CHAPTER 10

Challenges in interpreters’ coordination of the construction of pain

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The tasks performed by the healthcare interpreter are complex, as they involve bridging together beliefs and values from different speech communities. This complexity increases when conceptualizations of illnesses and worldviews are not shared. Pain is perceived and communicated differently by members of different cultural communities. Conversations about pain include discussions about intensity of pain based on pain-rating scales as well as discussions of pain management. Healthcare interpreters face challenges in constructing and co-constructing pain while facilitating cross-linguistic communication. In this chapter I analyze interactions of healthcare provider-and-patient interviews which are part of a larger study dealing with the issues faced by Spanish-speaking patients, English-speaking providers and Spanish-English interpreters who engage in measuring and describing pain with the use of a pain-rating scale. The implications of this work for professionals such as policy makers, educators, healthcare providers and interpreters are discussed.

1. Introduction

Interpreting and communication about illness and disease, diagnosis and treatment, caring and curing are complicated by the ‘meeting’ of different cultural communities. Examples of cultural communities, in this chapter, are the healthcare institution where the encounter takes place, the medical personnel, a distinct professional group of healthcare providers who are mandated to use a pain-rating scale in order to determine the best course of action for the case at hand, and the patients, people experiencing pain and seeking relief. A healthcare encounter does not occur in a vacuum, it is subject to the societal norms and cultural blueprints present in the environment in which it occurs and is influenced by the institutional culture that permeates every aspect of the healthcare encounter (Angelelli 2004a:9–10). During this encounter, providers and patients are expected to play roles and act according to mandates of the organization in which
the encounter takes place. The differences in healthcare beliefs and practices of persons seeking and providing healthcare, in addition to the different linguistic and cultural communities to which these interlocutors belong, can lead to problems in communicating with one another (Angelelli and Geist-Martin 2003; Geist-Martin, Ray and Sharf 2003). When patient and provider do not speak the same language, an interpreter coordinates and enables communication. Patients seeking care, providers supplying it, and interpreters coordinating communication rarely belong to the same speech communities (Angelelli 2000; Hymes 1974).

A speech community, as compared to a cultural community, is a socio-linguistic entity (Hymes 1974:47 in Angelelli 2000). Members of a speech community share same or very similar ways of speaking (a speech community can thus be formed by e.g. speakers of the Spanish language or of the English language). Healthcare providers constitute a cultural community and are also fluent speakers of their speech community, which differs from the speech community of their patients. Therefore the ways in which healthcare providers discuss pain (e.g. how they describe it, measure it, etc.) differ from the ways in which patients speak about pain. In addition, members of these diverse cultural and speech communities often perceive health, disease, pain, and healthcare practices differently (Gaston-Johansson, Albert, Fagan and Zimmerman 1990). When providers, patients and interpreters enter into a conversation to discuss pain as well as any other health issue, a new and cross-cultural community emerges through communication. This community is the site where culture gets constructed and re-constructed through emotional connection, a sense of belonging, and a common set of customs, rules, rituals, and language (Geist-Martin, Ray and Sharf 2003). As it will become evident from the interactions that will be discussed here, complex layers of meaning accompany conversations about pain, illness, and medicine in each of these cultural communities as well as in different speech communities. The complexity multiplies in the healthcare setting when interpreters are needed to bridge the cultural communities of the provider (and medicine) and the patient (see also Penn and Watermeyer, this volume), not only by interpreting the languages spoken, but also by coordinating talk, seeking answers to questions that providers and patients raise as they communicate with one another. Research investigating this complex context of communication with interpreters indicates that the difficulties in interpreted conversations lie in the construction of reciprocal understanding (Davidson 1998, 2000, 2001), the accurate transformation of semantic and pragmatic content (Bolden 2000; Cambridge 1999) and the role of the interpreter as linguistic facilitator (Angelelli 2004a; Metzger 1999). As it is evident in studies on English-speaking healthcare providers and Spanish-speaking patients, the interpreter is the instrument that keeps the patient on track; for the patient the interpreter is a co-conversationalist (Davidson 1998).
Pain, a frequent discussion topic of the medical encounter, is perceived and communicated differently by members of different cultural and speech communities. Conversations about pain include discussions about intensity of pain based on pain-rating scales as well as talk about pain management. Healthcare providers also have to understand pain from a cultural perspective. In a cross-linguistic medical encounter, healthcare interpreters take on the burden of facilitating talk about pain between patients and providers who do not share a language or culture (Angelelli 2004a, 2006; Bolden 2000; Metzger 1999; Valero Garcés and Guzmán-Mancho 2002). Researchers have studied a variety of strategies and behaviors that interpreters carry out as they provide their renditions of original utterances. Wadensjö’s taxonomy of interpreters’ renditions (1998: 106–108) is based on a comparison of the propositional context present in the original utterance and the rendition rather than on the different types of equivalences (lexical, grammatical, and pragmatic; Wadensjö 1998: 42). She also looks at the interpreter’s role in coordinating talk and coordination can be implicit (interpreter’s talk) or explicit (requests for clarification or requests to observe turn taking order; Wadensjö 1998: 107–108; see the Introduction to this volume). This taxonomy and classification of coordination demonstrates behaviors exhibited by interpreters as they participate in an interpreted communicative event.

Angelelli (2004a: 78) also notes a series of strategies interpreters use when they facilitate interactions in the medical setting. Interpreters use these strategies to exercise their agency as co-participants in the interactions. Examples include activities which are discussed in other chapters in this volume: exploring answers, expanding and summarizing statements, brokering comprehension and explaining technical terms, bridging cultural gaps, expressing affect, perpetuating or brokering power differentials between patients and providers, and replacing interlocutors. Angelelli (2004a: 79–104) found that as interpreters become “owners of text”, agency defined as visibility generally increases. When this happens, the interpreter’s role is highly consequential as it affects the quality and quantity of information communicated during an interpreted communicative event. Triggered by social factors such as gender, race, ethnicity, age, socio-economic status (Angelelli 2004b: 68–82), interpreters often introduce their own text and, in so doing, they have an impact on the medical or personal information exchanged during an interpreted communicative event. This impact also affects the provider-patient relationship.

In this chapter, I begin by briefly discussing communication about pain in monolingual interaction and how it is constructed and assessed. Subsequently, I focus on bilingual encounters and I explore the healthcare interpreter’s challenges in constructing and co-constructing meaning in conversations about pain while facilitating cross-linguistic communication. In particular, I present segments of
provider/patient interviews that demonstrate the challenges faced by Spanish-speaking patients, English-speaking providers and Spanish-English interpreters who engage in measuring pain with the use of standardized pain-rating scales. These segments are part of a larger research illustrated in Angelelli (2004). In the final part of this chapter, I discuss the implications of this study for policy makers, educators, healthcare providers and interpreters.

2. Pain construction, measurement, and communication

Expressing pain is important because the manner in which pain is conveyed is usually the framework upon which most therapies are based (Gaston-Johansson et al. 1990). A patient may feel that nonverbal communication shows the level of pain experienced, but the healthcare provider may not recognize the cues. Pain is a taboo topic for many patients: when pain is discussed it is often through uncomfortable talk where misunderstandings are likely to occur and outcomes are not optimal. It has been suggested, however, that pain description is more reliable than any other physiologic indicator (Jacox 1979). Statistics about pain in the US highlight that millions of people (including surgical, cancer, and arthritis patients) suffer from inadequate pain relief (Phillips 2000). Inadequate pain management diminishes patients’ trust in the healthcare system, leads to unnecessary health setbacks and higher costs of treatment in situations where appropriate pain management might have led to faster recovery, shorter hospital stays, fewer re-admissions and improved quality of life (Agency for Health Care Policy and Research 1992; Phillips 2000). Even when pain is a treatable symptom, it is often cited as problematic in modern medicine, due to the difficulty related to its assessment (Ferrel et al. 1995). In addition to differences based on affiliations to distinct communities of discourse and culture, as discussed in the previous section, providers and patients do not share equal power in conversations about pain. It has been established that providers ask the majority of questions and patients are limited to supplying answers (Prince 1986). Providers need to obtain information from the patient that they deem important and valuable. Patients need to make decisions based on information that is important and valuable to them. When constructing pain and measuring it, providers have the mandate to obtain a rating, a number from one to ten. In the United States, practice guidelines and accreditation standards require that clinicians ask patients about their pain and continue to assess, measure, and reassess each patient’s level of pain. Patients are commonly asked to make ratings on a single-dimension pain scale. According to the guidelines of the American Pain Society (American Pain Society Quality Care Committee 1995) patients are asked to rate ‘the intensity of their pain’ on a scale from 0 to 10. JCAHO, the Joint
Commission on Accreditation of Healthcare Organizations (2000), requires the use of a –0–10 pain rating scale to assess patients’ pain.

The pain scale is not the only available scale and a variety of methods are used to assess pain and the way in which it is expressed, making it difficult to compare different findings derived from studies about pain. A study carried out across four countries (McDermott 2000) looked at how nurses assess pain: (1) observing changes such as increased temperature, worsening of the illness, refusal to eat or loss of appetite, (2) listening to verbal complaints of pain, such as crying and/or screaming, (3) monitoring through physical examination, especially palpation of the involved area and technical monitoring, and (4) receiving information from the patient or their family members. It is important to look at how pain is expressed, as this is usually the framework upon which most therapies are based (Gaston-Johansson et al. 1990). Descriptions of similar symptoms, as well as verbal and nonverbal communication differ between cultures (Davidhizar and Giger 2004). The numerical rating is crucial for providers, as it helps them make subsequent decisions on treatment. In contrast, when communicating pain, patients need to tell their story or discuss and qualify pain using language meaningful to them. This language is related to the intensity of the pain as perceived by the patient, and is not necessarily representative of a measurement scale. It is not uncommon to hear a patient use the phrase “it hurts a lot” or “it is hard”. How much is “a lot” and how hard is “hard” is valuable, not necessarily shared information.

While discussing pain, McCaffery’s statement (1968) highlights the importance of patient’s perception and subjectivity. Healthcare professionals and family members often have difficulty in accurately recognizing pain because it is so subjective. Pain is recognized when the patient says that he feels pain or that something hurts, or he winces or grimaces because something hurts. Patients who are able to express themselves verbally may categorize their pain anywhere along the spectrum of mild to bad to constant to horrible to excruciating pain, or they may say that they feel like they are dying, or even that they would rather be dead. McCaffery has said that pain is what the patient says it is, and it is as bad as the patient says it is.

Pain is now considered the fifth vital sign. Vital signs are monitored in order to detect changes or trends that signal a need for further assessment, diagnosis and treatment. The rationale behind making pain a vital sign – along with temperature, pulse, respiratory rate, and blood pressure – is that it would ensure that pain is monitored on a regular basis (Clark et al. 2002). In the healthcare setting, administrators and healthcare providers use numerical pain scales to quantify pain. The patient is asked to choose a number (or a drawing of a facial expression thought to be the equivalent of a numerical expression of pain) that represents the pain they are feeling. Pain is commonly thought of as having at least two
dimensions, sensory and affective, which makes the wide popularity of single-dimension pain scales somewhat dubious. When asked to rate their pain on a scale from 0 to 10, patients often find it difficult to talk about their pain; they do not know how to interpret the meaning of this single-dimension scale.

Thus, pain refers to discomfort from illness or injury and can only truly be assessed by the person experiencing it (Aldrich and Eccleston 2000; Bolles and Fanselow 1980; Pasero and McCaffery 2001). According to the Agency for Health Care Policy and Research (1994) guide for acute pain management, the most reliable indicators of pain are self-reports by the sufferers themselves (Callister 2003). Researchers from medicine, sociology and medical anthropology have agreed that ethnic background affects pain perception and that pain is a complex, culturally defined multi-fac torial experience (Bates 1987; Greenwald 1991; Ramer et al. 2003; Rollman 1998; Strelzer 1997). Each culture has its own language describing pain experiences (Callister 2003; Zborowski 1952). Language and culture are bound together in the communication of pain, and cultural background is one of the major factors determining how people communicate and express pain (Lipton and Marbach 1984; Sternbach 1981). Members of a cultural background may understand the meaning of pain and suffering of another member from the same cultural background, a meaning that a person who does share that cultural background may not understand. In fact, cultural background has been found to influence ways of reporting about pain (DeTrill and Kovalcik 1997). It is a significant force in shaping beliefs and behaviors, giving meaning to pain experiences, and affecting the way it is dealt with.

Summing up, while the importance of expressing/assessing pain in healthcare/patient interaction is fundamental, communicating about it is very difficult in monolingual as well as in bilingual conversation, due to problems found by patients in understanding the meaning of a digit in a pain scale and by doctors in interpreting matches between verbal descriptions and non verbal behavior (see also Davidhizar and Giger 2004). When provider and patient do not speak the same language, these struggles become magnified and may lead to construct cultural or linguistic barriers that prevent health providers from understanding what the patient says. In these cases, a medical interpreter is called upon to facilitate communication.

In a bilingual bicultural medical encounter language interpreters facilitate communication between healthcare providers and patients who do not share a common language or culture. More than mere language decoders and encoders, these interpreters are actually powerful agents who bring their own perceptions, ideas, and beliefs into the interpreted communicative encounter (Angelelli 2004a, 2004b). Medical interpreters, as co-participants in the encounter, have a share in its co-construction. When pain is addressed during the encounter, interpreters
are vital in the co-construction of the (mis)understanding and communication of pain. Simply put, in a cross-linguistic medical encounter, the burden of facilitating talk about pain between patients and providers who do not share a language/culture seems to be placed upon healthcare interpreters (Angelelli 2003, 2004a; Davidson 2000, 2001; Metzger 1999).

In the next sections, I will first introduce briefly some aspects relating to the data discussed in this chapter. Then, I will explore the data from the point of view of the dilemmas that healthcare interpreters face in the construction of pain while facilitating communication cross-linguistically.

3. The study

The goal of this study is to investigate the complex interaction which is constructed by patients, healthcare providers and interpreters as they communicate about pain. Specifically this study aims to shed light on the strategies interpreters use to mitigate the need of a pain-rating scale. The data presented here is a subset of a larger sample collected for an ethnographic research on interpreting in the healthcare setting.1 The goal of the larger study was to investigate the role of healthcare interpreters in a public hospital in the United States.

3.1 The site

California Hope2 is a public hospital. Located in the Bay Area in California, it has established a strong foundation as the premier healthcare provider within the community. It is the only hospital in the county with an open door policy that guarantees access to needed medical care, regardless of patients’ ability to pay. The population served by California Hope ranges from middle class to working class, but the average patient falls below the socioeconomic poverty line. The residents of the area speak more than 40 different languages. When the ethnographic survey was conducted, the population served by California Hope consisted of White (49.6%); Hispanic (26.6%); Asian or Pacific Islander (18.7%); African-American (4.4%); other (0.8%).

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1. For more information on the larger study, see Angelelli (2004a).
2. All names referring to organizations and persons are fabricated to protect the identity of participants.
3.2 The participants

In this chapter we will look at the work of Mauro and Marcos. They are part of a group of fourteen staff interpreters who participated in the original study. Out of the fourteen staff interpreters, ten were full time Spanish-English interpreters, two worked part time, one worked night shifts in the Emergency Department, and one (an interpreter himself) worked as the Interpreting Service manager. Interpreters’ working hours were from 9:00 a.m. and 5:00 p.m. Monday through Friday. Of the ten Spanish-English interpreters, four were female and six were male. Their education varied. Three of the interpreters were physicians in their own countries, two graduated from college, one held a Master of Arts, one an Associate Degree, and three had a High School Diploma as their terminal degree. Their job description included facilitating communication between English-speaking members of the healthcare community and Spanish-speaking patients, both face-to-face and remotely, through the use of a speakerphone. In a remote trailer, interpreters answered calls in the order they were received. Both providers and patients were instructed on how to talk via speakerphone with the help of interpreters, according to guidelines written by the Interpreter Services manager on how to communicate effectively using the speakerphone. The interactions analysed here involve interpreters Mauro and Marcos together with healthcare providers and patients.

3.3 The data

Using a database of interpreter-mediated medical encounters (Angelelli 2004a), I reviewed and compared bilingual encounters to study discussions about pain. Of the larger database of 392 interviews representing interactions with ten interpreters, at least 4 instances of pain discussions were found for each of the participating interpreters, thus totalling 40 sequences. The interactions occurred between Spanish-speaking patients and English-speaking healthcare providers, both face-to-face and over-the-speakerphone. The interpreted communicative events (ICEs) were analyzed within the tradition of ethnography of communication, where recurrence and typicality are highlighted as indicative of participants’ communicative behaviour. This means that the extracts presented here are representative of the 40 sequences about pain and they do not constitute exceptions. In the following section I illustrate the construction of understanding of pain (or lack thereof), and the interpreters intervention to broker the pain scale. The analysis shows the role interpreters play in coordinating patient/provider participation in a cross-linguistic medical encounter. The
transcripts of the conversations allow us to see the cross-cultural challenges that arise in pain-rating interactions.\footnote{The transcription method used to present the data is that adopted in the rest of the volume. See Note on transcripts and transcript notation in the Introduction to this volume, for an illustration of the symbols used.}

4. The analysis

Interpreters deployed a variety of conversational strategies to discuss pain as well as to apply the pain rating scale. These strategies are similar to those found in previous research (see, for example, Angelelli 2004a; Metzger 1999; Wadensjö 1998). They ranged from brokering comprehension by giving expanded renditions, unpacking technical terms, sliding up and down the register scale, exploring answers, giving examples, checking for feedback on comprehension, to even replacing one of the interlocutors (see Angelelli 2004a:77). In the specific case of managing communication about pain, I studied how interpreters deal with the use of a mandated scale to assess pain. In particular, I look at: (1) whether they broker the possible ratings on the pain-measurement scale or not; (2) when they do so, how they broker the values and how they make the possible ratings comprehensible to patients (e.g. what is a 4 compared to a 7; what the two extremes 1 and 10 mean); (3) how they co-construct the rating with the patient to supply the answer that the provider is seeking. Following the tradition of ethnography of communication, I present two examples which represent interpreters' behaviour while brokering the pain scale. When healthcare providers ask the questions “on a scale from one to ten, how would you rate your pain?” interpreters give meaning to numbers by explaining the patients what a one or a ten may tell them, or what they may or may not be able to do with certain pain ratings.

4.1 Extract (1)

In the first example (Extract (1) below), a female Spanish-speaking patient calls the hospital to make a pre-natal appointment. She complains about abdominal pain. She is transferred to an English-speaking nurse to make an emergency appointment in pre-natal care. Mauro is the interpreter assisting in this interaction. Mauro is Mexican-American, born in Mexico, where he graduated as a physician. He is fifty years old and has worked as a medical interpreter at California Hope for eight years. Before giving her the appointment, the nurse needs to find
out what the problem is and determine if the patient needs to be seen right away. We join the conversation when the nurse asks the patient to rate the abdominal pain she is experiencing at the time of the call.


→ 01 N Okay (.) from a scale from one to ten (.), ten being the worst pain, is it a ten?
I ¿Señora? Madam?

→ 03 P Sí Yes

→ 04 I Mire, la señorita enfermera quiere que califiquemos la intensidad del dolor (.) recuerde, the nurse wants us to rate the intensity of the pain (.) remember
P Sí Yes

→ 06 I Siendo la intensidad cero cuando no tiene dolor a zero intensity means you do not have pain

→ 07 P Aha —

→ 08 I Y diez cuando tiene un dolor severo, como para que se vaya al hospital, que tan intenso el dolor del uno al diez and a ten means that you have severe pain and need to go to the hospital (.) how intense is your pain, from one to ten?

→ 09 P Pues sí que desde en la mañana que lo traigo no se me ha quitado, es lentito no muy fuerte pero sí — well (.) yes (.) I have had it since this morning...it is there, I can feel it, not very strong (.) but

→ 10 I Cuánto es lentito (.) un cinco (.) un (.) tres (.) o un how strong is not very strong, is it a five (.) a three (.) or a —

→ 11 P Más o menos como un cinco more and less like a five

→ 12 I Un cinco, eso es moderado (.) ¿okay entonces del uno al diez sería el cinco verdad? a five means a moderate pain. So between one and ten it would be a five, right?

→ 13 P Mh (.) sí Hmm (.) yes

→ 14 I Okay, she describes the pain as moderate or she says about a five

The nurse asks the patient to rate her pain using the one-to-ten scale (turn 1). Unlike other providers in the study, who simply present the scale by stating “in a scale from one to ten...”, this nurse helps the patient interpret the scale by stating...
what each extreme means as she says “ten being the worst pain” (turn 1). Mauro, the interpreter, however, takes this up as an indicator that the patient needs further explanation of that scale-rate. Mauro takes several turns (turns 2–8) to prepare the question that he finally asks in turn 8. In this preparation Mauro first speaks about what the nurse is asking “them” to do. By using the plural form of the verb “calificar” (to rate) in saying “califiquemos”, Mauro becomes the patient’s partner in the task of applying the pain scale. Not being directed by the nurse to broker the pain scale, Mauro takes it upon himself to offer the patient an explanation of the meaning of the two extremes of the scale first (turns 6 and 8). Realizing that patients may not be used to applying scales, he asks the patient to remember the value of the ratings so that she can use them to rate her pain (turn 4). While illustrating what the two extreme points of the scale mean, Mauro does not use long statements. He uses simple short sentences and waits for the patient’s feedback (turn 5 and 7) after each of the statements, to ensure that the patient is following along and understands the values of the extremes. In spite of the explanation of the ratings, the patient answers the question from her perception (“es lentito” – not very strong), and does not offer a rating. The patient’s own perception about her pain is not used as substitute for the rating. Mauro (like all other interpreters in the larger study) listens to the patient’s description of her perception (turn 9) but instead of rendering this information to the nurse, he continues searching for a numerical rating (turn 10), as indicated by the nurse’s request. In so doing, he also groups the scale middle points (turn 10) as he suggests some numerical value for “lentito”. In this case a ten-point scale is almost reduced to a three-point one, with one middle point and two extremes. From past experience in dealing with patients who fail to rate pain, Mauro, like other interpreters, even suggests a range of ratings to the patient (turn 10: a five, a three?). The patient accepts the suggestion of a middle point (turn 11), which the interpreter restates in turn 12, to make sure it is the patient’s statement rather than his. After twelve turns (2–14) of interacting solely with the patient, a rating is constructed and the interpreter turns to the nurse to provide her with the patient’s answer: “Okay, she describes the pain as moderate or she says about a five” (turn 14).

4.2 Extract (2)

In this segment we meet Marcos, a 48 year-old Chilean American, born in Chile where he graduated with a Bachelors of Science in Engineering. He is four years senior in this position. Marcos interprets between another English-speaking nurse and a male patient, Roberto The patient is calling because despite the fact that he was seen for a post-surgical check-up of his knee injury, he is not feeling
well and cannot find relief. He needs to get back to work but he is worried that his knee injury will worsen. He complains about pain at night and says that pain is sometimes so intense he can hardly sleep. We join the conversation when the nurse is asking him to rate the pain he is complaining about.


01 N How much pain are you having on a scale from one to ten how strong is it?
02 I ¿Roberto?
03 P Aha
04 I Cuando hablamos del dolor en el hospital, hablamos en números de la siguiente manera
when we talk about pain in the hospital we use numbers in the following way
05 P Aha
06 I Del uno al diez, un dolor que es tan pequeño que uno ignora es uno, un dolor que es fuerte podría ser cuatro, cinco, seis algo tengo que hacer ¿me entiende?
from one to ten, a pain that is so little that one can ignore it is a one, a pain that is strong could be a four, a five, a six, it means I have to do something about it, do you understand?
07 P Aha
08 I Tengo que ver al doctor o tengo que tomar algo, un dolor que me hace gritar es entre ocho y diez
I have to see the doctor, or I have to take something for it, and a pain that makes me scream is between an eight and a ten
09 P Aha
10 I ¿Qué número será su dolor ahorita?
what number is your pain right now
11 P Pues en la noche sería entre el ocho, porque en la noche es cuando no me deja dormir es más dolor
well, at night it would be between an eight, because it is at night when it does not let me sleep, when it is most painful
12 I ¿Ya y ahorita?
Ok, and right now?
13 P Y ahorita sería ¿dice que cuál era?
and now it would be, what did you say were the numbers?
14 I Okay uno es tan poquito que no le hago caso, no le hago caso, fuerte es entre cuatro y seis podría ser cinco no, muy fuerte es entre ocho y diez
Okay, one is so little that I do not pay attention to it, a strong pain is between four and six, and it could be a five; a very strong pain is between an eight and a ten
The nurse needs a rating in order to understand the intensity of the patient pain and how to proceed. She asks directly for such rating in turn 1. Marcos seeks for the patient’s attention (turn 2) and immediately starts his explanation about ways of speaking about pain in the hospital (turn 4). Marcos gives Roberto several examples about how to express pain intensity exploring a variety of adjectives, such as “little” (turn 6), “strong” (turn 6), and “very strong” (turn 8). Once Marcos has illustrated how the scale works, he asks the patient for a rating of the pain he is feeling at the time this interaction takes place. We see the patient trying to apply the scale to describe the pain he experiences during the night (turn 11), but when Marcos asks the patient to rate his pain at the present moment, the patient has already forgotten the equivalences for the rating scale. Marcos patiently goes over it once more (turn 14) enabling the patient to construct his answer and the kind of pain he feels at the time of the medical interview (turn 15). The interpreter then, brokered the pain scale and coordinated the ways in which the professional and the layman communities talk about pain. We are not certain as to what that rating (4 or 5 turn 15) means precisely for the patient, the nurse or the interpreter, it could though be argued that the communicative goal of this interview is achieved and that the participants have converged on the idea that the patient’s pain can be rated middle scale. The nurse has obtained the information she needed and the patient has stated the information he needed to communicate. The interpreter coordinated the effort. In this last example as well as in the previous one, we see that the interpreter coordinates the talk between provider and patient. At the surface level, what interpreters do is switching linguistic codes, in line with what interpreters are expected to do. Taking a closer look, we see that by doing this, the interpreter coordinates two speech communities, two distinct ways of speaking about pain. Interpreters not only navigate between languages and cultures but they make the ways in which the two speech communities talk about pain accessible to each other. They let patients talk and describe their pain as “it hurts a lot” or “when it hurts most I have to lie down” they then “translate” these descriptions into the ratings providers need.
5. Discussion and conclusion

Pain is a common problem and it affects people worldwide. Migration is increasing globally, thus racial and cultural diversity is growing in countries throughout the world making caregivers more likely to care for patients from different cultural backgrounds. The demand for interpreting services in the field of medicine is growing all over the world (Angelelli 2008; Angelelli and Slatyer 2012; Valero Garcés and Martin 2008). Multilingualism is the norm, rather than the exception in most countries. The effects of cultural diversity on pain management practices and healthcare strategies is inevitable (Davidhizar and Giger 2004).

Pain is a phenomenon with both personal and cultural significance. Expressions of pain may differ among patients, yet responses to pain are often similar in people from the same cultural community. Culturally competent care is a movement that strives to be aware of cultural beliefs and practices of individuals, families, and populations and incorporate them into the care already provided (Duggleby 2003). However, if pain continues to be measured with an ethnocentric scale, incorporating these cultural beliefs and practices may not be possible. As previous research in cross-linguistic communication has shown, the pain scale is only one way to measure pain, as supported by evidence from this study (Angelelli 2004a; Kaegi 2004; McDermott 2000). A clear understanding of definition, perception, expression, and communication regarding pain as seen through a cultural perspective is vital if the healthcare provider is to respond to the patient in a therapeutic, culturally sensitive manner (Davidhizar and Giger 2004).

Patients, healthcare providers and interpreters pertain to different speech communities (Hymes 1974 in Angelelli 2004a) and may or may not share the same understanding/construction of pain, as it is evident from the data above, as well as from the findings of the larger study from which these extracts derive (Angelelli 2004a). The findings of this study, however, should be interpreted within the context in which they were produced and should not be generalized. In constructing an understanding of the magnitude of their pain, interlocutors call on their linguistic repertoire. Yet, neither their linguistic repertoire nor their cultural background is always shared. However, the element imposed is the pain scale. From the discussion above and the examples we have discussed it is clear that the use of the pain scale to assess pain, even when mandatory, is problematic. When used across speech communities and cultures, it presents issues such as lack of common understanding of numerical values or clash of traditions in discussions of pain pertaining to e.g. the culture of the patient versus the culture of the healthcare provider or a monolingual versus a bilingual culture interacting in a medical encounter. These issues may result in inaccurate assessments on which important medical decisions are made. This study demonstrates that
interpreters need to make efforts in interpreting the pain scale for patients, showing that patients are not used to it and that cultural mediation is needed to achieve shared understanding.

6. Implications

Several implications for a theory of patient-centeredness (see Baraldi, this volume) have come to light from this study, as well as practical and theoretical implications for the education of healthcare professionals and interpreters, communication across cultures, and interpreting studies. In terms of patient-centeredness, when the use of a numerical scale to represent patients’ pain intensity is mandated by accreditation committees, little opportunity is left for patients to use their own perspective to explain their pain. This assessment instrument can assist healthcare providers in measuring a patient’s pain, but if there is a will to provide care based on a patient-centred approach this should not be the only tool. Healthcare providers should account for the variations in different cultural responses to pain and different communication styles, recognizing that constructions and communications about pain vary across cultures and languages. Patient-centred care requires providers who are culturally sensitive and who can appreciate and understand how to work with interpreters effectively. An increasing number of medical schools in the U.S. are including programmes on cultural sensitivity as part of their curricula and clinical skills assessment now includes examining patients in both monolingual as well as bilingual interpreted encounters. Young doctors are showing awareness about the need for cultural sensitivity and (plurilingual) patient-centred communication in medicine, learning to speak other languages and familiarizing themselves with the interpreting services available to help them communicate with patients whose language they do not speak. More importantly, they are paying attention to the ways in which to best utilize interpreters in the healthcare industry so that patients may be provided with the best possible care. In the setting in which this study took place, medical interpreters are extensively trained to understand medication instructions, discharge planning, and future care. Yet, even the best medical interpreter may struggle with translating the pain scale in terms of matching the information that the patient wishes to provide and the information that the doctor needs to obtain.

As for the education of medical interpreters, the interactions in this study demonstrate the need to revisit theoretical constructs such as those established in codes of ethics or standards of practice (e.g. neutrality, see Tebble, this volume). The findings in this study align with findings of other empirical studies discussed above (Bolden 2000; Davidson 1998, 2000; Metzger 1999 to name a few) that call for a
descriptive, rather than prescriptive approach to interpreter education. It should be empirically-based, and both teaching methods and materials should be authentic. Authentic interactions and empirically-based materials may improve interpreter training and learning by helping to-be interpreters to reflect on their roles as language mediators and cultural facilitators. By observing authentic interactions, training interpreters have the possibility to assess the consequences and responsibilities involved in playing a more visible role. This may help training interpreters to find solutions to stressful communicative situations such as conversations about rating pain intensity through the use of ‘culturally unfriendly’ pain scales.

In conclusion, the goal of culturally competent care is to be aware of and willing to incorporate the cultural beliefs and practices of individuals, families, and populations into the healthcare system (Duggleby 2003). Culturally-competent care involves all parties taking part in the healthcare encounter. To achieve this goal, the interpreter is pivotal. In order for the healthcare provider to understand patients’ pain in a therapeutic and culturally appropriate manner, she/he must understand definition, perception, expression, and communication of pain from a cultural perspective (Davidhizar and Giger 2004). The interpreter helps the provider achieve this goal by coordinating different ways of discussing pain that two distinctive speech communities may have—a coordinative task which requires cultural sensitivity and understanding, both of which are part of interpreters’ cultural brokering activity.

References


American Pain Society Quality Care Committee. 1995.


