

Dialogue interpreting and person-centred care in a clinical mental healthcare setting

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Abstract

This chapter examines the intersection between dialogue interpreting and the person-centred care approach to healthcare delivery and communication. Among the different values of person-centred care, this chapter focuses on the enactment of the following principles in interpreter-mediated talk: respecting the patient's autonomy, consideration of the patient's spirituality, and relational continuity. The excerpts discussed in this chapter were extracted from audio-recordings of authentic consultations that took place in an outpatient mental healthcare clinic in Scotland. Drawing on a qualitative analysis of the data, this chapter posits that interpreters may consciously or non-consciously enable or hamper person-centred communication through their performance. This chapter also illustrates how the way in which interpreters influence person-centred communication largely depends on the alignment, or lack thereof, that exists between the interactional goals of the primary speakers' utterances and the interpreters' renditions. Finally, because interpreters make interpreting decisions based on their understanding of the clinical, linguistic and interpersonal goals at play in the encounter, this chapter suggests that interpreters' awareness of the guiding values of person-centred care is crucial to ensure that linguistically diverse patients fully benefit from such values.

Key words:

Dialogue interpreting, clinical communication, person-centred care, mental health interpreting

1. Introduction

Healthcare interpreting is a unique form of language mediation because it is ancillary to the demands of the larger speech event that frames it: cross-cultural care (Hsieh, 2016). This means that the dynamics typically associated with interpreted talk are shaped by the expectations, values and goals of the event in which the interpreting activity unfolds. The interplay between interpreting practice and the discursive features of healthcare encounters is so significant that healthcare interpreting cannot be properly understood in isolation from its context (Angelelli, 2019). The highly situated nature of healthcare interpreting makes this practice

interdisciplinary to the fullest degree as it is located at the intersection of medicine, language and culture (Hsieh, 2015). This intersection has implications for interpreting performance standards and what is required for an interpreter-mediated encounter (IME) to be successful. For example, a degree of cooperation between the healthcare practitioner and interpreter is usually necessary to fulfil the requirements of the medical agenda (Flores, 2005). For this cooperation to be successful, the interpreter needs to be attuned to the healthcare practitioner's interactional goals (Rodríguez-Vicente, 2020). Against this background, interpreter awareness of the guiding values of person-centred care (PCC) seems to be a prerequisite for language discordant patients to fully benefit from the advantages of this approach to healthcare delivery and communication. The academic interest in the intersection of language mediation and person centredness in healthcare is increasing (see Angelelli, 2020). However, the unique ways in which interpreting intersects with the values of PCC in different medical specialties remain largely unexplored. This gap in the literature is worth addressing given the implications of this issue for language discordant patients' access to equitable healthcare services. In order to examine the intersection between language mediation and PCC, this chapter provides a discussion of the enactment of three core PCC principles in a series of interpreter-mediated episodes that took place in an outpatient mental health clinic in Scotland. The discussion is structured around the interplay between language mediation and the following PCC principles: respect for the patient's autonomy (Section 4.1); consideration of the patient's spiritual views on treatment (Section 4.2); and relational continuity (Section 4.3). With the aim of theoretically grounding the discussion, we first outline some fundamental notions of the PCC paradigm and discuss their relevance from the point of view of interpreting studies.

2. What is person-centred care and why is it relevant for interpreting studies?

2.1. Person-centred care

Person-centred care is defined in Scottish Government publications (2019: 1) as “mutually beneficial partnerships between patients, their families and those delivering health and care services which respect individual needs and values, and which demonstrate compassion, continuity, clear communication and shared decision-making”. Occasionally, the terms ‘person-centred care’ and ‘patient-centred care’ are used interchangeably in the literature as there is some overlapping meaning between the two concepts. However, the notion of ‘person-centredness’ is gaining ground in health research as this concept seeks to portray a more integral view of the patient. Person-centred care regards patients as individuals who have needs, strengths and preferences that may go beyond the clinical aspects of their care but can be

relevant for their health journey and thus, need to be actively considered in clinical decision-making processes (Starfield, 2011; Håkansson *et al.*, 2019). From the PCC standpoint, patients must not be seen as passive recipients of care. Instead, they should feel encouraged to actively engage in the making of decisions that may influence their health outcomes.

Whilst PCC has an explicit legislative expression in health and social care policy in Scotland, this concept is by no means limited to the Scottish context. Instead, PCC is a theory that initially originated in the fields of medical sociology and humanistic psychotherapy (Rogers, 1951) and has evolved to the extent that is now currently implemented in numerous countries and applied across diverse medical specialties (WHO, 2016). The evolution of PCC is tangible as a worldwide rising trend, as its philosophy has driven multiple quality improvement initiatives (Santana *et al.*, 2018). While the practical implementation of PCC may adopt different forms across a range of medical domains, the unifying factor underlying diverse PCC-driven initiatives is their critical view of doctor-centric approaches to healthcare, and their support for models of healthcare service delivery that actively attempt to cater for the patients' individuality (*ibid.*).

2.2. Communication in person-centred care approaches

As mentioned above, one of the core principles of PCC is that healthcare service users should feel encouraged to express their preferences for the care and treatment plans available to them. However, this patient engagement-focused approach does not truly work if patients assert their preferences in a decontextualised manner. Instead, effective PCC is reliant on the following bi-directional communication process. Firstly, in order for patients to assert their preferences in a way that is beneficial, the healthcare practitioner must equip them with the necessary education tools and information about their condition, prognosis and the care and treatment options available to them (Delaney, 2017). Without these resources, patients may not have the agency needed to make decisions that are fully informed. Secondly, involving the patient in clinical decision-making processes also requires healthcare practitioners to actively consider the cultural, spiritual, individual, family-related and/or other sociological factors that might help contextualise the patient's preferences (Epner and Baile, 2012). Active consideration of such contextual factors is pre-required for the integration of the patient's lifeworld into the biomedical debate. This bi-directional process is strongly reliant on effective language use as a tool to find common ground between the healthcare practitioner's medical goals and the patient's preferences, which is the foundation upon which PCC is built. Building on this idea

and drawing on Mishler's¹ (1984) terminology, it may be argued that PCC relies upon a process of collective meaning negotiation propelled by the contraposition of two voices. A 'voice' is understood in this chapter as the speech realisation of normative values. On the one hand, the Voice of Medicine (VoM), normally enacted by the healthcare practitioner, embodies the values of the medical establishment. Mainly, the biomedical approach to healing and the scientific assumptions that underpin such approach. On the other hand, the Voice of the Lifeworld (VoL), typically adopted by the healthcare service user, refers to the patient's understanding of their health journey, which may be shaped by socioeconomic, cultural and/or environmental conditions. From this perspective, the prioritisation of the VoM in a healthcare encounter represents a doctor-centric approach to healthcare communication. By contrast, the active consideration of the VoL in a medical consultation places the patient's lifeworld at the centre of the biomedical debate, thus enabling the implementation of an approach to healthcare delivery and communication that is person-centred.

2.3. Interpreter-mediated person-centred care

Considering the vital role of language use in conciliating the VoM and VoL, we hypothesise that language discordance between a healthcare practitioner and a patient may pose a challenge in ensuring that linguistically and culturally diverse patients fully benefit from PCC values. Building on this statement, we propose that, in the light of language and cultural differences, professionally trained interpreters are vital in enabling person-centred communication.

The role of interpreters as enablers of person-centred communication may be expressed in different ways. For example, Cambridge (2012: 26) drew on the findings of her study on interpreter-mediated psychotherapy and concluded that interpreters are often looked upon as a "major tool for creating common ground, which clinicians often feel unable to share fully". This is relevant because common ground is key in enabling PCC, as discussed in section 2.2. Additionally, the fact that interpreters naturally share a language and potentially a degree of cultural affinity with the patient places them in an influential position to either enable or hinder person-centredness. This is because interpreters have direct access to the patient's lifeworld and also have the agency to alter discursive features of the healthcare practitioner's talk. So, depending on how this power is managed, interpreters might align themselves differently in relation to person-centred communication, be that consciously or inadvertently. On the one

¹ Mishler developed the concepts of the 'Voice of medicine' (VoM) and the 'Voice of the Lifeworld' (VoL) by applying Habermas's Theory of Communicative Action (1984) to the analysis of medical interaction. For a further discussion on the VoM and the VoL in interpreter-mediated talk, see Leanza, Boivin and Rosenberg (2013).

hand, interpreters might hinder opportunities for PCC-based discussions to be initiated and/or maintained. This happens when interpreters act as agents of the health system by prioritising biomedical talk over the voice of the lifeworld (Bolden, 2000; Davidson, 2000; Leanza, 2005). On the other hand, interpreters may contribute to enabling person-centredness when rendering or even reinforcing the healthcare practitioner's displays of concern for and interest in the individual's lifeworld (Merlini and Favaron, 2005).

Acknowledging interpreters' ability to channel an exchange in the two abovementioned directions entails the recognition of interpreters as active managers of discourse. That is, interpreters are able to actively influence the communicative processes and outcomes of a speech event. Such processes may be influenced by the interpreting process because, according to the tenets of dialogism, communication is a collective sense-making activity achieved *in* and *through* interaction (Bakhtin, 1981; Linell, 1998). In other words, *meaning* results from the interplay between the three following factors: firstly, the speaker's intended meaning and pragmatic force when producing an utterance; secondly, the hearer's interpretation of the speaker's utterance and finally; the social, cognitive and wider contextual factors surrounding the production and interpretation of the interlocutors' interventions (Thomas, 1995). This multi-layered architecture of meaning establishes that sense-making processes are dynamically co-constructed as the speech event unfolds through speakers' turns. Wadensjö (1998) applied the notion of meaning co-construction to the conceptualisation and analysis of interpreter-mediated talk. Following this line of thinking, she established that interpreters' functions go beyond strictly translating texts and coordinating speakers' turns. Instead, interpreters are actively involved in the sense-making processes that underpin the production and reception of original utterances, thus influencing the progression of talk. Additionally, Wadensjö was able to systematise how this active involvement may manifest in observable practice by providing a taxonomy of potential interpreters' renditions. Differences between types of interpreters' renditions were marked by the quantity and quality of information included within them. Among the renditions included in this taxonomy, three types will be studied in section 4 of this chapter. Firstly, a *close rendition* reflects the quantity and quality of the propositional content conveyed in the source utterance. Conversely, when a rendition offers more information than originally conveyed, the interpreter's move becomes an *expanded rendition*. By contrast, if the interpreter's intervention conveys less explicitly expressed information than the original, it is called a *reduced rendition*. As originally proposed in Wadensjö's work, the accuracy of renditions should not only consider their closeness or divergence in relation to the original, but also the context surrounding the utterances at hand. This idea was further developed by Major

and Napier (2012). The authors applied Wadensjö's taxonomy to the examination of a series of interpreter-mediated healthcare interactions and concluded that achieving accuracy in the healthcare setting is a dynamic and context-dependent undertaking. This is because interpreters seek to produce utterances that reproduce the interactional goals of the original statements, and the notion of accuracy becomes linked to the fulfilment of such goals. From this point of view, producing expanded or reduced renditions is not detrimental to the fulfilment of communicative goals. Following this line of thought and considering that achieving person-centred communication is one of the main interactional goals in PCC approaches, it is worth examining the discursive enactment of PCC values in interpreter-mediated talk.

2.4. Research questions

So far, we have reviewed some fundamental notions around the process of dialogic meaning co-construction in interpreter-mediated talk and interpreters' involvement in the fulfilment of interactional goals. Building on these ideas and considering the vital role of effective communication in enabling PCC in practice, we set out to address the following questions:

- a. Do interpreters become involved in the discursive enactment of PCC values? If so, how and with what consequences?
- b. To what extent can interpreting performance contribute to enabling or hampering the realisation of PCC principles?

Section 4 below addresses these questions by providing an account of the interplay between interpreting performance and the discursive enactment of three core values of PCC: respecting the patient's autonomy (4.1), consideration of the patient's spiritual beliefs (4.2), and relational continuity (4.3). Such discussion was produced on the basis of a qualitative analysis of the data described below.

3. Research methods and data

The excerpts and participants' views discussed in section 4 below have been extracted from two datasets gathered as part of a doctoral research project on mental health interpreting (Rodríguez-Vicente, 2020). The interpreter-mediated encounters under scrutiny in the original study took place in an outpatient mental health clinic called *Psychological Medicine*, located within a public hospital in Scotland. Dataset 1 consisted of transcriptions of audio-recorded consultations featuring an English-speaking consultant psychiatrist, a Spanish-speaking patient and three different interpreters. The researcher conducting the original study, co-author of this chapter, attended these consultations as a non-participant and was granted permission to audio-

record them. Data collection was conducted following strict instructions to ensuring compliance with ethical requirements established by a Research Ethics Committee (REC) from the UK National Health Service (NHS). Among other issues, ethical guidelines required gathering informed consent by all participants taking part in the sessions before they took place. Dataset 2 consisted of retrospective interviews conducted with the participants involved in the sessions featuring in dataset 1. These interviews were semi-structured, and the design of their script was guided by the results from the discourse analysis of dataset 1. More in-depth information on the data-collection processes involved in the original study can be found in Rodríguez-Vicente (2020). In this chapter, sub-sets of the original data are re-interpreted based on the PCC framework. More particularly, excerpts of interest from dataset 1 and dataset 2 were jointly analysed to shed light onto how three PCC values are enacted in interpreter-mediated talk: respect for the patient's autonomy, consideration of her spiritual views and relational continuity.

In order to fully understand the context surrounding the excerpts shown in excerpt 4, it is useful to know about the remit of the healthcare setting within they take place. As mentioned above, the consultations featuring in dataset 1 took place in an outpatient mental healthcare clinic called Psychological Medicine. Patients referred to this clinic typically suffer from multiple ailments, normally with one physiological condition and another of a psychological nature. This type of multimorbidity may arise because mental and physical wellbeing exert a powerful influence over one another (McFarlane, 2010). Physical and psychological comorbidities might feed one another and, therefore, need to be treated jointly (*ibid.*). The conditions facing the patient in the excerpts presented below represent a clinical picture to be addressed in Psychological Medicine. The patient is an elderly woman who suffers from three co-occurring ailments: kidney failure, depression, and mild cognitive impairment. The complexity of her health status means that she needs to be supported by a physician who has expertise both in the physical and the psychological/psychiatric side of her clinical needs. The excerpts below provide examples of how the doctor in charge of this patient's case leads discussions on the treatment options available to her, as a way to manage her renal disease and comorbidities. The interpreters featured in the three excerpts shown in this chapter are professionally trained freelancers who regularly work in healthcare settings.

4. Data analysis and discussion

4.1. “Even if that would save your life?”: PCC and patient autonomy

Excerpt 1 took place as part of a larger discussion on the medical treatments that the patient might need in the future, given that her health status is gradually deteriorating due to her terminal illness. In accordance with section 5 of the Adults with Incapacity (Scotland) Act (2000), it is important to have anticipatory discussions on treatment options if the patient’s prognosis is poor. This is because discussing treatments in advance enables patients to express their preferences in a competent, and therefore informed, manner as their capacity to do so has not yet been compromised. Against this background, one of the medical treatments that the clinician featuring in our data offers the patient is a blood transfusion, which she refuses on religious grounds, as shown below.²

Excerpt 1

[S. 527] Clinician

Can I just check something you said earlier? You said that, as a Jehovah’s witness, you will not like to have a blood transfusion. Did I understand that correctly?

[S. 528] Interpreter

Para que me quede claro: como testigo de Jehová, ¿es cierto que usted no aceptaría una transfusion de sangre **en caso de que fuera necesaria?** ¿entendí eso correctamente? **¿no la aceptaría aunque le salvara la vida?**
*Just so I am clear: As a Jehovah’s witness, is it true that you would not accept a blood transfusion **in case it was necessary?** Did I understand that correctly? **You would not accept it even if it that would save your life?***

Segment (S.) 527 shows how the clinician recaps an immediately preceding discussion in which the patient disclosed that she is a member of a religious group whose doctrine does not approve of medical procedures involving blood products. In doing this, the doctor seeks the patient’s confirmation that she does not want to receive blood transfusions. Thus, the clinician is seeking the patient’s informed consent to *not* be treated, even in the potential case of acute need. In medical practice, discussions on informed consent are framed within the debate on the patient’s right to autonomy and self-determination, two core principles of person-centred care. The notion of ‘autonomy’ has been defined as “the right of competent adults to make informed

² Segment (S.) numbers refer to their place in the original transcripts. Features of interest in the excerpts are shown in bold. Back translations are displayed in grey italics.

decisions about their own medical care” (BMA, 2018). As a result, respect for the patient’s autonomy entails the duty to explicitly pursue their informed consent prior to the administration of any medical treatment. Drawing on these concepts, it can be argued that excerpt 1 shows how the patient is enacting her right to self-determination by refusing to provide her consent to be treated with a blood transfusion in the future.

In the field of biomedical ethics, there are two types of actions that healthcare practitioners can engage with in relation to a patient’s right to autonomy and self-determination. Firstly, the principle of ‘negative obligation’ entails refraining from taking coercive action or actively trying to convince a patient to make a certain decision (Coggon and Miola, 2011). Secondly, ‘positive obligation’ refers to the actions that a medical practitioner may take in an attempt to compensate for any difficulties the patient faces in making decisions in a competent, and therefore autonomous, manner (*ibid.*). Excerpt 1 shows a scenario where the patient needs the practitioner to adopt a positive obligation stance because she suffers from several conditions that may compromise her capacity to make informed decisions: an affective disorder (depression), as well as difficulty processing and remembering information due to her cognitive impairment. Consequently, the healthcare practitioner’s engagement with positive obligation behaviour is vital to increase this patient’s capacity for self-determination and thus, safeguard her involvement in competent decision-making. In excerpt 1, the clinician’s positive obligation stance is displayed through his attempts to obtain the patient’s explicit confirmation that she is unwilling to receive a blood transfusion, should she need one in the future.

Additionally, S. 528 shows how the interpreter seems to be *aligned* with the clinician’s positive obligation stance through an expanded rendition in which she adds the Spanish equivalents of “in case it were necessary” and “you would not accept it even if it saved your life?”. S. 528 demonstrates how the interpreter actively retrieves information previously discussed in the encounter and incorporates it into this sequence. In doing so, she evidences her desire to remind the patient that her life might become dependent on a blood transfusion.

As explained in section 3, the transcriptions of the medical sessions in the original datasets were triangulated with the views gathered through retrospective interviews conducted with the participants involved in the encounters. Having identified excerpt 1 as worth analysing further, the researcher showed it to the clinician and interpreter who featured in this excerpt as part of two separate interviews, in an attempt to explore the participants’ decision-making processes. When the clinician was asked to comment on the interpreter’s enhanced rendition in excerpt 1, he stated:

“I am okay with the interpreter’s action because, even though what she says is not fully accurate, it is *consistent* with what I am trying to do”.

This comment evidences the clinician’s positive disposition towards divergent renditions (what he refers to as ‘not fully accurate’), as long as the communicative intent of the interpreter’s utterance is aligned with his own communicative goals.

On another note, when the interpreter was asked to comment on excerpt 1, she stated:

“in my opinion, life is sacred. It is a God-given miracle, so I guess I felt unconsciously compelled to not let her give up so easily”.³

The interpreter proceeded to acknowledge that Catholic values give meaning and purpose to her own life. This acknowledgement suggests that the interpreter’s expanded rendition in excerpt 1 is motivated by a moral drive to protect life, underpinned by her Catholic values.

By drawing attention to this interpreter’s expanded rendition and the motivation behind it, we argue that the interpreter’s action is aligned with the clinician’s engagement in positive action behaviour, as she tries to make sure that the patient is fully informed when refusing potentially life-sustaining treatment. This action echoes Major and Napier’s (2012) finding that interpreters make interpreting decisions while engaging in a balancing act between clinical, linguistic and interpersonal goals. This is shown in excerpt 1, as the interpreter’s action is driven by an impulse to protect the patient from making a decision in a non-informed manner due to her potentially compromised capacity. All in all, excerpt 1 shows how the interpreter is trying to ensure the protection of the patient’s right to autonomy and self-determination, thus enabling the implementation of person-centred communication in this encounter.

Nonetheless, we cannot finish discussing this excerpt without acknowledging the further questions that it raises. Excerpt 1 provides an example of alignment between the interpreter’s principles and the institutional goals for this encounter, materialised through the healthcare provider’s actions. However, it can also be hypothesised that mismatches between an interpreters’ values and the institutional goals may occur. Drawing on this idea, we propose that interpreters’ awareness of the communicative goals being pursued in a given interaction, such as the enactment of PCC values, may increase the chances for alignment between such goals and interpreting performance.

³ The interpreters’ quotes shown in this chapter are translations of the original accounts, provided in Spanish.

4.2. “God will decide how long I will live”: PCC and spirituality

In excerpt 2 below, the clinician discusses with the patient the possibility of receiving a transplant, as her body is no longer adequately responding to treatment. This discussion was started in a previous consultation and resumed as shown in excerpt 2. To further contextualise this excerpt, we should also mention that religious beliefs are a core aspect of the patient’s life, and they even shape the way that she conceives her illness. Spirituality has a place in PCC models of healthcare delivery and communication. The philosophy of PCC promotes the identification of the patient’s spiritual, including religious, beliefs. This is because spirituality might be a core part of a patient’s individuality and serve as an asset when they are enduring health-related hardship (McSherry and Ross, 2010). For this reason, person-centred models of communication encourage healthcare providers to casually incorporate aspects of the patient’s spiritual beliefs into clinical conversations as a way to humanise the care provided (Ruddick, 2010). Finally, using Mishler’s (1984) terminology, the spiritual dimension of a patient’s individuality could be seen as a cornerstone of the patient’s lifeworld (VoL), a key aspect in the PCC model. Drawing on these notions, we discuss below how the patient’s spirituality is interactionally negotiated in the following subsection of our dataset.

Excerpt 2

[S. 286] Patient

Al principio yo me negaba rotundamente porque me daba miedo que me obligasen a tener un trasplante pero luego **un día cambió todo porque escuché a dios. Dios me dijo que quería que yo viviera más tiempo, que me quedaban cosas por hacer en vida.** Entonces ahora me siento más positiva con esa idea del trasplante porque si me lo está usted ofreciendo es por algo. De todas formas, **Dios dirá hasta donde vivo.**

*At first I totally refused [a transplant] because I was scared I might be forced to have it but then **one day everything changed because I listened to God. God told me that he wanted me to live longer, [and] that I still had things to do in life.** So now I feel more positive about the idea of a transplant because there must be a reason why you are offering it to me. In any case, **God will decide how long I will live.***

[S. 287] Interpreter

At the beginning I refused because I was scared that they will force me to have a transplant but **one day all changed when I listened to God’s voice and I think I can live longer to do more things while I live** so now I am more open to the idea of the transplant. There must be a reason why you are offering it to me.

[S. 288] Clinician

First of all, you can rest assured that you cannot be forced to have a transplant. There is no medical way, no legal way to do that.

Excerpt 2 shows how the patient tells the clinician about the aspects that influenced her decision-making processes when considering receiving a transplant. The patient directly connects her motivation to accept it with God's mandate to live longer. The final sentence in S. 286 evidences the patient's belief that the clinician's offer of a transplant must be a sign of God's will. The patient's feelings of gratitude towards what she perceives to be a God-sent signal drives her decision to accept the transplant. This display of spirituality is an example of what Mishler (1984) refers to as the Voice of the Lifeworld (VoL), as it is a direct expression of the patient's contextualised perspective on her health journey. The intricate relationship between the patient's spiritual standpoint and the potential course of her health journey makes the VoL in this case a subject worth integrating into the medical discussion. However, the spiritual dimension of the patient's utterance does not seem to come across clearly enough in the interpreter's rendition. There is no clear link in S. 287 between the patient hearing God's voice and her motivation to accept the transplant. The final sentence of S. 286 is also fully omitted in the interpreter's utterance. For these reasons, S. 287 can be classified as a *reduced* rendition, using Wadensjö's (1998) terminology.

It is well-established in the interpreting community that omissions may serve as a strategy by which to prioritise a rendition of key information (Napier, 2005). Omissions may provide a way to condense the essential meaning in an original utterance by eliminating what is perceived to be redundant, thus reducing the interpreter's cognitive load (*ibid.*). Due to the immediacy involved in the dialogue interpreting modality, interpreters are constantly and rapidly making decisions concerning what is redundant and what is essential information. This means that subjective judgements are necessary to enable a speedy and therefore competent performance. The subjectivity of this process means that judgements on what information is relevant or not are made in accordance with the interpreter's cognitive frame and values. For this reason, we decided to explore the decision-making processes behind the interpreter's reduced rendition in S. 287. In a retrospective interview with the interpreter featured in excerpt 2 and upon close scrutiny of S. 287, she stated:

“...as an interpreter, sometimes you need to gear the patient's answer towards what the doctor needs to hear because sometimes patients answer in a way that is not relevant, and everybody wastes time when that happens.”

This quote suggests that the interpreter perceives the spiritual component of S. 286 to be irrelevant and thus not worth including in her rendition. This position is controversial from the point of view of PCC, given that spiritual aspects in a patient's conception of their health journey are a direct expression of the VoL, a core aspect to be considered in the person-centred model. Interpreters' omissions of VoL aspects and their prioritisation of biomedical talk is a tendency that has been noted in previous literature. For example, Bolden (2000) explained how interpreters can block out the patient's VoL through reduced and discursively reframed renditions, in an attempt to preserve efficiency in the use of consultation time, a key aspect in healthcare settings. In a retrospective interview conducted with the clinician featured in excerpt 2, he was also invited to comment on S. 287. Upon examination of the excerpt, he admitted that it would have been useful for him to be aware of the importance that the patient attributed to religion. In fact, he added that he normally finds it useful to encourage patients' faith narratives due to the significance that they may have in times of distress. For example, he mentioned that a way of fostering this discussion would be to ask the following questions: "Do you think God has a plan for you?" or "Do you agree with God's plan for you to live longer?" This doctor's standpoint offers an illustrative example of the communicative pattern that Leanza, Boivin and Rosenberg (2013: 13) call the "integration of Lifeworld and biomedicine". By integrating the VoL and VoM, two different ways of conceiving the patient's health journey co-exist and even complement each other as they refer to two different dimensions: the psychosocial and biomedical side of patient care. This might partly explain why, during the retrospective interview with the clinician, at the end of the discussion on extract 2, he referred to the episode as "a missed opportunity".

Ultimately, it may be concluded that excerpt 2 provides evidence to suggest that interpreters are actively involved in the discursive negotiation between the VoM and the VoL, thereby actively contributing to managing the tension between the two voices. Interpreter agency might safeguard or block the patient's VoL and the progression of talk might, in turn, also be influenced by it. For this reason, it is important that interpreters are attuned to the doctor's communicative goals and reflect such goals in their performance. This is relevant from a PCC standpoint given that the protection of the patient's VoL is key to enabling person-centred communication.

4.3. “The one we talked about in our last appointment”: PCC and relational continuity

All the sessions audio recorded as part of the original study, also the source of data for this chapter, involved the same patient and clinician. This was the case because the patient’s condition was chronic. Thus, the progression of her illness needed to be monitored by a doctor familiarised with her clinical needs and psychosocial circumstances. In our data, the clinician’s presence is consistent. By contrast, there is a different interpreter in each consultation.

Promoting relationship continuity throughout a patient’s health journey is one of the main principles of PCC. This becomes particularly salient in cases involving patients suffering from chronic conditions as they need to regularly access healthcare services to manage their ailment (Paddison, 2015). Ongoing contact helps clinicians better understand patients’ circumstances and social history, as well as to explore their health needs and priorities in the context of their lifeworld (*ibid.*). This has consequences in terms of patient experience, evidenced by the fact that higher scores in patient satisfaction are associated with care provided by a regular physician (Nutting *et al.*, 2013). Whilst the benefits of consistent doctor-patient contact are well-acknowledged in the medical literature, not much attention has been paid to the notion of interpreter continuity in multilingual healthcare encounters involving long-term patients. In fact, defending the importance of continuity in interpreting provision might seem like a contentious issue, particularly for those who have a conduit-model view of language mediation. Benefits of interpreter continuity have been documented in studies set in a range of public service settings including healthcare (see Perez and Wilson, 2006; Hsieh *et al.*, 2010; Major, 2013; Schofield and Mapson, 2014). Among the benefits of continued interpreter allocation documented in these studies, the following are worth highlighting. Firstly, enhanced accuracy and speediness in interpreters’ renditions due to terminological and conceptual familiarity. Secondly, increased familiarity, which results in improved relational dynamics between participants. These aspects are illustrated in subsections of our data, such as in excerpt 3 below. Excerpt 3 took place in the third consultation observed and audio recorded by the author in the data collection stage of the original study (Rodríguez-Vicente, 2020). To contextualise this excerpt, we must mention that the discussions held in the observed sessions were mostly about the patient’s choice of dialysis treatment: either haemodialysis or peritoneal dialysis. In the end, the patient opts for the peritoneal version. Clinician and patient have this conversation several times in different consultations, and this topic is resumed in a follow-up session as shown in excerpt 3.

Excerpt 3

[S. 131] Clinician

In the last session, you said that you do not want to continue receiving dialysis. Is this still the case?

[S.132] Interpreter

¿En la última sesión dijo que no quería seguir con la diálisis?

In the last session you said that you did not want to continue with dialysis?

[S. 133] Patient

No, era... *[hesitant]*. Ay, ¿cómo se llamaba? Esa otra diálisis, la de volver al hospital. **¡Esa de la que hablamos en la última cita!**

*No, it was... [hesitant]. Ay, what was the name? the other one, the one [that requires me] to come back to the hospital. **The one we talked about in our last appointment!***

[S. 134] Interpreter

She does not want to come back to the hospital for the dialysis. She can't remember the name.

[S. 135] Clinician

I am not sure I understand that.

[S. 136] Interpreter

No entiende

[He] doesn't understand

[S. 137] Patient

Eh, a ver, la peritoneal sí, pero la otra no. *[Addressing interpreter]*. **¡Ay! ¿cómo se llamaba la otra?**

Eh yes to the peritoneal but not the other one. [Addressing interpreter]. Ay! what was the name of the other one?

[S. 138] Interpreter

[Addressing clinician] Yes for the peritoneal but not for the other one.

What is the name of the other one?

[S. 139] Clinician

Does she mean haemodialysis?

Excerpt 3 shows the clinician seeking the patient's confirmation that she does not want haemodialysis. Perhaps assuming that the patient is well-acquainted with the names of the two types of dialysis, the clinician does not explicitly mention them when asking the patient about her preferences [S. 131]. At this point, the patient seems to have a memory lapse as she is

unable to remember the word ‘haemodialysis’. As a result, the patient expresses frustration at being unable to remember the word and even asks the interpreter for help [S. 137]. However, this interpreter is unable to provide an immediate response because she is unfamiliar with the terminology and, most importantly, with this patient’s clinical case. The issue is finally resolved when the interpreter redirects the patient’s query to the clinician [S. 138].

This episode would have been initiated even if the same interpreter had been allocated to all of the consultations involving this clinical case. However, we argue that the tension built up between S. 133 and S. 138, shown in excerpt 3, could have been more effectively resolved if the interpreter had been able to quickly suggest the term ‘haemodialysis’ to the patient. Nonetheless, it must also be acknowledged that, for this seemingly small action to occur and be effective, the interpreter would have had to be acquainted with the different types of dialysis, particularly in the context of this patient’s case. This would have been an example of enhanced lexical retrieval caused by continuity of interpreter provision. Overall, drawing on excerpt 3 and building on the literature mentioned at the start of 4.3, we propose that an interpreter’s familiarity with the clinical case of a long-term patient might result in an enhanced interpreter capacity to draw on contextual assumptions and more effectively fill in meaning gaps, which would potentially result in a smoother communication flow.

Going a step beyond the discursive benefits of interpreter continuity, some authors have focused on the relational dimension of consistent contact between an interpreter and the interpreting users. For example, it has been proposed that interpreter continuity enhances rapport and trust dynamics between the interpreter and service users (Perez and Wilson, 2006). In a similar vein, it has also been suggested that sustained contact between an interpreter and a service provider might lead to a more effective working relationship between them, as they familiarise with one another’s communication patterns (Hsieh *et al.*, 2010). Some of these aspects were echoed in comments offered by the participants in our study. For example, one of the interpreters provided the following account:

“You can tell what seeing you in different sessions means for some people with complex physical or mental health issues. A lot of the content discussed in these sessions [psychological medicine] is very sensitive and can bring them [the patients] shame, so I can see why some of them might not feel comfortable talking about them in front of a different interpreter every time. Who the interpreter is *does* matter.”

What this quote suggests is that interpreter continuity can have a direct impact on the patient’s experience of, and satisfaction with, the care provided. This interpreter’s statement has multiple implications. For example, it challenges notions of interpreter invisibility that still predominate

in the minds of some healthcare practitioners and codes of ethics (Hsieh, 2016). If interpreters are translation machines, then why would it make a difference whether continuity of interpreter provision is ensured or not? The quote above raises more questions that would benefit from further research: what are the advantages and/or risks of ongoing contact between a healthcare practitioner, a long-term patient and a specific interpreter? Might boundaries be blurred due to increased familiarity? What would be the implications in terms of confidentiality and patient choice? Further, considering that many interpreting services in healthcare are outsourced: what level of coordination would be required between healthcare organisations and language service providers to ensure interpreter continuity? Finally, considering that relationship continuity is a key aspect of person-centred care: does this aspect also apply to interpreting provision for patients who are language discordant? The possibility of supporting person-centred care through interpreter continuity merits further investigation.

5. Conclusion

In this chapter, we set out to explore the intersection between interpreting and the person-centred approach in healthcare delivery and communication. The rationale behind this inquiry is that PCC is dependent upon effective doctor-patient communication, which might be compromised in sessions involving language-discordant participants. Among all the different values of PCC, we focus on examining the enactment of the following principles in three interpreter-mediated excerpts: safeguarding the patient's autonomy; consideration of the patient's spirituality; and relationship continuity. The excerpts were extracted from transcriptions of audio-recorded consultations that took place in a mental healthcare clinic located in a large hospital in Scotland.

The overarching finding, distilled across the discussions provided for each excerpt, is that interpreters have the agency to affect participants' talk in ways that may influence the accomplishment of person-centred communication. Interpreters may consciously or unconsciously enable or hamper person-centred communication through their performance, either by conveying and even reinforcing PCC cues, or by suppressing them.

The way in which interpreters influence the implementation of PCC depends on the *alignment*, or lack thereof, that exists between the interactional goals in the primary speakers' original utterances and the interpreters' renditions. Interpreters make interpreting decisions based on their understanding of the clinical, linguistic and interpersonal goals at play in the encounter (Major, 2013). Therefore, if such understanding correlates with the goals originally intended by the speaker's intervention, a primary speaker-interpreter alignment will result. For instance, extract 1 shows how the interpreter uses her agency to help the patient enact her right to

autonomously express her treatment choices in a fully informed manner. This is an example of alignment. By contrast, extract 2 shows how the interpreter's partial omission of the spiritual component in the patient's account hampers the doctor's ability to access the patient's lifeworld; thus, illustrating the notion of misalignment. The interpreters' actions in these episodes have direct consequences for the accomplishment of person-centred communication because respect for the patient's autonomy (excerpt 1) and spirituality (excerpt 2) are fundamental principles of PCC. Overall, interpreter alignment with these values contributes to ensuring the implementation of PCC, and the opposite is true if misalignment happens. Finally, extract 3 shows that there are circumstantial factors that may affect the provision of PCC for long-term patients who are language discordant. For example, the benefits of relationship continuity pursued through ongoing contact between a patient suffering from a chronic condition and a regular physician might not be fully experienced if different interpreters are allocated to each consultation.

These findings have practical implications. In particular, if interpreter alignment is driven by their understanding of primary speakers' communicative goals, then it may be assumed that interpreters' greater awareness of speakers' goals may increase the potential for alignment. Drawing on this, we propose that interpreter familiarity with PCC values may increase their agency in helping to enact the values of person-centred communication in multilingual healthcare encounters. Thus, when interpreters are familiar with the protocols and goals being pursued in clinical communication, they can make more informed interpreting decisions and multiply occurrences of alignment between their communicative practices and those of their clients. This supports the case for multidisciplinary training that encompasses aspects of both language mediation and healthcare communication protocols, in line with the work of Krystallidou (2018). However, helping ensure interpreter-mediated person-centred care is not limited to interpreter performance. As suggested in 4.3, there are organisational factors that might play a role in ensuring that linguistically diverse patients access PCC principles, such as interpreter continuity. Therefore, we suggest that the intersection between PCC and language mediation should be carefully considered by healthcare organisations and language service providers. To conclude, it is important to acknowledge that the discussion in this chapter is limited because it only focuses on three PCC values, out of the many aspects that may make healthcare delivery and communication truly person-centred. Therefore, we propose that the discussion in this chapter can serve as a starting point that encourages further research on the notion of alignment between interpreter performance and institutional goals, with a particular focus on the theoretical background of person-centred care.

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References

- Adults with Incapacity (Scotland) Act (2000). *Part 5 – Medical treatment and research*. UK statute law database.
- Angelelli, C. (2019). *Healthcare interpreting explained*. London and New York: Routledge.
- Angelelli, C. (2020). Language mediation and patient-centred communication. in E. Postigo-Pinazo (ed.) *Interpreting in a changing world: new scenarios, technologies, training challenges*. Berlin: Peter Lang.
- Bakhtin, M. M. (1981). *The dialogic imagination: four essays*. Austin: University of Texas press.
- Bolden, G. (2000). Toward understanding practices of medical interpreting: interpreters' involvement in history taking. *Discourse studies*. 2 (4), 387-419.
- British Medical Association (BMA) (2020). Autonomy or self-determination as a medical student. *Ethics toolkit for medical students*. [Online resource]. Available at: <https://www.bma.org.uk/advice-and-support/ethics>.
- Cambridge, J. (2012). *Interpreter output in talking therapy. Towards a methodology or good practice*. Unpublished doctoral dissertation. Warwick medical school, University of Warwick.
- Coggon, J. & Miola, J. (2011). Autonomy, liberty and medical decision-making. *The Cambridge law journal*. 70 (3), 523–547.
- Davidson, B. (2000). The Interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of sociolinguistics*. 4 (3), 379-405.
- Delaney, L. J. (2017). Patient-centred care as an approach to improving health care in Australia. *Australian college of nursing*. 25 (1), 119-123.
- Edwards, R., Temple, B. & Alexander, C. (2005). Users' experiences of interpreters: The critical role of trust. *Interpreting*. 7 (1), 77-95.
- Epner, D. E. & Baile, W. F. (2012). Patient-centered care: the key to cultural competence. *Annals of Oncology*. 23 (3), 33-42.

- Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical care research and review*. 62 (3), 255-299.
- Habermas, J. (1984). *The theory of communicative action* (Vol. 1). Boston: Beacon Press.
- Håkansson E. *et al.* (2018). Same or different? A review of reviews of person-centered and patient-centered care. *Patient Education and Counselling*. 102 (1), 3-11.
- Hsieh, E. (2015). Healthcare interpreting. in F. Pöchhacker (Ed.) *Routledge Encyclopaedia of Interpreting Studies* (pp. 177 – 182). Oxon and New York: Routledge.
- Hsieh, E. (2016). *Bilingual health communication: working with interpreters in cross-cultural care*. New York: Routledge.
- Hsieh, E. *et al.* (2010). Dimensions of trust: the tensions and challenges in provider-interpreter trust. *Qualitative Health Research*. 20 (2),170-181.
- Krystallidou, D. (2018). Training “doctor-minded” interpreters and “interpreter-minded” doctors: the benefits of collaborative practice in interpreter training.’ *Interpreting*. 20 (1), 132-150.
- Leanza, Y. (2005). Roles of community interpreters in paediatrics as seen by interpreters, physicians and researchers. *Interpreting*, 7 (2), 167-192.
- Leanza, Y., Boivin, I. & Rosenberg. E. (2013). The patient's lifeworld: building meaningful clinical encounters between patients, physicians and interpreters. *Communication and medicine journal*. 10 (1), 13-25.
- Linell, P. (1998). *Approaching dialogue: talk, interaction and contexts in dialogical perspectives* (Vol. 3). John Benjamins Publishing.
- Major, G. (2013). *Not just ‘how the doctor talks’: healthcare interpreting as relational practice*. Unpublished doctoral dissertation. Macquarie University (Australia).
- Major, G. & Napier, J. (2012). Interpreting and knowledge mediation in the healthcare setting: what do we really mean by ‘accuracy’? *Linguistica Antverpiensia* 11: 207–225.
- McFarlane, A. (2010). The long-term costs of traumatic stress: intertwined physical and psychological consequences. *World Psychiatry*. 9 (1), 3-10.
- McSherry, W. & Ross, L. (2010). *Spiritual Assessment in Healthcare Practice*. Cumbria: M&K Publishing.

- Merlini, R. & Favaron, R. (2005). Examining the “voice of interpreting” in speech pathology. *Interpreting*. 7 (2), 263 – 302.
- Mishler, E. G. (1984). *The discourse of medicine: dialectics of medical interviews*. Norwood, NJ: Ablex.
- Napier, J. (2005). Teaching interpreters to identify omission potential. In C. Roy (Ed.) *Advances in teaching sign language interpreters* (Vol. 2) (pp. 123-137). Washington DC: Gallaudet University Press.
- Nutting, P. A. *et al.* (2003). Continuity of primary care: to whom does it matter and when? *Annals of family medicine*. Vol. 1 (3).
- Paddison, C. (2015). BMJ roundtable debate: How can we get better at providing patient centred care?. *British medical journal (BMJ)*. Online resource. Available at: <https://doi.org/10.1136/bmj.h1127>.
- Paddison, C. (2015). How can we get better at providing patient centred care: does continuity matter? *British medical journal - letters*. 350.
- Perez, I. & Wilson, C. (2006). Translating, interpreting and communication support: A review of provision in public services in Scotland. *Scottish Executive Social Research*. Blackwell.
- Rodríguez-Vicente, N. (2020). *Dialogue interpreting in psychological medicine: an exploration of rapport management practices*. Unpublished doctoral dissertation. Heriot-Watt University (UK).
- Rogers, C. R. (1951). *Client-centered therapy: its current practice, implications and theory*. Houghton Mifflin.
- Ruddick, F. (2010). Person-centred mental health care: myth or reality? *Mental health practice*. 13, 24-28.
- Santana, M. J. *et al.* (2017). How to practice person-centred care: A conceptual framework. *Health Expectations*. 21 (2), 429-440.
- Schofield, M. & Mapson, R. (2014). Dynamics in interpreted interactions: an insight into the perceptions of healthcare professionals. *Journal of interpretation*. 23 (1).

- Scottish Government (2019). Person-centred care. *Community health and social care directorate*. Online resource. Accessible at: <https://www.gov.scot/publications/person-centred-care-non-executive-members/>
- Starfield, B. (2011). Is patient-centered care the same as person-focused care? *The Permanente Journal*. 15 (2), 63–69.
- Thomas, J. (1995). *Meaning in interaction: an introduction to pragmatics*. London and New York: Routledge.
- Wadensjö, C. (1998). *Interpreting as interaction*. Longman.
- World Health Organisation (WHO) (2016). *Framework on integrated, people-centred health services*. Summary record of the executive board at its 138th session, 10th meeting, section 2 (document EB138/2016/REC/2).