EDITORIAL

Communicative vulnerability and its mutation in interpreter-mediated healthcare encounters

SRIKANT SARANGI

Aalborg University, Denmark

Introduction

‘The field of interpreter-mediated interactions [...] appears to have plateaued in terms of its theoretical development’ – so observes Hsieh (2016: 131), in a work in which she endeavours to offer a model of bilingual health communication. Her theoretical model is proposed along the following intersecting parameters at individual and interpersonal levels: communicative goals, individual agency, system norms, quality and equality of care, trust-control-power and temporality. This list of parameters, one could argue, applies to any healthcare interaction – dyadic or triadic – with subtle and not-so-subtle variations observable in interpreter-mediated healthcare communication (IMHC).

A different theoretical angle on IMHC is provided by Greenhalgh et al. (2006), drawing explicitly on Habermas’s (1984) distinction between ‘communicative action’ and ‘strategic action.’ According to Habermas (1990: 63, italics in original):

Whereas in strategic action one actor seeks to influence the behavior of another by means of the threat of sanctions or the prospect of gratifications, in order to cause the interaction to continue as the first actor desires, in communicative action one actor seeks to motivate another rationally by relying on the illocutionary binding/bonding effect (Bindungseffekt) of the offer contained in his [sic] speech act.

This distinction between strategic action and communicative action, when applied to IMHC, means that the interpreter seeks to ‘influence’ rather than ‘motivate rationally’ the behaviour/understanding of the other participants, i.e. the healthcare provider and the care recipient. Based on empirical data – mainly interviews and focus groups comprising service users and different types of interpreters (professionally trained, family members, allied healthcare professionals/workers) – Greenhalgh et al. (2006: 1170) argue that ‘the interpreter’s presence makes a dyadic interaction into a triad, adding considerable complexity to the social situation and generating operational and technical challenges.’ By extension, ‘strategic action’ from the interpreter in a mediated consultation is unavoidable. This begs the question as to ‘how contemporary notions of patient-centredness, shared decision-making, concordance and empowerment might be applied to decision-making in interpreted consultations’ (Greenhalgh et al. 2006: 1183–1184; Hsieh also makes a similar point when contested goals are imminent).

In extending the theoretical considerations, I see ‘communicative vulnerability’ constituting the core of the interpreter-mediated healthcare encounter, which is simultaneously multilingual and multiparty in nature. More generally, illness – whether
acute or chronic – is a state of vulnerability in biomedical terms, as being ill amounts to disruptions to one’s health status and, consequently, dependence on expert and non-expert others. High levels of health literacy as well as individual autonomy can be markers of resilience during a state of vulnerability. When it involves patients who lack equipoise in linguistic and socio-cultural terms in addition to their poorer levels of health literacy, they remain dependent on others to manage their vulnerability at the communicative level, making possible the conditions of strategic action and message manipulation. As I suggest elsewhere:

In a sense, vulnerability is the other end of the competence spectrum, linguistically and communicatively. The notion of vulnerability also extends to include differences and deficits, especially with regard to unequal levels of health literacy with or without linguistic competencies in class-ridden societies. The communicative vulnerability at the linguistic, interactional level is not something that is only brought along by the participants to a given encounter. It is also the case that the interactional trajectory itself can potentially contribute to the emergence of such vulnerability in an intercultural healthcare setting. (Sarangi 2017: 242)

It is this latter point about interaction-induced vulnerability at the contingent level that concerns the contributors to this special issue on IMHC. Interpreter-mediated interaction embraces many different institutional settings such as law, social welfare, health and community care, bureaucracy, the corporate sector, the media and academic and other conferences. These various settings defy a unified set of parameters or generic skills for a professionally trained interpreter to follow in a rule-governed way. The interpreting/mediating activity in the healthcare setting has its own unique interactional (Pöchhacker and Shlesinger 2007) as well as multimodal (Davitti 2019) features, underpinned by differential role expectations concerning the interpreter and the other primary participants.

A typical bilingual clinic consultation involving family members as interpreters (Ebden et al. 1988) demonstrates communicative vulnerability at both linguistic and socio-cultural levels. In its extreme form, such vulnerability can cause serious misunderstandings and compromise the quality of patient care. The very co-presence of family members – not necessarily as ratified interpreters but simply as companions in paediatric, geriatric, palliative and genetic consultations – does signal a sense of vulnerability on the part of the patient in need of mediation. Traces of communicative vulnerability can also be noticed in any triadic consultation involving professional interpreters. In both scenarios, the absence of mutual competencies in each other’s first language or in a common language as far as the main participants are concerned occasions the mediating role of a third party – the interpreter, whether professional or lay1 – to minimise the communicative barrier.

The effects of the participation of an interpreter, whether a professional or a lay individual, is an ongoing debate. Based on an extensive review of published literature, Karliner et al. (2007) found that for those with interpreting needs, use of professional interpreters is more associated with improved clinical care than the use of lay interpreters, and indeed that the former approaches the quality of care for patients without a language barrier. In contrast, Aranguri et al. (2006), based on a detailed sociolinguistic analysis of interpreted consultations, found that needing to use an interpreter resulted in less satisfactory communication, both linguistically (e.g. alterations in content/meaning, reinforcement/validation, repetition) and affectively (e.g. absence of rapport-building small talk). As Elderkin-Thompson et al. (2001) point out, in situations where allied healthcare professionals, e.g. nurses, act as interpreters, they are likely to provide information congruent with clinical expectations but not with patients’ comments and thus slant the interpretations, reflecting unfavourably on patients and undermining patients’ credibility. The challenges and consequences surrounding IMHC are bound to be unique to individual encounters, irrespective of the status of the interpreter.

 Primarily, in the healthcare setting, the patient or care recipient with a language barrier is communicatively vulnerable because the preferred language of the care provider misaligns with that of the care recipient. This inevitably means that the care recipient does not have the opportunity to verbalise adequately the presenting symptoms or to communicate directly his/her subjective feelings
and emotions to the care provider. However, the care recipient's language deficit is only the tip of the iceberg. There can be other layers of vulnerability, ranging from power asymmetries to epistemological uncertainties to cultural differences surrounding the notion of care (see below).

Communicative vulnerability is not only confined to the care recipient but also engulfs the other participants – the healthcare provider and the interpreter. Given that the healthcare provider lacks the interpreter's bilingual competence, s/he has no means to assess the efficiency and accuracy of the transmitted message through back-translation and thus has to accept the interpreter's rendering of the message based on trust. In this sense, the care provider is vulnerable, as s/he is unable to access the subjective feelings and emotions in the patient's preferred language, although it is arguable that even in monolingual settings, patients' subjective, experiential meanings may remain tacit. In Kleinman's (1988: 231–232) characterisation of the role of the care provider as 'a mini-ethnographer' in their attempt to place themselves 'in the experience of the patient’s illness,' the language barrier can heighten the obstacle in the way of 'experiential phenomenology,' which 'is the entrée into the world of the sick person.' The patient's subjective experience of illness and its management/coping trajectories do not translate unequivocally through the triadic interpreting process. This feature of vulnerability is heightened if each consultation attended by the same patient involves a different interpreter, marking the absence of continuity of care (but see Hsieh 2016 on tensions relating to patient–interpreter vs. provider–interpreter relationships over time).

The professional interpreter is also vulnerable in the face of complex cognitive demands associated with the interpreting task. In addition, s/he is unlikely to be adequately familiar with the patient's illness trajectory, from both epistemological and experiential standpoints. The contingencies of the immediate encounter in most instances will override the interpreter's prior experiences with similar consultations involving other care recipients. In the multi-party encounter, the interpreter may be compelled or nudged to go beyond their code of practice to intervene much more than they should, thus raising ethical tensions.

Lay interpreters may be more vulnerable than professional interpreters in one sense, but the former have access to mutually shared experiential knowledge that the latter may not have. The vulnerability is particularly salient in the case of child and adult lay interpreters when it comes to terminology, which they may be unfamiliar with in their home language (Green et al. 2005). Cohen et al. (1999), based on interviews with general practitioners in the UK concerning teenagers and children as interpreters, draw attention to an instance where a teenage son interpreting for his mother confused 'stomach' with 'throat':

[H]e was saying that her stomach was a problem, but she kept on referring to here (points to throat), I said do you mean the stomach or do you mean the throat, he'd actually got the words wrong, he'd thought that stomach had meant throat. (Cohen et al. 1999: 173)

Six different layers of vulnerability in interpreter-mediated healthcare communication

Here, I identify six different layers of vulnerability that characterises IMHC in all its complexity.

(1) Professional–client encounters in general – and healthcare encounters in particular – are characterised by knowledge asymmetry, with tacit levels of interpretive procedures and frames that are not easily accessible. The expert care provider does not always explain explicitly the causes and consequences of their actions – say, during history taking or physical examination – which leaves both the interpreter and the care recipient communicatively vulnerable. The patient's lifeworld and culturally sensitive belief systems, which are likely to be shared between the patient and the interpreter, can also operate tacitly, thus putting the care provider in a vulnerable position.

(2) The intercultural dimension means that the interpreted consultation has to remain sensitive to the cross-cultural aspects of health and illness (Helman 1985). Napier et al. (2014) attest that efficient healthcare delivery must be based on an alignment between the biomedical culture and its assumptions on the one hand and the broader culture of values and norms on the other:
'When members of a society lack the capacity for self-reflection – i.e., when people find it difficult to assess their own dysfunctional practices – they become vulnerable to choosing bad meaning over no meaning' (Napier et al. 2014: 1634). According to Hsieh (2016: 148):

As interpreters assist in cross-cultural care, they inevitably need to tread in the boundaries of medicine as they bridge the blurry boundaries of medicine, language, and culture. Despite the provider’s claim and power over medical expertise, they face challenges in sharing their control over the process of care and meanings of medicine with interpreters in cross-cultural care.

Schouten and Meeuwesen (2006) suggest that the cultural dimension can be broken down into five components: (1) cultural differences in explanatory models of health and illness, (2) differences in cultural values, (3) cultural differences in patients’ preferences for doctor–patient relationships, (4) racism/perceptual biases and (5) linguistic barriers. In the clinical setting, the patient at least has some exposure to the target culture, although the quality of secondary socialisation will vary greatly among individual patients. The healthcare professional, in contrast, will very likely have had very little exposure to the patient’s cultural beliefs and practices, except in their limited experiences through clinical consultations and perhaps through intercultural training modules which may have presented stereotypes of cultures rather than the lived realities. Here, the interpreter in the role of ‘cultural broker’ – beyond the translator role – comes to the fore in minimizing the patient’s communicative vulnerability.

(3) It is important to keep the cultural barrier distinct from the linguistic, and most specifically paralinguistic, barrier. From an interactional sociolinguistic perspective (Gumperz 1982), communication difficulties may be prevalent at the level of contextualisation cues and conversational inferences. Talk in the clinic is not only about presentation of symptoms, but also about presentation of self: because of a lack of linguistic/paralinguistic resources, patients may have difficulties in expressing the nature of symptoms (It-ness) as well as in articulating the affective aspects (I-ness) (Roberts et al. 2004). The linguistic/paralinguistic deficit on the patient’s part, by extension, puts the interpreter in a vulnerable position as far as self-understanding is concerned, thus potentially affecting optimal communication with the healthcare provider.

(4) The multi-party character of the encounter, which involves the participation of a professional or lay interpreter, adds another layer of vulnerability in the face of interactional contingencies. According to Georg Simmel (1950), dyadic and multi-party relations are qualitatively different: ‘In the dyad, the sociological process remains, in principle, within personal interdependence and does not result in a structure that grows beyond its elements’ (Simmel 1950: 126). In triadic and multi-party encounters, the immediate reciprocity that the dyad relies on is constrained; there is a possibility of different dyads forming within the triad, thereby threatening the independence and autonomy of the individual participants and causing them to become subordinated. Although Simmel’s remarks are generally about forms and structures of social life (inclusive of the dialectic of freedom and constraint, of autonomy and heteronomy), studies in the IMHC setting would benefit by considering the participation dynamics of triadic consultations more critically (for an overview, see Laidsaar-Powell et al. 2013). In the paediatric clinic – which is a default triadic healthcare encounter – Silverman (1987) characterises the parent as carer in a ‘chauffeuring role’. Coupland and Coupland (2000) extend Silverman’s characterisation to the geriatric clinic and show how sons and daughters can become ‘mobilisers’ through adopting a less or more powerful role through participation. Also, in relation to triadic geriatric consultations in Taiwan, Tsai (2007) observes that the more companions participate in providing information, the less patients themselves volunteer information or respond to doctor’s questions asked prior to the companion’s intervention. Even with low-participation companions, patients rarely have a full turn to complete an information unit. In such scenarios, the care provider and the carer assume primary participant status, with the care recipient relegated to a vulnerable third-party status – almost in the role of a bystander.

(5) Following from the above, the nuanced status of the interpreter – whether professional or lay – adds to the complexity of the mediated consultation and, potentially, the communicative
vulnerability of all participants. The category of ‘lay interpreter’ is not homogenous – a spouse vs. a child vs. an adult may position themselves differently. Likewise, the category of ‘professional interpreter’ is not a unified label, with the possibility of many intervening variables. Among others, Singy and Guex (2005) draw attention to differential – even contrasting – role expectations concerning the professional interpreter. In the context of interpreting in French-speaking Switzerland based on questionnaires and focus groups, they show that while the interpreters (labelled ‘Interpreting Cultural Mediators’) perceived themselves as active participants in the consultation and took on broad cultural issues beyond language – to bridge the gap between physicians and patients – this view was not shared by physicians and patients. However, some physicians saw the interpreter as a co-therapist in need of specialized training. As one physician put it:

To sum up, my mediator is trained, with the linguistic knowledge, the knowledge of therapeutic techniques, knowledge of the institution, but also someone who has been through training with me – that is to say I also require from myself that I should be trained with him. (Singy and Guex 2005: 48)

As already indicated, both lay and professional interpreters may facilitate or inhibit the consultation. Ironically, the interpreter runs the risk of becoming a communicative barrier when he or she is meant to minimise the existing communicative barrier between the care provider and the care recipient. That is, in the process of rendering messages the interpreters may render the care provider and/or the care recipient communicatively vulnerable.

(6) A final layer of vulnerability relates to contemporary western healthcare practices and paradigms such as patient-centeredness, patient autonomy, informed consent, shared decision making, concordance etc., where linguistic, communicative and cultural competencies of the care recipients cannot be taken for granted. The different cultural assumptions surrounding the concept of care can disfranchise the patient in terms of participation in the interaction and decision making within and beyond the clinic encounter.

Some terminological and analytical considerations

Given the complex layering of vulnerability, the metaphor of mutation offers a way of capturing the significant levels of alteration that can potentially occur in IMHC as the interpreter routinely shifts between ‘just translating’ to ‘mediating’. The argument that the role of the interpreter goes beyond being a bilingual dictionary and/or a neutral translator has long been made in interpreting studies (e.g. Wadensjo 1998; Roy 1999; Davidson 2000, 2002; Angelelli 2004, 2005). In many subsequent studies undertaken from within the language/interaction perspective (e.g. Pöchhacker and Shlesinger 2007; Baraldi and Gavioli 2012), the interpreter is shown as not just a linguistic medium/conduit but as one who mediates the consultation, potentially influencing the communicative processes and also the outcomes.

On the surface, the label interpreter-mediated healthcare communication (IMHC) suggests that the interpreter’s mediating role is designed to have a beneficial effect on the encounter. Other cognate terms such as participation, coordination, interaction and involvement are useful, but they need to be understood as being both distinctive and interrelated – conceptually and empirically. Goffman’s (1974, 1981) distinction between ‘sphere of participation’ based on production and reception formats within the participant framework, and ‘sphere of [focused] interaction’ readily comes to mind. He illustrates this distinction in reference to the game of bridge, where a kibitzer (non-player) can participate but not interact – s/he can look at one or more hands and join in during the post-mortem discussion (Goffman 1974: 225). In other words, the kibitzer is mainly an onlooker with a ratified participant status during the game, but once the game is over s/he can interact actively with the other players.

As regards the sphere of participation, the interpreter is positioned for the main part as the mouthpiece of the primary participants – the healthcare provider and the care recipient – whereas in relation to the sphere of interaction s/he can take on the role of spokesperson or author or principal, to use Goffman’s (1981) terminology concerning the participant framework. Within the sphere of interaction, for instance, the interpreter can
initiate a side activity to gather more information or explain certain phenomena by putting on hold the triadic mode and entering into a dyadic mode. In occasions like this, the interpreter assumes the role of primary participant rather than remaining a secondary participant, thus making a framing/footing shift to the sphere of interaction. If the interpreter is a family member, it is not a simple matter to designate who the primary and secondary participants are in such a complex encounter. With regard to the sphere of interaction, it implies not only active involvement in the communication process through dyadic exchanges but also requires participant-pairs (patient–interpreter and physician–interpreter) to have access to shared knowledge and experience at interpersonal and institutional levels. In sum, the spheres of participation and interaction do become conflated in IMHC.

Typically, while the professional interpreter may claim access to professional and institutional knowledge in order to shift from participation to interaction, the lay interpreter will have access to family-based intersubjective knowledge which would allow for a more active – even aggressive – form of interaction. Interactionally, the lay interpreter can background the patient by answering directly the care provider’s questions – thus breaching the ideal four-part sequential structure – or by not transmitting everything that transpires in the consultation, thus altering/mutating the content of turns during the interpretive process. An example would be to change a wh-question (e.g. ‘when do you feel the pain?”) to a yes/no-question (e.g. ‘do you feel pain when you lie down?”) as well as deleting key message components, which would constitute a form of recontextualisation, or in the Habermasian sense, a form of strategic action.

While translation and mediation as communicative activities have been kept distinct, I would like to suggest that they should also be seen as distinct communicative activities. The literature on interpreting suggests that interpreters are not supposed to mediate (cf. the translation vs. interpretation format). In contrast, the literature on mediation suggests that mediators are not supposed to interpret but facilitate the interaction neutrally. As I see it, interpretation and mediation as communicative activities can be mapped onto a cline of participation, with mediation signalling an increased level of participation/involvement. Participation therefore seems to be a key variable in teasing out interpreting and mediating activities in a given encounter involving professional and lay interpreters, with no or little mediation at one end and with taking over the interaction as a primary participant and relegating one of the other primary participants – usually the patient – to a third party status on the other.

There is extensive literature surrounding the role of the professional interpreter in the healthcare setting. An early typology by Bloom et al. (1966) identifies three different interpreter roles: taking over the interview, acting as a tool to facilitate communication and working in partnership with the healthcare provider. Davidson (2000) characterises the professional interpreter as co-interviewer rather than conveyor of information. Leanza (2007) proposes four professional interpreter role categories: system agent, community agent, integration agent and linguistic agent. According to Greenhalgh et al. (2006), the interpreter performs a nuanced set of roles – as interpersonal mediator, system mediator, cultural broker, educator, advocate and link worker. Many others have suggested different typologies using different labels and there is consensus that the role-types are rather porous and that they mutate constantly in relation to the contingencies of a given encounter. The nuanced nature of the professional/lay interpreter’s role taking (e.g. translator, cultural broker, mediator, gatekeeper etc.), which to a large extent is tacitly manifest across the participation-interaction continuum, can be appraised more fully through the notion of role-set (Merton 1968; see also Sarangi 2010, 2016) and activity/discourse roles (Halvorsen and Sarangi 2015) vis-à-vis participation/involvement.

Interactional tensions are likely to emerge when shifting between the various role categories, targeted differentially for communication support (reproducing speech action, organising turn taking) and for primary participant status (answering questions, seeking clarification, explaining cultural norms, etc.). The interaction order of multi-party mediated encounters is inherently complex in terms of participation framework and participation status (self-presentation and role performance). All the contributors to this special issue address, in different ways, the complexity...
surrounding the concepts of ‘participation’ and ‘role’ and their interactional manifestation.

The individual contributions

The interpreting/mediating role of the interpreter – whether professional or lay – resembles a scaffold with regard to coordinating and facilitating the triadic encounter. The role taking is subject to many contingent variables – and it is these that the contributions to this special issue attempt to unveil. In introducing the contributions and in keeping with the earlier remarks, I reinterpret the core arguments by embedding them in the notion of communicative vulnerability and with particular reference to Goffman’s (1974) above-discussed distinction between the sphere of participation and the sphere of interaction. The contributions, however, do not allow for a neat clustering, and there are variables across many axes, including professional vs. lay interpreters, primary vs. tertiary care settings and low- vs. high-stake encounters, not to mention the many different linguistic, ethnic and cultural backgrounds represented. The order in which I introduce the individual contributions is necessarily eclectic.

Role expectations concerning the professional interpreter in both face-to-face and telephone formats in different clinical settings remain the focus of Claudia Angelelli’s paper. The complexity of the mediated encounter at times occasions the professional interpreter’s going beyond the normative role of ‘interpreting’ to deliver cross-cultural care, which may be regarded as ethically inappropriate. When the interpreter has a medical background, as in one of the clinics here, s/he takes over the history-taking phase of the encounter, following the nurse practitioner’s directive. This serves as an example of the interpreter moving from the sphere of participation to the sphere of interaction to minimise the patient’s communicative vulnerability. On other occasions, the interpreter may feel compelled to shift his/her normative role to align with the expectations of the co-participants, which means a sense of vulnerability on the interpreter’s part.

Staying with the topic of role shifts and their activity-specific configurations at the interactional level, Galina Bolden compares the professional interpreter’s interactional routines in cases of misunderstandings and during the physical examination phase of the consultation (see also Bolden 2000). With regard to misunderstandings, the interpreter would actively initiate and resolve specific repair sequences. During the physical examination phase, the interpreter’s participation may be minimal, but his/her bodily actions become salient, complementing the verbal actions. In terms of bodily actions, then, the interpreter enters the sphere of interaction, when the patient can be seen as communicatively more vulnerable. What Bolden characterises as ‘interpreting action in context’ is not limited to translation, as the act of interpreting is influenced by the interactional contingencies on the one hand and the ongoing medical activity on the other. The interactional contingencies of the multi-party situation, as in Angelelli’s case, can demand that the interpreter’s role be either amplified or muted in a given interactional environment.

Claudio Baraldi and Laura Gavioli specifically focus on question-answer sequences in the consultation, as the doctor’s designing of questions has to be optimised to enable adequate responses for the management of the patient’s present condition. In adopting an active mediating stance, the interpreter instantly recognises the communicative vulnerability of the patient at the linguistic level (what the authors call ‘communicative uncertainty’) and simultaneously enters the sphere of interaction for the benefit of the patient’s understanding. The extended turn design is aimed at minimising the apparent communicative uncertainty and potential misunderstanding in an anticipatory manner. Like in Bolden’s paper, the interpreter steps outside their translating role and intervenes with a role shift to ensure that medically relevant information is optimally communicated. What we see here is that the triadic interaction gives way to dyadic interaction between the interpreter and the patient in the patient’s first language, whereby the doctor as one of the primary participants is relegated to a vulnerable third-party status. The doctor does not normally interrupt the dyadic interaction, which signals a form of collusion.

Cecilia Wadensjo considers the professional interpreter’s involvement vis-à-vis topic control and mutual trust. She suggests that relational exchange is built upon the idea of the interpreter as conversational partner, with the broader argument...
framed in relation to co-participants’ attitudes towards professional interpreters. Different interpreters show different levels of involvement, thus trading selectively between the spheres of participation and interaction. Such variations will have interactional consequences in terms of topic control and the building of rapport and mutual trust. The emotional aspects, for instance, may not be transmitted on all occasions, and this carries a sense of vulnerability. The analytical distinction between ‘relaying by displaying’ (representing) and ‘relaying by replaying’ (re-presenting) becomes useful, while also pointing to how face-work can potentially impact the organisation and content of talk. To preserve face and credibility ‘displaying’ rather than ‘replaying’ vagueness might be preferred by the interpreter.

Mutual understanding and misunderstanding is the topic underpinning the paper by Sione Twilt, Ludwien Meeuwesen, Jan D. Ten Thije and Hans Harmsen. With lay interpreters, the quality of interpreting is at stake, including the increased vulnerability of the patient. In the primary care setting, a lay interpreter may facilitate the communication process through their participation/interaction, but there is also a likelihood that their role taking will instead impede it by introducing misunderstandings. Analytically, the authors draw on the notion of reception format of reporter, recapitulator and responder to characterise the lay interpreter’s role shifts during the encounter. While the reporter role keeps the interpreter firmly in the sphere of participation, the responder role amounts to entering the sphere of interaction. The more the lay interpreter moves into the sphere of interaction (i.e. taking on the role of responder) the more one party – usually the patient – is relegated to a third-party status, thus rendering them vulnerable. The authors compare instances of good and poor mutual understanding using external criteria, leading to the triangulation of their findings, i.e. the extent to which different interpreting practices can lead to facilitating or inhibiting understanding. They identify key differences in the role of the lay interpreter with regard to omission of content and undertaking of side-talk activities, which at times can exclude the care provider from the sphere of interaction.

The role of the lay interpreter – as facilitator, as intermediary and as direct source – parallels the position taken by Celia Roberts and Srikant Sarangi, who consider family members as interpreters and more generally as companions in the primary care setting. They compare two settings: a monolingual triadic scenario, which they describe as being a ‘mediated consultation’, and a bilingual triadic consultation, which they call an ‘interpreted consultation’. In the former, the companion/carer in the study plays a mediator role and becomes a ratified co-narrator in expanding and/or streamlining the patient’s contributions, while occasionally challenging the patient’s account of affairs. Thus the companion/carer moves in and out of the spheres of participation and interaction effortlessly in terms of both activity-specificity and topic-specificity, albeit with different communicative consequences. In the interpreted consultation, in contrast, the lay interpreter does not translate everything for her mother, choosing protection over autonomy. When the patient is unable to participate in the language of the clinic, the carer’s interpreting and mediating roles become conflated, requiring the doctor to have ‘communicative dexterity’. According to Roberts and Sarangi, lay interpreter-mediated consultations are quite similar to triadic monolingual consultations, which differ in terms of role shifts and alignments from mediated consultations involving professional interpreters. They suggest a cline of mediation as far as lay interpreters/companions are concerned in order to capture the dynamic role alignments in a given encounter.

Charlene Pope and Jason Roberson, based on a comparative study design involving dyadic monolingual and triadic bilingual consultations, examine how shared decision making is accomplished or not in the obstetric clinic – leading to disparity in quality of care. In the triadic consultation, they observe, the normative role expectations may prevent the interpreter from engaging with life-world issues, including affective and emotional ones, and humour sequences. As is shown, the sphere of participation and the sphere of interaction unfold differentially in the dyadic monolingual and the triadic bilingual consultations. The findings reveal that, unlike the dyadic monolingual encounter, in the triadic bilingual encounter involving patients with limited English proficiency (LEP) less information is exchanged, as evident in the nature of question-answer sequences – i.e.,
use of open questions to facilitate participation in the conversational floor vs. closed questions in agenda-specific ways to manage surveillance. Such discrepancies may amount to LEP patients receiving lower-quality care and therefore being vulnerable. More specifically, the nature of shared decision making is rated following an established scale and differences are identified, particularly affecting the LEP patients because of their ethnon-linguistic identity.

The paper by Louisa Willoughby, Marisa Cordella, Simon Musgrave and Julie Bradshaw considers a scenario where the healthcare provider is bilingual and uses the patient’s first language (Italian) for the consultation, with the bilingual daughter co-present as companion and interpreter. They refer to this scenario as an example of triadic monolingual consultations (language concordant consultations), although there are some elements of bilinguality (use of English in a dominantly Italian consultation). All three participants, because of their shared linguistic repertoires, albeit to different levels of competencies, can partake in the sphere of interaction. As the consultation progresses the daughter assumes a supportive role and only occasionally challenges her mother’s account of affairs. One is expected to consider the presence of the bilingual doctor as an optimal, even ideal, solution to interpreter-mediated consultations; unlike the monolingual doctor in such triadic interpreted consultations, the bilingual doctor seems to manage the family member’s participation more effectively in an attempt to minimise communicative vulnerability.

Finally, Peter Roger and Chris Code deal with the speech pathology clinic, in a setting where the mediating role of the professional interpreter extends to an assessor role. According to them, this setting places ‘an excessive cognitive burden’ on the interpreter and there are ‘special challenges’ that can make the interpreter communicatively vulnerable. The interpreter is expected to align their role to that of the speech therapist rather than to perform their normative interpreter role. This means a move from the sphere of participation towards the sphere of interaction in their role as co-assessors of people with aphasia. The tensions are amplified when assessing aphasia as the interpreter orients to message content/meaning and the speech pathologist orients to language form. This differential orientation is underpinned by the goal of assessment concerning what constitutes normal/abnormal language abilities. The ‘uninterpretable’ nature of many of the utterances produced by speakers with aphasia makes the situation even more complex. In a sense, the interpreter is expected to be activity-focused. but here the interpreter lacks form-specific expertise to carry out the joint assessment. We have a mismatched knowledge schemata at the interprofessional level in terms of production and reception formats, with the interpreter placed in a communicatively vulnerable position. Roger and Code identify three frames: the Testing-Translating frame, the Discussion-Description frame and the Cultural-Linguistic frame. Whereas the Testing-Translating frame can be seen as the default frame belonging to the sphere of participation, the other two frames progressively move the interpreter to the sphere of interaction, thus relegating the person with aphasia to a communicatively vulnerable third-party status. The lack of shared understanding between the two professional groups – speech pathologists and trained interpreters – raises serious questions about the efficacy of such mediated encounters targeted at functional goals.

Conclusion

In the context of interpreter-mediated healthcare communication (IMHC), when triadic encounters mutate into being dyadic – a development sometimes referred to as side activity – one of the primary participants is excluded from the main participation/interaction frame, making him/her communicatively vulnerable. The vulnerable participant becomes almost a bystander and is not even in the sphere of participation, let alone in the sphere of interaction. The role shifts in the case of both lay and professional interpreters – a theme running through the contributions – are also shifts in frames and footings (Goffman 1981), which can be mapped on to the continuum of the sphere of participation at one end and the sphere of interaction at the other. Viewed from the perspective of Goffman’s (1981) participation framework and the associated production and reception formats, mutation may affect the interactional equipoise.
when one party shifts or is made to shift. The complexity of the encounter and the different configurations/mutations of participation are played out at different levels of role taking and shifts between the spheres of participation and interaction.

Communicative vulnerability also extends to the epistemological positioning of the researcher-analyst, who may not be equally competent in the languages of the clinic as well as being outside the experiential trajectories of illness, the family dynamics involved and the institutional and professional orders in play in a given encounter. A key methodological – and, by extension, analytical – issue concerns what does not get translated/interpreted by the interpreter. In some cases, such omissions and at times misinterpretations are only spotted at the time of transcription and/or translation. Such post hoc discoveries pose an ethical dilemma for researchers: what would they do with such incidental findings, something that was not part of the main objective of the study? This needs more systematic investigation, given that such practices are likely to be commonplace in triadic healthcare encounters.

In terms of study designs, our knowledge of what is unique about interpreter-mediated communication would be richer if we knew what goes on when the encounter is not mediated by an interpreter or when it is mediated by a family member whose primary role is not as an interpreter but as a companion/carer, and the language of consultation is the same for the patient and the companion/carer. Other comparative study designs can range from encounters involving native and non-native care recipients (Twilt, Meeuwesen, ten Thije and Harmsen) to mediated (bilingual) and non-mediated (monolingual) consultations involving the same healthcare provider (Pope and Roberson) to triadic monolingual and interpreter-mediated bilingual encounters (Roberts and Sarangi) to the possibility of comparing the communicative practices of bilingual and monolingual doctors involving family members as companions/carers (if we were to extend it to the study by Willoughby, Cordella, Musgrave and Bradshaw). In addition to comparative study designs, triangulation of findings on the basis of external criteria for mutual understanding (Twilt, Meeuwesen, ten Thije and Harmsen) and shared decision making (Pope and Roberson) provides a stronger evidential basis to appraise discourse analytical findings.

Although several studies (e.g. Aranguri et al. 2006; Dysart-Gale 2007), including the contributions here, suggest that the presence of the interpreter affects the interaction both positively and negatively; and as with medicine, the good that an interpreter’s mediation brings must outweigh any potentially harmful side effects.

Note

1. Researchers use different terminology such as ‘formal’ (trained, professional) vs. ‘informal’ (ad hoc, proxy, family member) to characterize the status of the interpreter. I here use professional interpreter vs. lay interpreter, while acknowledging that such a distinction becomes blurred within and across given encounters. This special issue covers both types of interpreters. The allied healthcare professional as interpreter falls within the professional–lay continuum.

References


Gumperz, John J. (1982) *Discourse Strategies*. Cambridge: Cambridge University Press. [https://doi.org/10.1017/CBO9780511611834](https://doi.org/10.1017/CBO9780511611834)


Leanza, Yvan. (2007) Roles of community interpreters in paediatrics as seen by interpreters, physicians and researchers. In Franz Pöchhacker and Miriam...