Bilingual Risk Communication

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1. Interpreting and bilingual communication

In general terms, bilingual communication is constituted by the fact that participants in a given speech situation use more than one language. Switching between two or more languages in discourse is usually perceived as a linguistic procedure that allows the assignment of membership, the co-construction of the participation framework, and the achievement of mutual understanding (see for example Auer 1998, Müller 1989, Wei 2002).

Unlike other bilingual settings, interpreter-mediated communication is determined by the fact that the primary interlocutors are not able to communicate successfully in the language of the other(s), and therefore need the support of a third, bilingual person. This leads to a specific participation framework in which the bilingual participant plays a central role in the entire ongoing interaction, and in which he or she may even acquire the status of a primary party. The fact that, especially in situations of ad hoc interpreting, interpreter roles are not always fixed, is extremely important for communication in hospitals. Several studies have shown that interpreting has an impact on the interactional organization of medical encounters, e. g. the frequency of questions, the mediation of cultural differences, or the coordination of primary parties (Bolden 2000, Davidson 2002, Pauwels 1995, Prince 1986, Rehbein 1985, Wadensjö 1992).

Although the view is becoming more and more accepted that interpreters have to be "critically engaged" (Davidson 2002: 1275) in order to achieve mutual understanding it is nevertheless undeniable that, because of their active participation, they might (or sometimes even must) "bring their own agenda into the clinical encounter" (Hardt 1995: 174). The question that I will address in this paper is how the interpreter's engagement affects the communication with migrant patients in briefings for informed consent. I will use a discourse-analytical approach to medical interpreting (Bührig & Rehbein 2000, Bührig 2001, Meyer 2001, 2002b). Propositional and illocutionary dimensions of source- and target-language discourse will be analyzed by taking into account "the relationship between the given speech situation, the action process between the primary actors, and the actions of the interpreter" (Meyer 1998). In doing so, I will show that ad hoc interpreters, such as nurses or relatives of the patient, manage to bring across the probabilistic aspect of complications, but tend to frame statements about complications quite differently.

The study is based on 24 mono- and bilingual briefings from internal medicine, surgery, and anesthesia. All of the authentic interactions were tape-recorded in public hospitals in Germany. These give insights into communication between migrant patients and physicians in hospitals, and the results may also apply to interpreter-mediated communication in other social institutions. Based on an analysis of how briefings for informed consent are structured and how they are integrated in the flow of medical work, the conclusion has to be drawn that the 'accuracy' of interpreter performance can, in the end, not be evaluated by simply counting omissions, additions, or substitutions of propositional elements, but rather by looking at the action quality of interpreted discourse, i.e. the ways in which changes on the propositional level lead to changes in the achievement of communicative purposes.[1]

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2. Risk communication and briefings for informed consent

In briefings for informed consent, doctors prepare patients for treatment by announcing and describing medical actions that they plan to perform.[2] The planned medical actions in this study are, for the most part, standard procedures that are repeatedly carried out, such as gastroscopies or bronchoscopies. From a medical point of view, they are not very dangerous, but for legal reasons, doctors have to inform patients about the risk a procedure might entail.

The purpose of briefings for informed consent is that, in the end, the patient should consent to a proposed treatment although she or he has been informed of possible complications and undesired outcomes the treatment might entail. The default case is that doctors do not adopt an impartial stance regarding the patient's decision-making. Rather, they want the patient to agree to the proposed treatment, and the briefing is organized in such a way that this purpose is achieved. This perspective on informed consent is based on three sources of information: The analysis of authentic doctor-patient communication, ethnographic information (personal observations during the data collection, interviews with physicians), and a review of literature from the areas of sociology and law.

Comparing data from these different sources we can conclude that the activity called 'briefing for informed consent' is very much determined by the institutional setting. Briefings for informed consent have a prototypical form that allows doctors to inform the patient and, at the same time, maintain the patient's compliance.[3] The prototypical form shows up on the propositional level as well as on the level of speech actions (Table 1).

INFORMED CONSENT
Announcing the procedure
Describing the procedure
Pointing out risks of the procedure
Monitoring
Authorization

Table 1: The prototypical form of briefings for informed consent

The doctor's action scheme for the briefing can be separated into two parts. First, the medical procedure is announced and described. After doing so, the doctor switches to the communication of risks. Risks are named, illustrated and/or described. After giving a rough estimate of their frequency and seriousness, the doctor will monitor the patient's further need for information and then conclude by letting the patient sign the consent form.

By announcing and describing the method, the doctor orients the patient towards the institutional plan of action and tries to make sure that the patient is able to cooperate in the planned procedure, but this future cooperation is put into question by the obligatory information about risks. Pointing out risks is therefore one of the more difficult tasks for the doctor during the briefing.

From a legalistic point of view, the information provided by the doctor should serve as a basis for the patient's decision-making and the carrying out of the procedure depends on the outcome of that decision-making (Meyer 2002a). Although it should be the patient who decides whether a treatment will be carried out or not, many patients do not know that they have the right to reject a treatment. To illustrate the fact that the constellation between doctor and patient is not fully transparent for the latter, Bührig (2001) characterizes the doctors' speech actions as "one-sided". As it is difficult for the patient to infer the purpose of risk communication, the reciprocity of perspectives cannot be taken for granted.

[2] Informed consent for clinical trials is not in the scope of this study.

[3] See Biel 1983, Mann 1984, Meyer (2002b), Jung (forthcoming) on the generic structure of briefings for informed consent. Askehave & Swales 2001 discuss 'purpose' as a relevant category for the analysis of institutional types of discourse.

In terms of a recent approach to the analysis of activity type, we may call this a case of 'interactional hybridity' (Sarangi 2000).

The concept of informed consent places contradictory demands on the doctor: he or she has to ensure the patient's cooperation and, at the same time, has to make clear that this cooperation could have negative consequences for the patient. The obligation to talk about complications and at the same time maintain the patient's compliance leads doctors in many cases to downplay the relevance of risk information by characterizing the frequency and seriousness of possible complications as low. This allows them to meet both demands: to talk about complications, and at the same time, to achieve the patient's consent. Before I give some examples of how physicians meet this demand in different situations, I will have a brief look at the notion of 'risk'.

2.1. What is a 'risk'?

The assignment of 'risk' is relative to the expected severity of any negative consequences resulting from an action. A potential undesired consequence (in this case, a complication during the course of a medical procedure) may be considered 'risk' only if it is both serious and occurs frequently. Something that rarely happens will not influence our decisions. Neither will something that has a negligible impact on us, even if it occurs frequently.

Although 'frequency' and 'seriousness' are essential features of risks, an event should only be called a 'risk' if an actor takes it into consideration. An undesired outcome might be dangerous and to some extent frequent, but an actor might not take the possibility of undesired outcomes into consideration during his or her decision-making process. The actor might view such possibilities as inapplicable to her or him. This is probably the case with persons who exhibit a 'risky behavior'. In other words: Nothing is a risk per se (Adelswärd & Sachs 1998, Candlin & Candlin 2002). In the process of planning and deciding on a future action, actors may come to regard the planned action as risky. By anticipating and evaluating, actors integrate knowledge about such possibilities in their decision-making process.

Therefore, it is crucial how doctors present the possible negative consequences of a medical procedure: are they presented as relevant or as irrelevant to the patient's decision-making? With respect to this, our data suggests that in anesthesia and in diagnostic briefings, doctors more likely present complications as irrelevant. At times, complications are not even mentioned. In briefings that prepare for therapies, however, it is more likely that complications are presented as risks, which makes them relevant for the patient's decision-making. The data further suggest that ad hoc interpreters do not always follow this systematic differentiation. By omitting or adding estimations of frequency and seriousness, they deepen the inherent asymmetries and communicative contradictions of briefings for informed consent.

2.2. Pointing out complications in interpreter-mediated briefings for informed consent

As I have shown in table 1, briefings have a sort of prototypical form that seems to guide the linguistic actions of doctors. This is not only true of the briefing as a whole, but also of that particular section of the briefing in which complications are the main topic. Table 2 gives a scheme of action for this section of discourse. This scheme should not be interpreted as a deterministic structure which is institutionally imposed on doctors. Rather, it results from the fact that the speech situation in all briefings, despite situational variations, share certain features. This is due to the generic purpose of the briefing: informing the patient on one hand and achieving his/her consent on the other.

SPEECH ACTIONS	PROPOSITIONAL REALIZATION
Announcing a new topic (Obligation to know and/or to say)	"Ich muß Ihnen sagen" (*I have to tell you*)
Describing, naming and/or illustrating complications	"Sie können eine Lungenentzündung bekommen" (*You may end up with pneumonia*) "Es kann mal bluten" (*It could bleed*)
Estimating seriousness and/or frequency	"Das passiert nicht sehr häufig" (*That doesn't happen very often*) "Normalerweise hört das von selber wieder auf" (*It usually stops on its own*)

Table 2: Pointing out complications of the procedure

Bührig (2001: 115) analyzes risk communication in briefings for informed consent as being of the action type of 'pointing out something to someone'. The section of discourse in which complications are pointed out to the patient can usually be separated into three steps: First, doctors announce the new topic (complications). Very often they do so by using modal verbs in combination with verba dicendi in order to highlight the obligatory character of this communicative act (*you need to know, I have to tell you*). The obligation may be presented as being an obligation of the patient (to know), or an obligation of the doctor (to say). Secondly, doctors refer to possible complications. Sometimes they use the professional term to designate these events, like in the case of "Lungenentzündung" (*pneumonia*). In other cases, they just illustrate complications. Thirdly, doctors estimate the frequency and seriousness of complications. In most cases complications are presented as non-frequent and non-serious.

As table 2 illustrates, doctors may indicate the relevance of information about complications before or after they talk about it. In most cases, they do it afterwards by estimating the seriousness and frequency of complications as low. In some cases, doctors already indicate relevance during the announcement of the new topic. The announcement of the new topic and the estimation of frequency or seriousness are therefore supportive actions: Whereas the announcement orients the patient towards the crucial topic, the following estimation usually downplays the relevance of the given information. The doctor raises a delicate topic which for institutional reasons should not get all of the patient's attention. Therefore, the topic has to be downplayed as soon as it has been mentioned.

In the following case, a female doctor of internal medicine (D) speaks to a sixty-four year old Portuguese, a retired worker who has been living in Germany for many years (P). The interpreter (I) is a twenty-eight year old nurse who grew up in Germany bilingually. The briefing is about a bronchoscopy. The doctor has already described the procedure and now refers to possible complications.[4]

The doctors' turn (60 – 64) can be separated into four steps: In utterance (60) she takes her turn after the nurse has completed her translation (not in the transcript). Next, in utterance (61), she announces a new topic and characterizes the hearer's mental process as an obligation (*you need to know a few things*) without, however, revealing the source of this obligation. In the following utterance (62) she talks about the risk of contamination by bacteria and, as a possible consequence, pneumonia. By using the modal verb "kann" (*can* or *may*), she marks the risk as a potential event. In (63), she gives an estimation of its frequency (*It's rare*) and refers to it in (64) again to its potentiality (*but it could happen*).

[4] Transcription conventions: Numberings ('/60')refer to segments of ongoing discourse. ‚•' refers to short hesitations of less than a second. ‚/' refers to utterance-internal self-repair. Underlined sections indicate emphasis on the underlined syllable(s). Repetition of vowels indicates lengthening ('Thee'). Single brackets indicate an doubtful transcription. The transcript is presented in 'score format' (Ehlich 1993), translations of the original utterances are provided below each utterance.

29
D /60 /61 Ja? • Dafür • müssen Sie folgende • Dinge wissen:
Right? For that you need to know a few things:
I inflamação.
/59
P Sim
Right

30
/62
D Es kann • bei der/ • dieser Untersuchung sein, dass Keime
It could be that during the/ during this examination germs get carried into
P ((coughs))

31
D in die Lunge verschleppt werden, Bakterien, und dass Sie hinterher•
the lungs, bacteria, and that you could end up with pneumonia afterwards.

32
/63 /64
D eine Lungenentzündung • kriegen können. Das is selten, aber das
It's rare, but it could

33
D kann passieren.
happen.
/65
I Agora ela tá a contar que • quando eles meterem a
Now she is saying, that when they insert the probe

34
I sonda que você/ que podem entrar • • bactérias ou assim coisas •
that you/ that bacteria or things like that could enter into the/ the lungs.

35
/66
I para dentro doo/ dos pulmões. Você pode ficar com uma
You could end up with pneumonia.

36
/67 /68
I pneumonia. • Pode acontecer. Não acon/ não acontece muitas vezes
It could happen. It doesn't ha/ it doesn't happen very often,

37				
D				/73 /74 Ja? • Was Sie noch Right?
I	/69 mas pode acontecer. but it could happen.	/70 E ela tem que dizer. And she has to say it.	/72 • Ja. Right.	
P		/71 Sim Right		

Transcript 1: Briefing for informed consent (bronchoscopy)

The modal verb "kann" (*can, may*) plays a crucial role in segments (62) and (64). It serves to express the possibility of risk. The modal verb 'müssen' (*have to, must*) in segment (61) indicates that the communication of risk is not based on the doctor's own decision, but is rather an obligation that has been established by an anonymous force. By using the verb "wissen" (*to know*) and addressing the patient directly, the doctor points out that the communication of risks is not just a formal act and that the patient should process the given information in some unspecified way. Utterance (61) is the only one in this stretch of talk that may help the patient infer what he should do with the information provided by the doctor.

Another linguistic element is "selten" (*rare*) in utterance (63). This adverb has modal effects without being a modal verb: it allows the doctor to qualify the frequency of complications as low without presenting any numerical facts. To sum up, three aspects of how doctors communicate the possibility of complications can be identified in the physicians' talk: first, that it is obligatory to know about them, second, that they are potential events; and third, that their frequency is low. As we will see in section 2.3., these aspects of complications (OBLIGATION, POTENTIALITY, FREQUENCY) can be found throughout our data.

Let us now take a brief look on how the ad hoc interpreter brings this stretch of discourse across in the target language Portuguese. In utterance (65), the nurse starts with the risk of contamination (*bacteria or things like that could enter into thee/ the lungs*). In (66), she brings across the risk of suffering from pneumonia. In both cases, these risks are marked as potential events by a modal verb ("poder", *can, could*). However, the causal relation established between the two events by "pode ficar" (*end up with*) is less explicit than the doctors "hinterher …kriegen können" (*end up with afterwards*). In (67) and (69) she repeats that both events are possible (*It could happen*), whereas (68) can be analyzed as an attempt to characterize the frequency as low (*it doesn't happen very often*).

Although several differences between source- and target-language discourse can be detected, the (low) frequency and possibility of complications as such are translated correctly. The most important change occurs with regard to the obligatory character of communicating risks. In utterance (70), the nurse transforms the patient's 'obligation to know' (61) into the doctor's 'obligation to say': *And she has to say it* (70). The semantic content of the Portuguese periphrastic construction ("tem que") used by the nurse is quite similar to the German 'müssen', as well as to English 'have to'. It basically conceptualizes an action or event as occurring obligatorily without revealing the source of this obligation. The difference between (61) (*you need to know a few things*) and (70) (*she has to say it*) lies not in the use of modal expressions, but in the predicate.

Another aspect of risk communication shows up in the case of a briefing that prepares for surgical intervention. Here the seriousness of potential complications is more explicitly highlighted than in the first case. In transcript 2 the doctor is a male surgeon (S). The patient (P) is a Portuguese woman who doesn't speak much German although she has been living in Germany for more than ten years. The purpose of the operation is a resection of her gallbladder. The surgery has been proposed to stop the flux of gallstones in her bile ducts. The ad hoc interpreter (N) is the same Portuguese nurse as in

transcript 1. Again, the doctor has already described the medical procedure and then switches to the communication of complications.

67	S	/98 ((1s)) Äh • nun Uh let's go now to
	N	certeza que não tem mais, • mais pedras. that there are no more stones.
	P	Hm
68	S	kommen wir zu den Komplikations • möglichkeiten dieser Opera the possible complications from this operation.
69	S	/100 tion. • Das heißt also: Was ist gefährlich an dieser Operation. /101 Und In other words: What is dangerous about this operation. And
	N	/99 Hm
70	S	was sollte man wissen als Patient. what should you know as a patient.
	N	/103 Ele agora só tá a dizer que é He's now just saying that, what
	P	/102 Hm
71	N	que pode haver/ ou pode haver complicações. /104 Ele só vai agora there may be/ or that there may be complications. Now he will only tell those
72	N	dizer as complicações que podem aparecer. /106 Mas não/ não é/ complications, that could appear. But not/ it is not/ well
	P	/105 (Vão) aparecer. (Will) appear.
73	N	pronto agora, • pode aparecer, • mas também não, não é/ now, it could appear, or even not, it is not/
	P	/107 Não pode It could not appear.

74		/108
S		(Es) gibt also erstmal die
		There are first of all the general
N	não pode aparecer, né?	
	it could not appear, right?	
P	aparecer.	

Transcript 2: Briefing for informed consent (resection of the gallbladder)

In transcript 2, the surgeon S announces the new topic in utterance 98 (*Let's go now to the possible complications from this operation*). The following two utterances (100 and 101) make his announcement more precise. *What is dangerous about this operation* elucidates the notion of complication ("Komplikationsmöglichkeiten") that he has used in his announcement. The relevance of the topic is highlighted by the term *dangerous* in itself. In addition, emphasis is put on the base vowel of "gefährlich" (*dangerous*). The second utterance *And what should you know as a patient* highlights the fact that risk communication is obligatory, and that the patient should integrate the given information into her knowledge. Again, emphasis is put on the base vowel of "wissen" (*to know*). In his introductory statement, the surgeon explicitly indicates that complications are dangerous and may have the status of being a risk. Moreover, he makes clear that the patient's processing of the given information is significant (obligation to know).

The interpreter starts her turn with a matrix-construction. In the matrix clause (*He's now just saying*) she weakens the descriptive realization of the illocutionary force of the Portuguese verb "dizer" (*to say*) by adding the particle "só" (*only, just*).[5] Whereas the matrix construction as such reflects the participation framework, i. e. the specific position of the interpreter within the triad[6], the particle plays down illocutive dimensions of the surgeon's statement by reducing the content of "dizer" (*to say*) to be a act that does not relate to an addressee. Then, in the subordinate clause, the nurse breaks down the German compound "Komplikationsmöglichkeiten" (*possible complications*) by emphasizing that complications are potential events. She omits the characterization "gefährlich" (*dangerous*), as well as the fact that the patient should know about complications and their properties. Therefore, her version of the surgeon's announcement is restricted solely to the fact that complications "podem aparecer" (*could appear*) or that they "não podem aparecer" (*could not appear*) and that he, the surgeon, will only talk about those complications that *could appear*. Even without considering the patient's misunderstanding in segment 105 (*will appear*), we may presume that it is difficult to infer the relevance of the interpreter's utterance 106 and to assess the information given in the subsequent turns.

Comparing how the surgeon (in Transcript 2) and the internist (in transcript 1) talk about complications, we may note that they differ slightly in how they embed risk communication into the ongoing discourse. Although both explicitly mark the change of topic, the internist just highlights that the patient should know about complications. The surgeon, however, emphasizes the fact that complications are dangerous. The nurse partially fails in both cases. In transcript 1, she changes the 'obligation to know' into an 'obligation to say'. In transcript 2, she omits the doctor's reformulations of the announced topic, which could have helped the patient process the information given by the surgeon in his subsequent turns. In the following section I will compare various briefings in order to show that these two cases do not stand in isolation.

2.3. Quantitative aspects of interpreter-mediated risk communication

The following tables give an overview of how physicians communicate about complications in our data. The first table (table 3) shows that complications were not mentioned at all in only in three of twenty-four briefings. In seven cases, physicians mentioned only a few possible complications, but in

[5] Cf. Rehbein 2003 on the role of verba dicendi for descriptive or performative realizations of illocutive acts in matrix constructions.

[6] Cf. Knapp & Knapp-Potthoff 1987, Mason 1999.

fourteen cases most possible complications that appear in the official information sheet were also mentioned during the briefing.

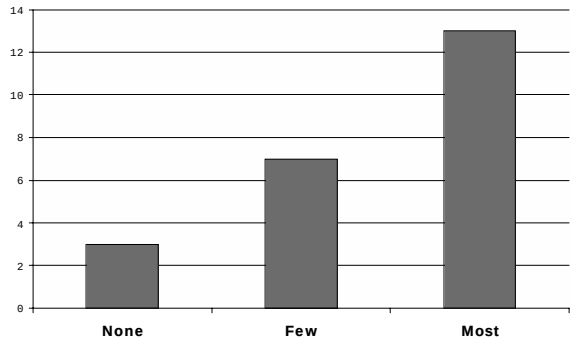

Table 3: Complications mentioned

Table 4 shows that doctors differ with regard to if and how they highlight the fact that it is obligatory to talk and know about risks. In twelve of twenty-four briefings they don't say anything about this issue, but in the other briefings, the obligation is mentioned in one way or another, i. e. as an obligation of the doctor (to say), or as an obligation of the patient (to know), or both.

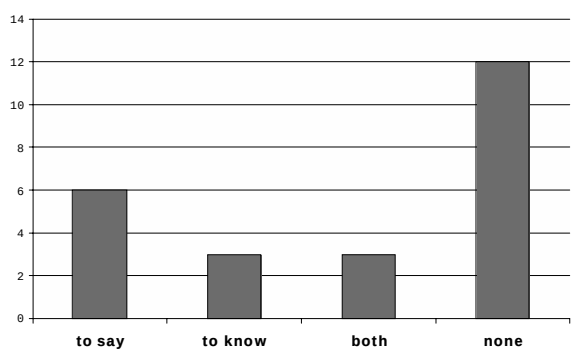

Table 4: Risk communication as an obligation

As already has been indicated, important features for the patient's reception of the given information are the frequency and seriousness of complications (table 5). These features are decisive for taking complications into account as risks. In seven cases, doctors didn't say a word about the frequency and seriousness of complications, but three of these cases were those in which complications were not mentioned at all. In another six briefings, doctors rated the frequency of complications as low. Three times, complications were characterized as non-serious, and in five cases they were presented as being both nonserious and nonfrequent. In three cases, at least some of the complications were presented as serious. Two of these briefings occurred in a unit for surgery.

The numbers show clearly that doctors do not always act in the same way when they talk about complications. Sometimes they use more downplaying devices, like reducing risk communication to a formal act or presenting complications as nonfrequent and nonserious. In other cases, they avoid such statements, and in some briefings, they explicitly mention that complications are serious. As I have argued elsewhere (Meyer 2003), this variation is presumably not just based on individual choices, styles or situational parameters. Rather, it might be a systematic variation that is at least partially determined by the institutional flow of work.[7]

[7] Physicians more likely seem to minimize complications in situations where room for decision-making is quite restricted, as in anesthesia or before diagnostic procedures. In many cases, after the diagnosis has been made, a

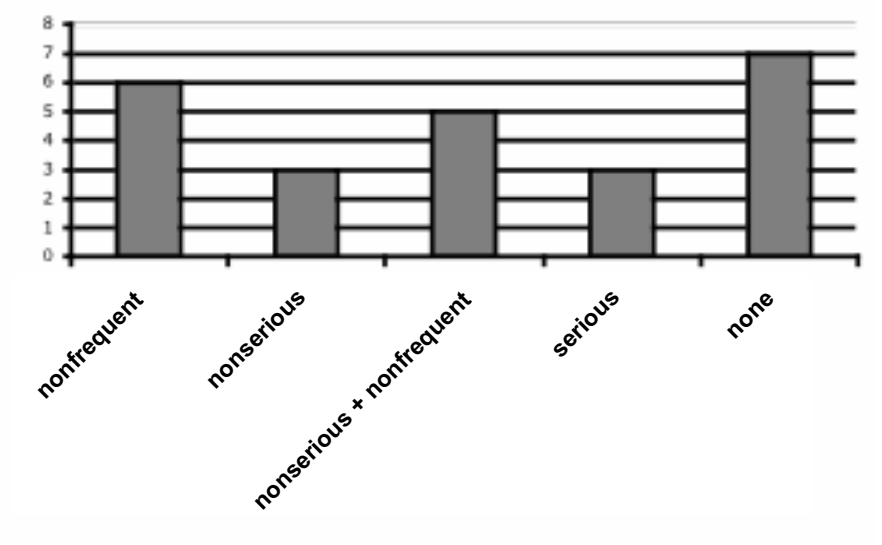

Table 5: Complications are…

Whatever the reasons for variation in risk communication may be, a comparison of ten interpreter-mediated briefings from our corpus shows that the accuracy of ad-hoc interpreting varies as well. Ad-hoc interpreters tend to work faithfully in some areas of risk communication, and they are more likely to leave out or to add something in other areas (table 6). All the briefings compared in table 6 are from a unit for internal medicine and prepare patients for diagnostic procedures. Table 6 does not say anything about the quality of interpreter performance. It simply contains information about if doctors (and, subsequently, ad-hoc interpreters) have referred in one way or another to the potentiality, frequency, and seriousness of complications, as well as to the obligatory character of risk communication.

TALK NO.	POTENTIALITY OF MPLICATIONS		OBLIGATION				FREQUENCY		SERIOUSNESS	
			To know		To Say					
	DOC	INT	DOC	INT	DOC	INT	DOC	INT	DOC	INT
5	–	–	–	–	–	–	–	–	–	–
8	+	–	–	–	–	–	+	–	+	–
10	+	+	–	+	+	–	+	+	–	+
14	+	+	+	–	–	–	+	+	+	+
22	+	+	–	–	–		+	–	–	–
27	+	+	+	–	–	+	+	+	–	–
29	+	+	+	+	–	+	+	+	+	+
37	+	+	–	–	+	–	+	+	–	+
39	+	+	–	–	–	+	+	–	–	–
43	+	+	–	–	+	–	+	+	–	–

Table 6: Risk communication in 10 interpreter-mediated briefings[8]

As table 6 shows, doctors and interpreters converge regarding the potentiality of complications. In other words, whenever doctors mention that a procedure might have some undesired outcome or side effect,

decision has to be reached about if and how the treatment should proceed. The diagnosis serves then as a basis for decision-making. Before that, there is no such basis to rely on.

[8] + = occurrence; – = no occurrence.

interpreters do so as well (the only exception is talk no.8).[9] In the right-hand columns, however, less convergence between the performance of doctors and interpreters can be found. These areas refer more directly to the patient's decision-making. If we take the communicative purpose of risk communication into consideration, i. e. that the patient should consent although he or she has been informed about possible negative consequences, it is crucial if and how statements about these consequences are made relevant for the patient. Ad-hoc interpreters seem to treat these areas (OBLIGATION, FREQUENCY, SERIOUSNESS) as less important. To pick up the quote from Eric Hardt, these are the areas in which ad-hoc interpreters more likely bring their own agenda into the briefing for informed consent.

3. Conclusions

In a recent article, Juliane House emphasizes the need for linguistic analysis in translation criticism. Evaluative judgements about the quality of translation should be based on a description and explanation of the "relevant linguistic features of the translation text" (House 2001: 254). These features can be detected by systematically taking into account the purpose of a certain type of discourse or textual genre, as well as the institutional 'context' in which the linguistic activity is embedded.[10]

Focusing on risk communication in briefings for informed consent, I have tried to show that the information about complications as such goes systematically hand in hand with certain linguistic procedures by which doctors allow (or disallow) patients to infer the relevance of the given information and the fact that the carrying out of the planned medical procedure depends on their own decision.

Ad hoc interpreters seemingly do not always treat these procedures as relevant linguistic features of the source-language discourse. Rather, they show variation in the presentation of complications. Further case studies of interpreter-mediated briefings for informed consent could be devoted to the question of how personal and professional backgrounds of ad-hoc interpreters lead to different outcomes in their performance as interpreters. We may assume, for example, that because of interpersonal aspects, relatives of the patient intervene differently in risk communication than nurses do. By analyzing such communicative processes in detail we could further support the assumption that the 'accuracy' of interpreter performance is at least partially based on the interpreter's understanding of the communicative event, its purposes and institutional implications.

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[9] This does not imply, however, that the ad-hoc interpreters in our data work faithfully regarding what complications are mentioned and how they are described in detail.

[10] On 'purpose' as a helpful linguistic category for the analysis of doctor-patient communication, see Rehbein 1986, 1993.

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