Communicating decisions with a multilingual patient population

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1. INTRODUCTION

THE NOTION OF 'LINGUISTIC BARRIERS' in medical settings usually refers to the use (and possible abuse) of interpreters. However, the language and cultural diversity of patient populations in an increasingly globalised world leads to many encounters where a common language or lingua franca is used. The use of an interpreter is not necessarily a possible option nor indeed may it be the preferred one. Many patients bring to the consultation some fluency in the dominant language of the country in which they are now resident and both patient and doctor may choose to carry out the consultation as a dyadic interaction without the mediation of an interpreter. The decision whether to use an interpreter or not is more complex than many systems allow for. It is often not a simple matter of being able to 'speak the language' or not. Everyone is on a continuum of linguistic/cultural competence and so the conditions for negotiating shared understanding (Gumperz, 1982) can be elusive.

This paper is based on a study carried out in London between 2001-2003[1] looking at the interactions in English between family doctors and patients with either relatively limited fluency or a very different communicative style in English from the doctor. In the 'superdiverse' (Vertoveç, 2007) settings of south London clinics, we found that it was commonplace for family doctors, in a typical morning session, to consult with patients from at least six different language

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backgrounds. Such consultations often led to misunderstandings and we have charted the prevention, management and repair of mis-understandings, ambiguities and potential misdiagnosis (Roberts et al., 2005; Roberts, 2009).

2. DECISION MAKING

A crucial element of the consultation is decision making. There is an increasing recognition that involving patients in the decision making process can have a positive impact on patient health (Brody et al., 1989; Frosch & Kaplan, 1999). Stivers, among other conversation analysts working on the family practice encounter, has shown that the decision making process is not necessarily the result of an explicit invitation by the doctor to involve the patient. Rather, decision making is the result of negotiation and implicit resistance often initiated by the patient or parent of the patient (Stivers, 2006).

However, these general patterns of doctor-patient decision making do not account for any variability in the process which results from different assumptions and ways of communicating in the consultation. The widely used shared decision making models (Elwyn et al., 1999) may not resonate with patients whose experience with health professionals does not include sharing information (Charles et al., 1997, 1999) or discussing their feelings and ideas about treatment (Stewart et al., 1995, Silverman et al., 2005). Communicating decisions and agreeing on outcomes are doubly problematic when differing expectations about the style of consultations mesh with different communicative styles and struggles over meaning.

Communicating decisions are even more complex if the decision making process is not seen as a discrete phase but as a means of engagement throughout the consultation. Much of the medical communications and consulting skills literature assumes there are distinct phases to the consultation, of which the decision making stage is one (Byrne & Long, 1976; Heritage & Maynard, 2006). But some recent conversation analysis studies echo Boden's work that in

the workplace the decision making moment 'escapes'; it is always elsewhere (Boden, 1994). In other words, decision making is distributed throughout one or indeed many interactions.

Collins and colleagues (2005b:120) describe the 'bilateral' doctors who use opportunities to explore and build on patients' understanding, build on and shape patients' talk within and over a series of consultations and who build on individual patient's inclinations, beliefs and preferences and recognise variation in communicative behaviour (see also Collins, 2005a and Collins et al., 2007). With such doctors, an environment for shared decision making is set up early on in the consultation and responded to by patients: 'People become environments for each other' (McDermott & Gospodinoff, 1981). Similarly, even such a discrete phase as closing the consultation, turns out to be more open-ended than the term suggests. West (2006) identifies closings in American consultations as 'like ordinary conversations'. Closings are routinely done by recycling arrangements already made; for example, taking a prescribed drug. So the fact that this is the close of the consultation is performed indirectly. It is usually inferred by the patients as the end but does not explicitly shut down the possibility of the patient contributing more. Indeed, this can be the moment when the decision is returned to and possibly renegotiated.

So shared decision making can be threaded through the conversation and much of it is achieved indirectly by creating and maintaining patient involvement from the start and throughout. Decision making depends heavily on indirect and implicit processes used to establish a doctor-patient role which balances doctor authority with patient knowledge and agency. The bilateral doctors discussed by Collins et al. rely on shared inferential processes with patients. As patients and doctors infer meanings from each other, patients become more engaged in the discussion of their treatment and future action (Collins et al., 2007; Thompson, 2007). In the same way, involvement and so the conditions for shared decision making are also created through alignment and informal social footing (Goffman, 1981). In these cases, doctors work towards building up rapport with patients through humour and through sharing information.

In the superdiverse settings of south London, not only are the models of decision making often markedly different but differing modes of talk and interaction challenge the assumptions that patients and doctors can create positive environments for each other through shared inferencing and alignments. From the opening moments of the family doctor consultations, routine inferences and alignments can be made or unmade. Local patients[2] tend to blend the presentation of symptoms with an evaluation of self and feelings and so set up a chain of inferences for the doctor, including clues to their patient identity and how they orientate to the health professional. By contrast, other patients generally do not follow this routine and as a consequence the interaction shifts from shared inferencing and informal alignment to a more interrogatory space where facts and feelings are more explicitly elicited (Roberts et al., 2004).

In the rest of this paper, I will focus on two aspects of inferencing and footing and the consequences for developing patient resistance to decisions made when these interactional processes are not shared.

3. HUMOUR IN THE CONSULTATION

In many of the consultations with local patients and doctors, humour was used by both sides to save face and create alignment when there was the potential for resistance in decision making. In data example 1, an elderly local patient uses humour to complain about the terrible side effects of some prescribed tablets. As the conversation draws to a close, the patient deftly puts the relationship on a different footing from which she can project her future resistance to any decision to give her a repeat prescription:

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[2] Local patients are defined here as those born in the UK or having very long residence there.

Data Example 1

1. D   right good well well done
2. P   yeah
3. D   we did think it might be a bit of a problem
4. P   If doctor P. says you've got to go on more of those
5. D   you might argue with him
6. P   just let me die just let me die
7. D   right

At line 4, the patient imagines a scenario in which she is talking about Dr P rather than to him, since it is easier to talk about resistance to someone else rather than face to face with the person you are challenging. Dr P goes along with this device, imagining that he is not Dr P so that the patient can argue with the non-present Dr P rather than the real one in front of her (line 5 'You might argue with him'). She then exaggerates what her response would be at line 6 'just let me die' in order to humorously reinforce how much she suffered from the side effects. In this way, the patient flags up what her response will be to any future suggestion from Dr P that she should go on these tablets again. At the same time, she manages to balance the doctor's authority with her own agency through humour and by aligning herself with the real Dr P while resisting the imaginary absent one.

Humorous footwork is often less successful when doctor and patient do not share the same inferential processes upon which the humour is based. In data example 2, the local doctor is treating a patient from Bangladesh who is in the surgery with his son:

Data Example 2

1. D: yes (.) definitely hot try and keep stiff that's right (.)
2.   well done (.) don't run away

 3. P: (No reaction from the patient)

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51. D: with your little boy to look after you (eh) ((laughs))
52. P: ((laughs))
53. D: back to front
54. P: (No reaction from the patient).

In the first part of this example, the doctor is taking a sample of blood from the patient who moves his body slightly away from the doctor as she does this. She uses humour at line 2 rather as the patient in example one. She exaggerates his possible reaction to the needle: 'don't run away' to soften or hedge the implied instruction to keep still. His lack of response suggests that the humour has misfired or that he does not infer the remark as humorous. So her humour designed to align herself with him (acknowledging that having an injection is painful and that he must want to run away from the pain) instead leaves a potentially awkward silence.

Later in the section, the doctor attempts to share the treatment decisions with the patient. She laughingly suggests that the little boy can look after the father. The patient also laughs but it is not clear whether he understands the humour or is simply laughing to show reciprocity. She then unpacks her remark when in line 53 she makes a general comment about a topsy-turvey world in which children have to be like responsible adults. Again there is no reaction from the patient which again may be attributed to a lack of shared inferencing about what is going on. The doctor again tries to align with the patient, by sharing the paradox of children being like adults, to downplay her authority. However, there is no evidence that this is a successful strategy.

4. EXPLANATIONS, INFERENCING AND INVOLVEMENT

Another strategy that local doctors use to create patients' involvement is to engage them with explanations that are interwoven into the diagnosis and discussion of treatment. Patients who are not local often cut off doctor explanations and instead pursue their own agenda of gaining specific action or treatment for their symptoms or concerns. In this third example, a local doctor is talking to an Italian patient who has come with several complaints. Repeatedly the doctor tries to set up an environment where they can discuss together possible treatments by giving explanations but is never able to get very far with her shared decision making model:

Data Example 3

1. D	=it's= the- to do with the joints
2. P	=ah the joints=
3. D	=and as= we get a bit older they get a bit =worn=
4. P	=gett=ing old too no
5. D	old<u>er</u> ((laughs)) but it's erm (.) it's really important to: er
6. P	and =the- the- (.) listen this this this er=
7. D	=keep your fingers moving (.) do some exercises=
8. P	this dust mite is e:r (.) is <u>dan</u>ger for the house you know
9. D	it's not dangerous no:
10.	it's nothing (.) that will do harm to your h- home =it's=
11.P	=yeah= but ah he go in the food as well this mite or not

The patient and doctor in example 3 have known each other for many years and in lines 3 – 5 share a joke together about growing older. But as the doctor tries to explain about the importance of exercise for the fingers, the patient at lines 6 and 8 interrupts to return to an earlier concern about 'dust mites', insects that live in the home and can cause allergies. So the doctor's attempts to encourage the patient's agency so that they can together discuss treatment decisions on an equal footing are closed down by the patient.

Some doctors aim to realise the patient-centred and shared decision making models quite explicitly. Rather than the more indirect strategies to create sharedness, they opt for explicit attempts at alignment. In the fourth example, a Somali women has brought her baby daughter to the surgery where a local doctor sees her:

Data example 4

1. P   it not stop diarrhoea and when she c- [change the nappy]
2.   she cry he cry cry cry
3. D   oh dear so it's been worrying for you
4. P   yeah: cos eh: you know I don't give nothing (.)
5.   I n- I will stop the milk de: doctor K.
6.   =he said=
7. D   =mm=
8. P   stop the milk (.) just give the: water
9. D   right

While the doctor in line 3 shows explicit empathy for the baby's mother and possibly aims to elicit more of her concerns, the mother gives a minimal receipt token 'yeah' before returning to a display of her own action. Earlier in the consultation the doctor is even more explicit in realising the shared decision making model. After checking that the mother has virtually stopped breast feeding her baby, she moves to a general question about the mother's expectations from the consultation. The patient-centred model used regularly in training in the UK, explicitly requires family doctors to elicit the patient's (or carer's) 'concerns, beliefs and expectations'.

Data example 5

1. D   = =little bit (.) right so you're virtually stopped (.)
2.   so what sort of questions have you got in your mind for me today (.)
3.   what do you want me to do (..) =today=
4. P   no: =she say= eh: the lady she say if you want to contacting doctor eh:
5.   you want eh: talk him

The doctor's open question at line 2 is responded to with a 'no' and then an explanation that may refer to the receptionist, 'the lady'. Instead of inferring from the question that she is expected to present herself and her child's symptoms, her answer seems to relate to what questions she asked the receptionist about seeing a doctor. This misunderstanding may be because of differences in assumptions about consultancy styles in the West combined with some difficulty in linguistic processing.

So, in both data examples 4 and 5, the shared decision making model initiated by the doctor falters and then fades away under the pressure of misunderstandings.

5. RESISTANCE AND ITS ALTERNATIVES

Although examples 2-5 illustrate a challenge to the prevailing notions about shared decision making, there is no evidence of active resistance to the doctor's agenda. However in other consultations, the patient's resistance pulls doctor and patient apart. And just as the environment for shared decision making can be established early in the consultation, so can that for resistance. In the next example, a west African woman with bipolar disorder talks to a doctor of south Asian origin. She has come to see the doctor with her mother who needs a letter from him to extend her visa to stay in the UK so that she can take care of her daughter:

Data Example 6

1. D   is there anything we could do to help you (1)
2. P   no bu:t the- the reason- the reason why my mum's here
3.   is that she says she wants a <u>le</u>tter from you
4. D   fine okay I mean I know about that I- we can talk about that we'll(.)
5.   when do you have a next hospital appointment

The doctor sets aside her request and instead focuses on the management of her illness and this sets up some dissonance between them which percolates through the whole encounter. Towards the end, the doctor attempts to gain some shared agreement with her but this is explicitly resisted:

Data Example 7

1. D.   okay (.) may I suggest you keep in touch with me(.)
2. P   keep in touch with =you: (.) about=
3. D   =yeah [   ]=
4. P   a=bout=
5. D   =a=bout
6. P   my health and =things=
7. D   =yeah= I think that's er
8. P   yea:h
9. D   okay (.) and and that will help you
10. P   how d'you mean (.) how =will it help=
11. D   =because then= if you don't have an appointment
12. D   or you're feeling sleepy or not eating or any questions
13. P   mm=m:=
14. D   =it'll= be easy for you to liaise isn't it(.)
15. P   yeah but

While the idea that she should keep in touch with him does not seem unreasonable, the early non-alignment set up in example 6 is played out through the consultation until patient resistance is a routine response to the doctor's attempts to establish a joint plan of action. At lines 2, 4, 10 and 15 she questions his authority and the basis for his suggestion, showing active resistance to him. The inferences embedded in the doctor's suggestion in lines 1 and his statement in line 9, that doctors can be taken for granted to be helpful and that keeping in touch must be good, are actively disrupted by the patient. Conversation analysts suggest that there are formats doctors can adopt to overcome resistance (Maynard, 1992; Gill, 1998; Stivers, 2006). For example, Maynard identifies a pattern of 'perspective

display' sequences in which the patient's parents are asked for their perspective on their child's development before the doctor presents her or his assessment. In this way, the parents' perspective can be built into the doctor's assertions, thus overcoming potential disagreements and resistances. However, no examples are given where differences in language and cultural backgrounds would have the potential for misunderstandings because perspective display sequences could not be smoothly negotiated. In such environments, typical of the superdiverse south London clinics, the conditions for shared inferencing and informal footing are more difficult to negotiate and resistance can become more entrenched. As example 7 shows, the increasingly resistant stance of the patient is not the result of any overt misunderstandings but is a potent mix of differences. The south Asian doctor takes a medical-centred approach to the consultation and does not first respond to the patient's agenda about her mother's bureaucratic request for a letter. And towards the end, while the formal aspects of his talk 'may I suggest …' index a tentative and more face-saving orientation to the patient, embedded in his suggestion is an assertion that she will benefit from seeing him. Rather than tuning in to her current concerns, he persists in his doctor-centred position. Resistance can be, but is not necessarily, a direct result of socio-cultural misunderstanding. However, such differences in assumptions about the role of doctor and patient may routinely contribute to resistance or may reinforce it (Rehbein, 2001). In other words, the difficulties experienced in coming to a shared decision cannot be simply accounted for by 'language' or 'culture'. Rather such difficulties are a complex mix of brought along and brought about social and role relationships, ambiguities over institutional and medical knowledge, linguistic resources for doing facework and how trust and confidence are co-constructed.

By contrast with some of the examples above, the strategic communication of 'bilateral' doctors works towards an environment where shared problem solving pre-empts resistance. 'Bilateral' doctors (Collins et al., 2005) work with patients' communicative styles and their assumptions about doctor/patient role so some of the tensions/gaps between models/ideologies and practice on the ground

are resolved or bridged. In the final example a doctor, who would fall into Collins' category of 'bilateral', consults with a patient originally from West Africa. Mr G has had multiple problems including depression and now presents with dry skin. After a long consultation of nearly 20 minutes the doctor returns to the original problem of the dry skin and for the fifth time in the consultation, raises the fact that the patient's use of Dettol (a well known brand of disinfectant) may well be the cause.

Data example 8

1. D	=I= think it's not so good to use all the- to use every time	
	(. .)	
2. P	=mm:=	
3. D	=cos= it does make the skin quite dry	
	(2.0)	
4. P	=see er=	
5. D	=all right= so it's not wrong	
6. P	yeah	
7. D	it's just that I think you're using it I think too often	
8. P	I- I'm using it <u>that</u>'s a =fact=	
9. D	=mm=	
10. P	I- I- I admit that (.) I =do=	
11. D	=hm=	
12. P	(.) I'm used to it right in the home s- =since=	
13. D	=mm=	
14. P	I was in Africa (.) =yeah=	
15. D	=yeah=	
16. P	I been doing the same	
17. D	yeah so- n-	
	(12.0) ((Dr typing))	
18.P	well I will stop using it for the time being now until= =	
19.D	= =okay	
20.P	I've er=	
21.	(.)	
22.D	mm	
23.P	yeah I will ease dettol for the time being (.) I'll stop	

The patient's initial concerns about stopping using Dettol in his bath arise from his belief that the disinfectant will thoroughly clean him, while the doctor is aware of how bad it is for the skin. In contrast to example 7, the doctor tunes in to the patient's communicative style which appears to be influenced by patterns of speaking in the language practices of people with their cultural roots in Africa. In particular, the patient circles around the central theme of his use of Dettol in Africa, returning to it on four occasions in the consultation. African rhetorical styles analysed for example in the speeches of Martin Luther King and other black preachers and politicians (Davis, 1985; Tannen, 1989) show a pattern of circling and repeating that may account for this patient's style. And the doctor, instead of pressing on with proposed treatment and action plans, revisits the theme with the patient until he finally accepts that he must forego his beloved dettol baths. The doctor's receipt token at line 19, 'OK' accepts the decision in a conversational way. He does not press home or upgrade his response in a doctorly mode by evaluating the patient's decision but simply receives the information, acknowledging it, with his minimal response, as the patient's own.

6. CONCLUSIONS

The joint accomplishment of successful decision making illustrated in example 8 began in the early stages of the consultation when the doctor first begins to suggest that the patient may have to change a habit of a life-time. Shared decision making is not a specific act but rather an environment jointly negotiated at the beginning of the consultation. It relies on creating conditions for shared inferencing and so depends upon the doctor's overall orientation to patients and the capacity for both sides to negotiate alignments in the potentially face-threatening moments of intimate talk and physical examination. Where such conditions are not easy to create, more direct and explicit means are not necessarily successful, despite the current ideol-

ogy on patient-centredness and the ways to communicate it (Silverman et al., 2005).

These face-threatening moments can turn into resistances, and ultimately poor outcomes for doctors and patients, unless doctors can tune into patients' communicative styles and assumptions. The metaphor of the 'barrier' to evoke the difficulties posed by language/cultural differences should, perhaps, be replaced by that of the 'puzzle'. Working with linguistic/cultural diversity is not so much about breaking down barriers which suggests a forceful and one-off action but about gradually solving puzzles, piecing together a joint vision of how something might be. This, in turn, means attending to the small and subtle dynamic of the consultation, looking at the micro and how that implicates the whole. From a practical point of view, training medical professionals to examine and work on their own micro interactional behaviour entails educational interventions that involve analysis and awareness raising based on actual consultations. In the UK context, we have developed DVDs for family doctors based on the data from the PLEDGE project (Roberts et al., 2003, 2006). Just as the argument in this paper is that any outcomes from a consultation arise from engagement with the detailed processes of relating and informing, so the training of family doctors needs to shift from models and prescribed behaviour to a reflexive sensitivity towards their talk in interaction and the challenges of health communication in a superdiverse society.

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