if she goes out to buy something and comes back home and then she does her work at home, to do her household chores and cleaning or cooking. | VoL | |
| 76. | MD: Is she able to do that? | VoM | (LRat) |

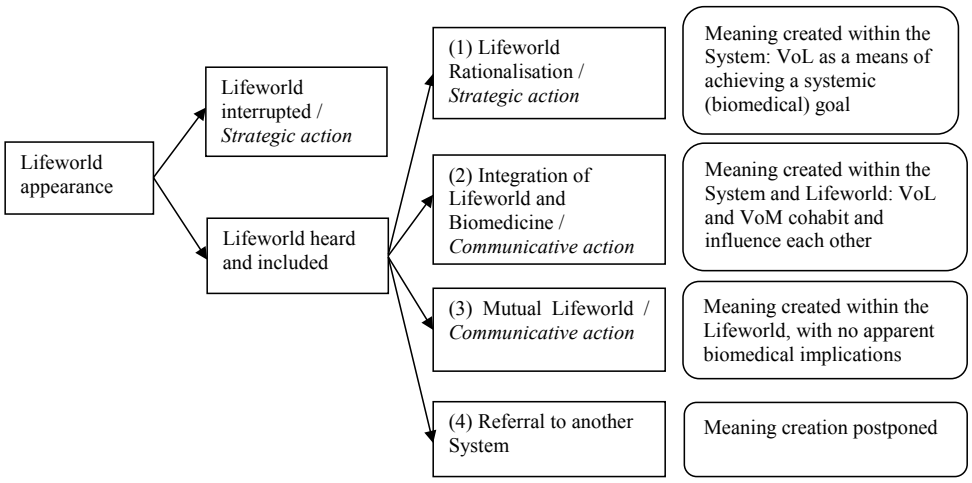


Figure 1. *Ways of interacting with the Voice of Lifeworld*

The last question (line 76) informs us of the physician's purpose in asking these questions. She remains in control of this incursion into the VoL (since she initiates and closes it) so it does not disrupt the VoM and it deviates very little from what Mishler calls the 'unremarkable interview' (Mishler 1984). The VoL is heard but the frame of understanding remains the medical System.

### *3.2. Mutual Lifeworld [ML], an interest in the Lifeworld for itself*

**Excerpt 2:** Case 7 (professional)

| | | | |
|---|---|---|---|
| 322. | MD: Good luck for your hearing with immigration, OK? I will be thinking about you! | VoL | |
| 323. | PT: *Thank you. I also wish that your words will bring me luck.* | VoL | (ML) |

The ML pattern is used to build meaning in the Lifeworld register. First described by Barry *et al.* (2001), it represents dialogue in which both physicians and patients predominantly use the VoL in a fashion similar to natural conversations of everyday life. In these instances, Barry *et al.* (2001: 497) observed 'more evidence of responsiveness on the part of the doctors in recognizing and respecting the patient's unique situation'. The VoL seems here natural and acceptable. The pattern is characterized by communicative action, as it aims at mutual understanding and it allows the drawing of a more complete and contextual knowledge of the patient and, in some cases, of the physician. It contributes to creating, maintaining, or re-establishing the relationship. This communication pattern can take various forms such as humour, sharing or expressing emotions related to the quality of the relationship, and speaking a few words in the patient's language, as can be seen in Excerpt 3.

**Excerpt 3:** Case 2 (family)

| | | | |
|---|---|---|---|
| 281. | PT2: *When water comes, I put a pillow under my legs.* | VoM | |
| 282. | INT3: She tried to leave on a pillow... | VoM | |
| 283. | MD2: (interrupting)...to put her feet up... | VoM | |
| 284. | INT3: (continuing)...yeah...that time, from noon to evening it's always like that. | VoM | |
| 285. | PT2: *It goes in at night. In the morning there is nothing. But from morning until evening it comes again.* | VoM | |
| 286. | INT3: It's normal, and then in the morning it...and again it goes down... | VoM | |
| 287. | MD2:...it goes down... | VoM | |
| 288. | (turning towards PT2)...*paani* (Bengali word for water)? (MD2 is slapping her calf) | VoL | (ML) |
| 289. | INT3: Yeah, *paani* (laughs). | VoL | |
| 290. | PT2: *It does not come at feet, just this leg.* | VoM | |
| 291. | INT3: Only here, not there (gesturing to legs). | VoM | |

Patients who resist physicians' methods of assessment, insights or recommendations may use this pattern after their resistance in order to protect their relationship with the physician. For instance, a diabetic patient hugged her physician at the end of a conflict-laden consultation after having refused the insulin her physician advised (Case 9 [professional]).

### *3.3. Integration of Medicine and Lifeworld [IntegML]*

The integration pattern is a communication event meant to build meaning in both the Lifeworld and Medical world.

**Excerpt 4:** Case 5 (professional)

| | | | |
|---|---|---|---|
| 150. | MD5: [...] I know that all the symptoms that she's going through, I know she can identify, have become a little bit back to what it used to be because of the stressful period because of the [court] hearing that's coming up. And naturally it's a more stressful period. She can always be taking the medication for sleeping especially so that she's able to rest properly before the hearing. I'll re-prescribe if she needs any more. And what I'll be doing is to see her after the hearing to see how everything is going and how everything went. | | (IntegML) |
| 151. | INT5: *As you know that before, because of your hearing, you are so tensed and you're not feeling well. You are more worried about your hearing, and you're more tensed.* | VoL | |
| 152. | PT5: *Yes, my tension is increased. I have more tension.* | VoM | |
| 153. | INT5: *I'll explain to you, let me finish what she said. As you don't sleep at night, and she already gave you the sleeping pills, you can take that at night. But she's going to make you another prescription for the medication, and it's going to help you.* | VoM | |

The VoM is expressed at the same time it takes into account and adapts to the Lifeworld. The outcome can go from mere comprehension of medical System functioning (e.g. the patient learns why her next appointment is in three months, Case 9 [professional], line 486), to an adaptation of the medical System (e.g. changing the specialist a patient is seeing if the patient's confidence in him cannot be restored, Case 1 [professional], line 125). The integration may consist of taking into account the context of the patient to make services available, making sense of the lived experience in the medical System, linking medical knowledge to the patient's expressed concerns, linking medical symptoms to their everyday context, taking into account both System and Lifeworld constraints in problem-solving, acknowledging the legitimacy of folk remedies or theories on a medical problem. These exchanges correspond to communicative action as they aim at mutual understanding, and intentions and validity claims are manifest and therefore open to critique.

It is the only pattern in which there is a search for integration of two different ways of conceiving health, illness and treatment. This pattern can be initiated by patients who are seeking meaningful and personalized interventions or by physicians who wish to adapt to the patient's specific situations. In Case 5 (professional), both biomedical and lay treatments are proposed by the physician herself for pain in the throat and cough.

**Excerpt 5:** Case 5 (professional)

| | | | |
|---|---|---|---|
| 267. | MD: [...] There are many, many ingredients that she could put, but basically the honey, the ginger. She could put black pepper. She could put cardamom. It's almost like the masala for the tea, but without the tea itself. | VoL | |
| 268. | INT: *Whatever you like. Different people put different things: black pepper, ginger, cardamom...You can use it...it can turn out to be a masala chai but actually without using the tea.* | VoL | (IntegML) |
| 269. | INT: Whatever she likes, she can use it. | VoL | |
| 270. | MD: Exactly. I can give her one or two bottles of cough syrup, just if it becomes like the fits. Because viral infections generally do take 7 to 10 days to completely get over them. So she might be having a cough for the next couple of days, | VoM | |
| 271. | but let her not be worried unless she feels that she's getting worse. | VoL | |

In this exchange, the distinction between VoL and VoM is unclear or even absent; folk remedies and biomedicine are both presented as having worth and complementing each other. The fact that there is no interruption between the VoL and the VoM is not surprising, as both come from the physician. This brings us to distinguish the VoL expressed by physicians from the one expressed by patients. In some IntegML exchanges, physicians adapt to the Lifeworld as they infer it. The integration then results from the physician's own internal deliberation. In other instances, physicians acknowledge the actual patient's VoL, allowing negotiation to co-construct a shared narrative or to reach a consensus on the appropriate course of action. The greater the perceived magnitude of difference between two worldviews, the harder it is to achieve integration. For example, home remedies such as massage and warm baths (Case 17 [family], line 160) are easily integrated by the physician. However, faced with a patient who induced vomiting to lower gas pressure in her head (Case 9 [professional], line 199), a physician offered a variety of biomedical and home remedies for 'gas' as she understood the term without exploring the meaning of 'gas' for the patient. This physician adapted to the patient's Lifeworld as she thought it was, not as it actually was. A sign of the inadequacy of the integration is the patient's reassertion of her concern later in the consultation (line 396): '*Ask her to treat my gas. That is my only problem.*' As mutual understanding is the aim of the conversation, it is by nature communicative. This aim is however not reached, as both patient and physician assume they share the same knowledge about gas and the difference is not made explicit.

Finally, physicians suggested referrals to other Systems (social work, psychology, medication insurance authority, etc.). In only one instance did the patient express dissatisfaction at the referral, to a psychologist, which she interpreted as an assertion that she was crazy (Case 3 [professional], line 244).

### *3.4. Communication dynamics in the presence of professional vs. family interpreters*

We observed differences only with the IntegML pattern between consultations with a family interpreter and those with a professional interpreter.

Table 3 shows the frequency of each pattern according to the type of interpreter. A chi-squared test showed significant differences in communication patterns according to interpreter type ($\chi^2(3)=10.19$, $p<.05$). Subsequent chi-squared tests comparing

patterns one to another showed that IntegML is significantly or marginally more used by professional interpreters than by family interpreters (IntegML vs. ML: $\chi^2(1)=7.63$, $p<.01$; IntegML vs. Other Sys.: $\chi^2(1)=6.66$, $p<.01$; IntegML vs. LRat: $\chi^2(1)=3.52$, $p=.06$). The IntegML vs. ML chi-squared test shows also that ML is significantly more used by family members than by professional interpreters (when compared to IntegML). Other one-to one-comparisons do not give any significant or marginal results.

Table 3. *Communication pattern frequency according to interpreter type*

| Com. patterns / Interpreters | (1) LRat | (2) IntegML | (3) ML | (4) Other Sys. | Total |
|---|---|---|---|---|---|
| Professional | 6 | 29 | 17 | 7 | 59 |
| Family | 7 | 10 | 22 | 11 | 50 |
| Total | 13 | 39 | 39 | 18 | 109 |

The effect of the greater frequency of IntegML patterns with professional interpreters needs to be explored in the larger context of the interactions. IntegML patterns can be 'confrontational' with professional interpreters: in their presence, physicians and patients might disagree about narratives aimed at integrating Lifeworld and medical world whereas physicians and family interpreters usually agree (see Excerpt 6: the exchange is between the interpreter, who is the patient's daughter, and the physician only).

**Excerpt 6:** Case 17 (family)

| | | | |
|---|---|---|---|
| 312. | MD18: OK. I think that a lot of these little pains that you're having are just from using the bone for so long. And the best treatment is what you're doing, is massage. | VoL | |
| 313. | INT18: And the best is warm bath. | VoL | (IntegML) |
| 314. | MD18: Warm bath is good. Anything that you find is helping lower the pain is good. | VoL | |

The patient's exclusion from the dialogue and an easier 'integrability' of the elements of the Lifeworld presented by family interpreters may partly explain these agreements. For example, home remedies such as massage and warm baths (Case 17, [family] Excerpt 6) seem less 'disruptive' of biomedicine than a belief of gas in the head (Case 9 [professional]) or a fear of needles for insulin injection (Case 4 [professional], Excerpt 7).

**Excerpt 7:** Case 4 (professional)

| | | |
|---|---|---|
| 133. | MD: I'm not gonna try to convince her that it's OK [to receive insulin injections]. | VoM |
| 134. | PT4: *I understand that, but as long as God will help me, and I will have the strength, I would not like to take the insulin because I am so scared of the needle, but if nothing works, then we'll see. I will believe in you only when get me get rid of this needle.* | VoL |
| 135. | INT: She will try to control her sugars with the medication, with the pills. | VoM |
| 136. | INT: She doesn't want any insulin; she's just scared of the needle. | VoL |
| 137. | PT4: *I already taken the blood out of my fingers, which is very very painful; but the other one is going to go into my stomach, which is going to be very painful.* | VoL |
| 138. | INT: When she checks her sugar, it's quite painful, she doesn't like it and just to imagine taking the needle in her stomach it's something that she's not ready. | VoL |
| 139. | PT4: *(Pointing towards her husband). When he pricked on my finger two three times, it hurts me so much. I'm better off dying than taking the needles. [...]* | VoL |
| 141. | INT: She says it's better to die than to have the needle. | VoL |
| 142. | MD: We're not gonna try to convince her today. | VoM |

Family interpreters validate physicians' integrative narratives and suggest their own. Professional interpreters convey the narratives suggested by physicians or patients. They also shed light on the patient's reality with their own understanding (adding their own text) helping to clarify the patient's concerns and therefore promoting mutual understanding, as in the following excerpt.

**Excerpt 8:** Case 1 (professional)

| | | |
|---|---|---|
| 293. | INT: What he's trying to say is that he's really in trouble; he's really having this pain. And he was getting treatment from an Indian person for 3 months like traditional medication and he had to pay for that $60 for 15 days and there's another pack. But what he wants to try to convey is that he's really in pain. That's why he's trying all kind of other ways. That's what he's trying to convey. | VoL |

| | | | |
|---|---|---|---|
| 294. | MD: I understand this and I understand that you're worried also about this pain and not knowing exactly what's going on. | VoL | (IntegML) |
| 295. | MD: I think, as I told you, we don't have all the answers but our main objective now is to control the pain as much as possible. And I think we obtained it because you said that your symptoms were well controlled with the medication. | VoM | |

This patient's concern does not reappear afterwards (while it has been repeated many times before). It is difficult to know whether the concern has been adequately addressed, as there is no feedback from the patient. Still, this interpreter's intervention had the effect of changing the physician's frame of reference, allowing her to respond to a specific patient concern in both the VoL and a congruent VoM. We see this dynamic with two other interpreters who conveyed their own understanding of patients' feelings:

> *She's saying sometimes she has these kinds of feelings and that she gets mad. She didn't use the word mad, but she's saying that she feels the doctor doesn't understand what she's going through [...]* (Case 3 [professional], line 212)

> *He's saying that in the x-ray, he knows that they see something inside, some kind of piece, something inside. [...] So that's what's affecting him.* (Case 10 [professional], line 226).

These interventions made patients' VoL heard and contributed to the adaptation of the System (e.g. seeking an orthopaedist's opinion).

## 4. Discussion

Most Lifeworld exchanges are part of relationship-building or attempts to take into account the Lifeworld in the medical tasks, but this does not occur in a single way. We observed four different patterns which include the Lifeworld.

In encounters where interpreters are present, we have observed instances where physicians engage with the Lifeworld. Without giving up control of the consultation process, they frame the interactions within the patient's Lifeworld context. We also observed the use of incursions into the Lifeworld to advance the biomedical task. There is evidence from the work of Barry *et al.* (2001) that when Mutual Lifeworld exchanges occur, more of the patient's agenda (psychological plus physical problems) is voiced. Integration of both medical knowledge and interactional moves denoting empathy is an essential part of a successful medical consultation (Cordella and Musgrave 2009). We have found the integrative schema to potentially be an interesting option to further both medical and Lifeworld agendas.

Elsewhere, we have described how patients' VoL is controlled by physicians' VoM in these same consultations (Leanza *et al.* 2010). Patients' VoL is frequently interrupted to keep the interview on track to meet biomedical goals. In the present set of analyses, we showed that when physicians engage in LRat and ML patterns, they are likely to control these exchanges, deciding their beginning and closure. When integrations (IntegML) take the form of physicians' own internal deliberation with patients' Lifeworld, physicians are not sharing much control with patients; therefore, negotiation with the actual VoL of patients may not occur. Others have found that control is a key issue for physicians in interpreted consultations and affects many aspects of communication (Greenhalgh *et al.* 2006; Hsieh 2010; Brisset *et al.* 2013). Based on our work, dealing with the patient's Lifeworld is one more of these dimensions.

We also observed exchanges in which physicians engage with patients' actual VoL. The VoL was acknowledged and influenced the direction of the consultation and the resulting consensus. Physicians may benefit from both types of interpreters' understanding of the patient's specific situations, although we observed differences in communication patterns between consultations with professional interpreters and with family interpreters. Professional interpreters are likely to transmit patients' Lifeworld utterances to physicians. We observed that trained interpreters are significantly more prone to be involved in integrative communication patterns compared to family members. A family member, on the other hand, may provide extra biomedical and Lifeworld information (the ML patterns are more frequent with them than with a trained interpreter), but also prevent the patient's Lifeworld accounts from reaching the physician. Their active involvement excludes patients' VoL to the benefit of their own views which were easily integrated in the medical System. The exclusion of the patient spares the physician a confrontation with a Lifeworld at variance with the medical System and an opportunity to negotiate a mutually meaningful narrative with the patient. Moreover, when family interpreters actively spoke in the VoL, physicians valued their contributions, assuming they represented patients' Lifeworld. This finding is consistent with physicians' discourse about family interpreters

(Rosenberg *et al.* 2007). Even if physicians are less satisfied with family members (Kuo and Fagan 1999), they probably value their perspective as caregivers. Diamond *et al.* (2009) found that residents are 'getting by' in choosing untrained interpreters even if they are aware of the biases and a professional service is available: residents' choice is one of easiness. Our results show that communication is less confrontational with family members as interpreters, which could also explain residents' choice.

As Janzen and Shaffer (2008: 335) emphasized, 'coherent, discourse-appropriate interpretation necessitates that the interpreter have numerous language and overall discourse strategies within easy reach; any single strategy may work well in one circumstance, but fail in another'. Contextualization by adding text may be a beneficial interpretation strategy in some contexts, but it may also impede communication between primary interlocutors (Janzen and Shaffer 2008), as in the cases where patients are excluded from meaning-generating conversations by family interpreters. Our results emphasize the active role of interpreters in the achievement of the communicative aim of mutual understanding.

The study has three main limitations. The first is the small number of cases involved. It prevents us to say whether differences observed between professional and family interpreters are by chance. We have been careful to nuance our results by reporting the contexts in which they were produced. The aim of the research is not to generalize results but rather to identify some communication processes, grounded in the particular context of triadic clinical encounters in the presence of professional and family interpreters, and their influence on the course of communication.

The second limitation relates to the coding process and the analysis grid. The validity of our analyses is strengthened by our use of three coders. Moreover, interpretation was based on the utterance itself and its place in the whole consultation. In addition, the analysts brought different training, expertise and experience to the interpretation discussions: family medicine practice, patient–physician communication, and the roles of interpreters in medical care. Nevertheless, ambiguities in the coding and the analyses were very helpful: they are the 'places' in discourse where meaning co-construction can be observed. Ambiguities are where the different worldviews meet and (sometimes) connect to create something new and meaningful for everybody, as it is the aim of communicative action.

The fact that cases varied in the degree of gender concordance is the third limitation, as some consultations are gender concordant (e.g. all three participants are male) and some are not. We verified whether all-female consultations, patient–interpreter, patient–physician or interpreter–physician gender concordance had an influence in the use of communication patterns, but we did not get any significant results. However, hierarchical relationships between male and female, culturally organized, certainly influence the way communication occurs. This hypothesis should be tested in systematic observations of family interpreted consultations comparing male and female interpreters with male and female patients and/or physicians and involving different linguistic/ethnic groups.

## 5. Recommendations for practice

Overall, in the whole project we found trained interpreters are interrupted significantly more often (Leanza *et al.* 2010), use significantly more integration patterns than family interpreters, not without confronting the VoM (this paper), and they tend to transmit patients' resistance whereas family members do not (Leanza *et al.* 2010). These untrained interpreters are seen as caregivers by physicians (Rosenberg *et al.* 2007): they significantly transmit less psychosocial and emotional content (Rosenberg *et al.* 2011) and tend to control the patient's agenda and express their own VoL (Leanza *et al.* 2010), but they also might add some helpful Lifeworld information (this paper). These analyses allow us to make a few tentative suggestions to physicians working with professional and family interpreters.

Physicians' training should not only focus on how to work with professional interpreters and prohibit working with others, as seems to be the norm in proposed training (Jacobs *et al.* 2010). While working with a professional interpreter is the best option, training should include advice on working with all types of interpreters, showing differences in communication dynamics and advantages and limits of each possible situation. From our research we can advise physicians working regularly with family interpreters to: (1) make clear at the beginning of the consultation that all utterances need to be translated; (2) inform the interpreter that his/her point of view could be helpful and that there is room for it to be heard, after the patient's point of view is heard; (3) ensure that the patient express him/herself during the consultation; and (4) make sure to plan on occasion a consultation with a professional interpreter (it might be telephone interpreting) when there is a special issue to discuss.

Promoting mutual recognition of medical and Lifeworld voices necessitates sharing control with patients, providing them with opportunities to be active participants in the encounters (sharing topic initiation, expressing their agenda, verbalizing their feelings; Babul-Hirjia *et al.* 2010). There is a need for co-constructed interventions that promote understanding of each other's world-views, build on each other's strengths, and allow for patients' choice and control and honour their sense of self (Cohn *et al.* 2009). Li *et al.* (2004: 153) point out a new task for training: 'teaching patients the skill of interrupting physicians successfully when they have to' with the aim of making more collaborative consultations. In the same line of thought, it seems interesting to ask ourselves how control can be shared with interpreters and how to make the best use of their strengths while keeping in mind medical and Lifeworld agendas. This study allowed us to take some steps in this direction.

Interpreters' training should include cultural mediation competencies, as is put forward in some European countries (Bancroft 2005), in order to intervene adequately when conflicting perspectives or misunderstandings (whether or not due to cultural differences) might alter the quality of care. The 'cultural clarifier' role identified in some interpreters' professional standards (CHIA 2002) and put forward by sensitive clinicians (Fernandez and Schenker 2010) might change the power dynamic. Negotiation is necessary and interpreters can play an active role in it with proper training and proper recognition of their contribution.

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