Migranten im Gesundheitswesen der Schweiz

Marina Sleptsova Schwander

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Zunehmende Migrationsströme führen weltweit zu multi-ethnischer Gesellschaften. Im Jahr 2013 gab es weltweit rund 232 Millionen Immigranten (WHO). In der Schweiz hatten 34.8% (Basel: 42%) der Wohnbevölkerung einen Migrationshintergrund. Dies stellt auch im Gesundheitssystem eine grosse Herausforderung dar, In der vorliegenden Arbeit werden zwei unterschiedliche Projekte aus diesem Themenbereich vorgestellt.

Chronische Schmerzen sind bei Immigranten in Europa häufiger als in der Bevölkerung des Gastlandes. In der vorliegenden Studie wurde im Rahmen einer randomisierten kontrollierten Intervention über eine Zeit von 4 Jahren an insgesamt 116 Patienten die Wirksamkeit eines standardisierten Therapieprogrammes an Migrantinnen und Migranten evaluiert. Die Ergebnisse zeigen keine Verbesserungen (SF 36, GHQ, PDI und Krankenkassenkosten) nach der Therapie. Dennoch berichteten die Patienten in halbstrukturierten Interviews, wie zufrieden sie mit der Therapie sind.

Ein Teil des Problems im Umgang mit Migranten ist ihre z.T. ungenügende Sprachkompetenz in der Sprache des Ziellandes. Daher war es naheliegend, sich im zweiten Projekt mit der Rolle des Dolmetschers im klinischen Gespräch auseinanderzusetzen. Eine Literaturübersicht zur Rolle des Dolmetschers im medizinischen Gespräch ergab, dass kein einheitliches Modell für die Rolle des Dolmetschers existiert. Die Wahrnehmung der Dolmetscherrolle durch medizinische Fachpersonen und Dolmetscher in der Kommunikation mit fremdsprachigen Patienten wurde mit einem auf Englisch validierten und von uns auf Deutsch übersetzten Fragebogen (*Interpersonal Role Inventory*, IPRI) gemessen. Insgesamt wurden 1005 Fragebögen ausgewertet. Die Analyse zeigt, dass sowohl Dolmetscher als auch medizinische Fachpersonen die Rolle des Dolmetschers überwiegend als eine neutrale Rolle definieren. Im nächsten Schritt wurde überprüft, in wieweit diese Rollenpräferenz in der Realität umgesetzt wird. Hierfür wurden insgesamt 19 gedolmetschte Konsultationen auf Video aufgenommen (865 Minuten), transkribiert, übersetzt und analysiert. Die Datenanalyse ergab erhebliche Mängel bei der Dolmetscherleistung. Zudem fiel auf, dass die Dolmetscher in den Konsultationen häufig eine aktive (und nicht neutrale) Rolle annehmen und ohne Rücksprache erklärend auftreten oder mit eigenen Äusserungen intervenieren. Diese Daten gewähren einen detaillierten und aufschlussreichen Einblick in die gedolmetschte Kommunikation in Spitälern. Es wird deutlich, dass die Erwartungen von Fachpersonen mit der Realität der Dolmetscher-Tätigkeit nicht übereinstimmen.

Aus beiden Studien lässt sich schlussfolgern, dass es in der Schweiz ein gewisses Verbesserungspotential im Bereich Dolmetschleistungen im Gesundheitswesen gibt. Die fehlende Effizienz der standardisierten Interventionsprogramme bei Migranten mit chronischen Schmerzen ist mit den vorliegenden Erkenntnissen schwer zu klären; hier besteht zunächst einmal Forschungsbedarf.

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Culturally sensitive group therapy for Turkish patients suffering from chronic pain: a randomised controlled intervention trial

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Summary

SUMMARY OF BACKGROUND DATA: The incidence of chronic pain is higher among immigrants in Europe than among the native European population. Therapeutic interventions in this population are far less effective than in patients for whom these programmes were originally developed.

OBJECTIVES: In a randomised trial, we investigated whether a cognitive behavioural treatment (CBT) programme supplemented with culturally sensitive aspects (CsCBT) improves pain intensity, pain disability and quality of life among immigrant patients, compared with a treatment of culturally sensitive exercise therapy (CsET) alone. Furthermore, we investigated whether healthcare costs would decrease.

METHODS: First-generation Turkish immigrants residing in Switzerland (20–65 years of age) who suffered from chronic pain were enrolled in the trial. Patients were randomised to attend either CsCBT or CsET. The CsCBT intervention was based upon a manualised cognitive-behavioural group treatment programme for chronic pain patients and adapted to the needs of a Turkish immigrant population. The CsET intervention was based on principles of exercise therapy for treatment of nonspecific low back pain.

RESULTS: A total of 116 outpatients were recruited between October 2004 and November 2006. The intervention was completed by 89 patients (77%). A total of 78 subjects (67%) completed follow-up, 12 months after the completion of the intervention programme. The intervention showed no effects in reducing pain, pain disability or quality of life. The analysis of healthcare utilisation yielded no intervention effect.

CONCLUSIONS: Cognitive behavioural intervention is feasible with immigrants with chronic disabling pain, but the evidence-based CBT programme, as well as exercise therapy supplemented with culturally sensitive aspects, showed no improvement.

Key words: *randomised controlled trial; chronic pain; immigrants; culturally sensitive cognitive behavioural therapy; culturally sensitive exercise therapy*

Introduction

Pain disorders are frequently encountered among immigrants. In England, chronic pain is more prevalent among African-Caribbean and South Asians than the English population [1–3].

Results of most investigations on experimental pain show significant ethnic differences in response to experimental pain across multiple stimulus modalities [4–8]. Most clinical pain studies agree that. in contrast to the native population, ethnic minority groups report more severe pain, more depressive symptoms, increased avoidance of activity, more fearful thinking, more physical symptoms, greater physical and psychosocial disability, wider-spread areas of pain, as well as greater disease activity [9–28]. Some authors point out that patient ratings differ from physician ratings. Physicians ascertain no specific difference in global physical assessment in immigrant patients [27, 28], and even less physical damage in these groups [19]. However, affiliation to a racial or an ethnic group may not necessarily be responsible for differences in the perception and experience of pain, as these variations may sometimes be better explained by socioeconomic status and level of education [29–32].

Additionally, racial and ethnic differences exist not only in the experience of pain but also in pain treatment. A majority of studies find that patients with a different ethnic background do not have the same access to pain therapy and are not given the same treatment. This inequality in pain treatment between ethnic groups has been observed across all types of pain and in many settings [15, 33–38]. As an example, white patients with pain were more likely to receive an opioid than black, Hispanic, or Asian patients; these differences did not diminish between 1993 and 2005. White workers claiming compensation were 40% more likely than African Americans to receive a diagnoses of a herniated disc and consequently twice as likely to undergo surgery.

Patients also differ in coping with pain. Compared with native Swedes, immigrants in Sweden rely more on passive coping strategies to manage pain [39]. Passive pain-coping strategies focus on treatment modalities that do not require a patient's active participation, such as increasing pain medication or massage therapy. First-generation Turkish immigrants in Germany suffering from chronic headache overuse acute headache medication [40]. A comparison of US African-Americans and Caucasians shows the former to be less physically active and report lower perceived control over pain. African-Americans also employ more external pain-coping strategies such as the belief someone else could offer a successful therapy, be it a competent doctor or God himself [41–43]. Similar results have been found in a pain-free sample of young adults [44]. This suggests that ethnic differences in pain coping within clinical samples do not result from prolonged exposure to chronic pain, but might be evident even in the absence of chronic pain.

The importance of a culturally sensitive approach to the treatment of immigrants has been much discussed in the literature [15, 45–47]. Nevertheless, we were unable to find any publication about specific cognitive behavioural programmes for the treatment of culturally diverse patients who suffer from chronic pain. Either such programmes have not yet been developed or, if in existence, have not yet been evaluated. According to our own relatively extensive clinical experience, we assumed that conventional evidence-based cognitive behavioural therapy (CBT) programmes of pain management would not be effective for immigrants with chronic pain. Therefore, we modified a standard treatment programme for chronic pain patients to accommodate the specific needs of an immigrant sample with a culturally sensitive approach. The current paper describes the intervention and reports on its efficacy within a randomised controlled trial.

Methods

The trial was carried out at the Department of Psychosomatic Medicine University of Basel Hospital and was planned as a randomised intervention trial with an active treatment group and a control group who received an equal amount of therapist attention: exercise therapy plus playful activities. An active control group was chosen because there is some evidence that both therapies, a CBT approach and exercise therapy are more effective than a waiting list control group [48–53].

The anonymity of the patients' data was retained and informed consent was received according to the requirements of the institutional ethical review board. The trial protocol was approved by the Ethical Committee of Canton of Basel on 9 September 2004 (207/04).

Study Population

First-generation Turkish immigrants in Switzerland suffering from chronic pain, 20–65 years of age, were enrolled in the trial. Patients were referred either from general practitioners, from the outpatient unit of the Hospital or from other clinics in Basel or the region. We defined chronic pain in accordance with the German version of International classification of diseases (ICD) 10: The predominant complaint was severe and distressing pain of more than 6 months duration, which cannot be explained fully by a physiological process or a physical disorder. Psychological factors are assumed to contribute significantly to intensity, exacerbation or persistence of pain (http://www.icd-code.de/icd/code/F45.41.html).

Exclusion criteria among patients were the following: (1.) evidence of physical disability preventing participation in physiotherapeutic exercises, (2.) a request for asylum was pending, (3.) documented behaviour indicating a lack of minimal motivation or inability to cooperate with therapists or other group participants, or (4.) specific conditions, i.e., organic brain syndromes, schizophrenia, affective psychosis, bipolar affective disorders, illegal substance abuse or addiction, dissociative disorders, or pronounced symptoms of post-traumatic stress disorder.

Both patient groups received the same trial information sheet and completed informed consent.

Table 1: Demographic characteristics of group participants.

Characteristic	**CsCBT group** (n = 44)	**CsET group** (n = 34)
Mean age ± SD, y	44.0 ± 7.4	43.8 ± 7.1
Sex, %		
Female	70.5	67.6
Male	29.5	32.4
Marital status, %		
Married	93.2	91.2
Unmarried (single, widowed, divorced)	6.8	8.8
Nationality, %		
Turkish	65.9	55.9
Kurdish	34.1	41.2
Others	0	2.9
Educational level		
no school	20.5	23.6
elementary	54.5	52.9
Intermediate	20.5	14.7
College	4.5	8.8
Occupation		
Unskilled	95.5	100
Skilled	4.5	–
Employment status, %		
Employed	9.1	5.9
Unemployed	90.9	94.1
Current source of income, %		
Salary	9.1	5.9
social welfare, unemployment compensation	25.0	32.3
health insurance	–	23.5
disability insurance, SUVA	31.8	14.8
income of spouse	27.3	23.5
no indication	6.8	–
Ill or unemployed spouse, %	56.8	44
Mean of years in Switzerland; range	19; 4–34	18; 6–34
Reason of immigration, %		
accompaniment of spouse or parents	65.9	52.9
economic reasons	18.2	20.6
political reasons	15.9	20.6
other	–	5.9

CsCBT = Culturally sensitive cognitive behavioural therapy; CsET = Culturally sensitive exercise therapy
NOTE: Some percentages do not total 100% due to missing data
* Multiple answers are possible

Interventions

Patients were randomly allocated to attend either culturally sensitive cognitive-behavioural treatment (CsCBT) or culturally sensitive exercise treatment (CsET). Both interventions comprised twenty-five 90-minute sessions within a six-month period and were adapted concerning structural and didactic aspects to a culturally sensitive context.

The CsCBT intervention was based upon a manualised cognitive-behavioural group treatment programme for chronic pain [54] and combined cognitive behavioural principles with culturally sensitive migration-specific elements. Cognitive behavioural approaches focus on the way individuals cope with their pain, instead of assuming that a biological reason for the pain can be identified and treated. Interventions include patient information about the origin of chronic pain, identification of aspects in life that are less affected by pain, and areas that are linked to positive experiences. As part of a behavioural component patients are advised to make bodily experiences by using stretching and strengthening exercises.

The CsET intervention was based on principles of exercise therapy for treatment of non-specific low back pain. Exercise therapy (ET) is defined as “a series of specific movements with the aim of training or developing the body by a routine practice or as physical training to promote good physical health” [55].

Structural adaptations for each of the two interventions included (a) the separation of male and female patients into different groups, (b) an increase in the number of sessions from 14 in the original programme, to 25 in ours,(c) sessions being conducted in Turkish with the aid of an interpreter. Didactic adaptations also took account of the educational level of our sample. The use of written materials was limited in order not to exclude illiterate patients. When written material was used, it contained graphical displays, e.g., for exercises or of the vicious cycle between emotion (a weeping eye), muscle tension (a bent arm) and pain (a painful face).

Groups were co-led by a licensed clinical psychologist and a physiotherapist, both German speaking. The clinical psychologist had extensive prior experience delivering CBT to immigrants with chronic pain. The CsET intervention was conducted by a German-speaking physiotherapist. Since most patients lacked sufficient comprehension of the German language, a Turkish interpreter was required in both interventions. The interpreters were certified by the Swiss organisation for Interpreters as medical professional interpreters, and most of them had already been cooperating with our department for more than four years. They were integrated in the therapist team and received continuous supervision by the first author.

Study outcomes

The primary endpoint with respect to efficacy of CsCBT was improvement in physical functioning and mental health from baseline to 12 months after the intervention, as measured by the Short Form 36 (SF-36) in the subscales Physical Functioning and Mental Health [56]. Additional analyses were performed on quality of life in the remaining subscales of the SF-36, depression was measured with the General Health Questionnaire (GHQ) [57], disability was measured with the Pain Disability Index (PDI) [58]. Healthcare costs incurred by the patient, within three months preceding vsafter the intervention, were analysed retrospectively by gathering information from insurance companies.

All subjects were first tested after enrolment in the trial (T1), then after completion of the intervention (T2), and finally after twelve months follow-up (T3). Both groups followed the same assessment protocol.

Semistructured interviews were all translated by trained interpreters. Standardised tests were filled in either by the patient him- or herself or, in the case of illiteracy, together with the interpreter.

List of measures

1. The revised semistructured Interview of Clinical Symptoms (SICS-R) describes pain history, symptoms, and cognitive and emotional aspects that influence pain.
2. Pain drawings allowed the identification of topographical distribution of pain to be quantitatively recorded.
3. A visual analogue scales (VAS) was used to quantify the intensity of subjective pain.
4. The Turkish translation of the Short Form 36 (SF-36) assessed quality of life in chronic patients for the following scales: physical functioning, physical role, bodily pain, general health, vitality, social functioning, emotional role and mental health.
5. The validated Turkish version of the General Health Questionnaire (GHQ; Kiliç [59]) is a screening instrument for psychopathological symptoms in general healthcare. The 28-item scale includes four dimensions, somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression.
6. The validated Turkish version of the Pain Disability Index (PDI) [60] assesses the extent of pain-related interference performing activities considered normal for a particular age group.
7. Healthcare utilisation costs for the period of three months before and after participation of the patient in the intervention were calculated by Swiss insurance companies.

Sample size and power calculation

Based upon previous experience with the intervention, we expected a treatment-related improvement with an average effect size (Cohen’s d) of 0.6 on the SF-36 primary outcome scales of physical functioning and emotional health (based on published norms, http://www.sf-36.org/research/sf98norms.pdf), manifesting positive outcomes in these two primary outcome variables ($\alpha = 0.025$): With 45 patients per group, this yielded a power of above 80% in power analyses. We planned to have equal numbers of men and women and to randomise 60 patients in both treatment arms per year (15 men and 15 women in the CsCBT and in the CsET per year, respectively). To include a sufficient number of patients in each arm, we repeated the intervention in the same manner during the second year.

Randomisation

A computer-generated randomisation list was drawn up for each gender by a statistician of the Basel Institute of Clinical Epidemiology. Details of the series were not known to any of the investigators. Allocation concealment was guaranteed through sequentially numbered, opaque, sealed envelopes enclosing assignments. The envelopes were handed over to the research psychologist after intake interviews were completed. Patients had an equal probability of assignment to each groups. The randomisation took place after the initial assessments and was immediately communicated to patients.

All initial and follow-up interviews were conducted by a research psychologist not involved in the treatment. Blinded assessments were not feasible for follow-up meetings because patients inevitably relayed information about their treatment experiences to the research psychologist.

Statistical methods

Treatment effects, (means and standard deviations (SDs), were estimated at post-treatment and 12 months follow-up for the primary outcomes (two items of SF-36) and secondary outcomes, which included the other six subscales of the SF-36, the GHQ, the PDI, a visual analogue pain rating scale (VAS), and healthcare costs. Significance levels were $p < 0.05$ (two-tailed analyses). For the questionnaire data and pain rating, change scores (post-treatment or 12 month-follow-up minus pretreatment levels) were computed, and groups were compared employing general linear models, after covariate adjustment for baseline levels of each measure. Independent t-test analyses were used to examine possible differences in healthcare costs between groups. CSS Statistica was employed for all statistical analyses (StatSoft, Inc. STATISTICA (data analysis software system), version 6.0. www.statsoft.com).

Results

Flow of participants

Eligible participants were recruited from September 2004 to March 2007. Figure 1 is a flowchart of the trial. A total of 158 potentially eligible patients with chronic pain were referred, 146 patients agreed to take part in the trial. A total of 116 patients completed the pre-trial assessment and were found to be eligible, consented, and were randomised.

At the follow-up 12 months later, the drop-out rate for both groups was quite high: 29% with CsCBT and 37% with CsET. Only a small percentage refused therapy, 6% in the CsCBT group and 15% in the CsET group. Most patients gave plausible reasons not to continue to attend group therapy. Their reasons are listed in figure 1.

Protocol deviations

There was one protocol violation regarding the recruitment of men. We could not recruit as many male patients as we had planned. We chose to include more female participants to obtain a sufficient number of patients, but at the same time had to abstain from analysing data separately for men and women.

Demographic data

Baseline demographic characteristics are presented in table 1. Examination of demographic characteristics at baseline showed only one difference between groups: a larger percentage of participants in CsET reported that compensation from health insurance was their main source of income. Mean age was 43.9 years (range 29–61). Overall, 61% of patients were of Turkish and 38 % were of Kurdish origin; 54% of patients had formal education of five years or less; 22% of patients were illiterate. Almost all (98%) had worked as unskilled workers in the cleaning business or in construction. The majority (92%) of patients were unemployed at enrolment.

Baseline clinical characteristics of trial groups are presented in table 2. In the majority of patients pain was distributed among multiple regions of the body (fig. 2).

Table 2: Clinical characteristics of group members as collected in the Semistructured Interview.

Characteristic	**CsCBT group** (n = 44)	**CsET group** (n = 34)
Mean pain chronicity; range, y	4; 1/2–17	6; 1–30
Pattern of pain, %		
Permanent pain	88.6	82.4
Several times daily	9.1	14.7
Several times weekly	2.3	2.9
Negative modulation of pain*, %		
Weather	65.9	61.8
Stress	50.0	67.6
Physical strain	70.5	52.9
Pain trigger*, %		
Illness	9.1	2.9
Accident	25.0	35.3
Workload strain	25.0	35.3
Traumatic life events, death in the family	15.9	14.7
Stress and conflict in the family	11.4	11.8
Migration	2.3	8.8
Pregnancy, surgical operation	11.4	26.5
Violent experience	2.3	5.9
Indefinite triggers	29.5	20.6
Do patients recognise any connection between their chronic pain and psychosocial stress? %		
yes	52.3	61.8
none	47.7	38.2
Mood disorders, %		
Mild depressive episode	27.3	44.1
Moderate depressive episode	27.3	32.4
Severe depressive episode	4.6	–
None	22.6	14.7
Missing data	18.2	8.8
Anxiety disorders, %		
yes	27.3	11.7
none	72.7	88.3
Persistent somatoform pain disorder, %		
yes	79.5	88.2
none	20.5	11.8

CsCBT = Culturally sensitive cognitive behavioural therapy; CsET = Culturally sensitive exercise therapy

Analysis of treatment effects

Participants were tested after randomisation (baseline) and again after their participation in the intervention, and finally after 12 months follow-up. Of 116 randomly assigned participants, a total of 87 were included in the analysis of baseline and post-treatment effects, and 78 patients in the analysis of the difference between baseline and follow-up 12 months later. Intention-to-treat analyses were not performed owing to lack of significant effects (the three significant findings reported in table 3 can be attributed to chance as a result of the multiplicity of comparisons).

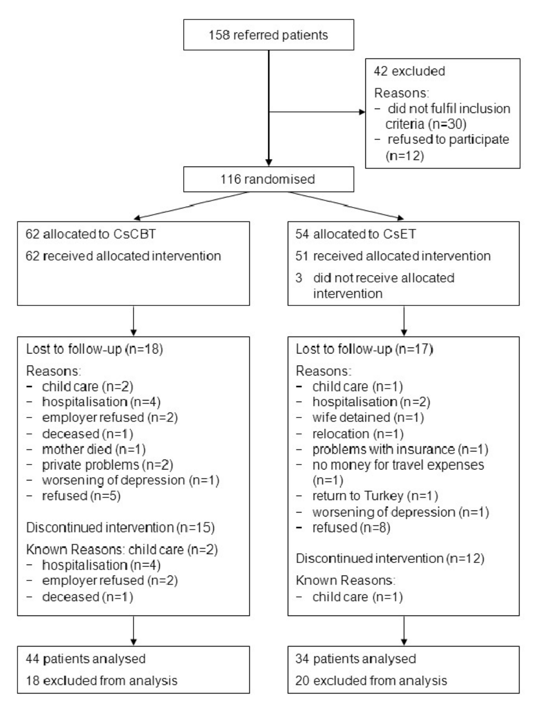

Figure 1

Flow chart of participants.

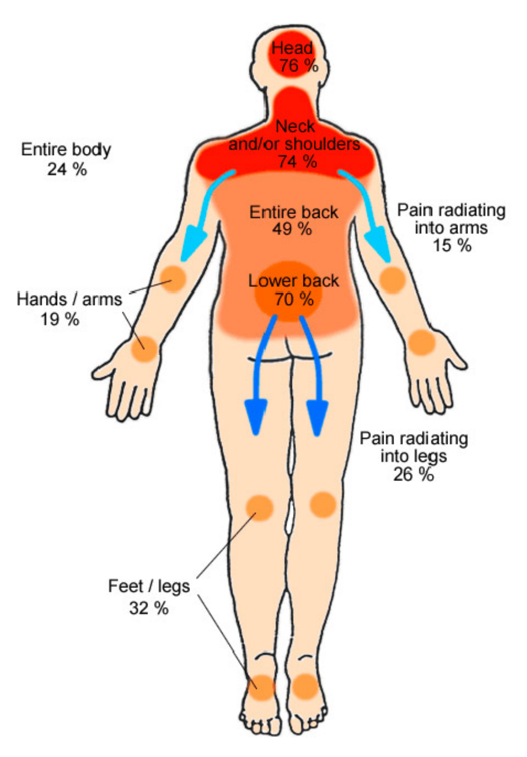

Figure 2

Graphical display of pain localisation, reported by the patients on a sketch as shown. Multiple responses were allowed (n = 114).

Primary and secondary outcome scores of SF-36, GHQ and PDI for men and women in both groups showed no improvement, neither at short term follow-up after three months, nor at long-term follow-up at 12 months (table 3). Interestingly, the SF-36 scores were extremely low, indicating low levels of quality of life and functioning (see table 3). The same was true for any single score of the SF-36.

The same holds for GHQ scores which indicated low quality of life and showed no improvement in either group. The pain disability index demonstrated a high pre-intervention level of disability due to chronic pain.

Pain intensity

The analysis of pain intensity (VAS) presented in table 4 showed no significant change.

Healthcare utilisation

Health insurance companies provided the data on healthcare procedures and costs for 105 patients. Again, there was no significant difference before and after treatment, or between groups.

Patients also evaluated the therapy in the semistructured interviews in a less formal way: 80 percent of participants claimed to be satisfied with the intervention. Patients especially liked that the therapy was offered in their mother tongue.

Discussion

A brief synopsis of our key findings

Sixty-nine percent of our patients successfully completed the intervention, which indicates that long-term behavioural interventions on an out-patient basis is generally feasible in this patient group. Also, anecdotal feedback from patients indicated a broad acceptance of the intervention. We have no indication of any significant difference between participants who were included at the beginning of the intervention and later dropped out, and those who generated data at the end of the intervention. These findings are important, in themselves, in suggesting that first-generation Turkish immigrants in Switzerland suffering from chronic pain are amenable to long-term interventions of a behavioural nature that attempt to be culturally sensitive. On the other hand, the general lack of treatment effects was disappointing: There was no significant or clinically relevant improvement at the 12month follow-up in any of the major outcome measures, including the SF-36, GHQ, PDI or in VAS pain. Modest beneficial effects of two SF-36 scales, assessed directly after treatment, were no longer found 12 months later. Healthcare costs remained unchanged from before to after therapy.

Consideration of possible mechanisms and explanations

Although the intervention showed no improvement in standardised assessment scales, 80% of participating patients in both groups reported satisfaction with the intervention. In fact, many expressed regret that the intervention could not continue beyond six months. This might point to a mismatch between study assessments of treatment effic-

Table 3: Tests of change ccores during treatment at post-treatment and follow-up.

Primary outcomes	**Group**	**Baseline scores**			**Change: baseline to post-treatment**			**Change: baseline to 12-month follow-up**		
		Mean	**Lower 95% CI**	**Upper 95% CI**	**Mean Change**	**Lower 95% CI**	**Upper 95% CI**	**Mean Change**	**Lower 95% CI**	**Upper 95% CI**
Physical functioning (SF-36)**	CsCBT	32.22	27.57	36.87	–1.74	–7.44	3.96	–3.30	–11.45	4.85
	CsET	32.92	28.22	37.62	–2.75	–9.17	3.67	–4.79	–13.95	4.37
Mental health (SF-36)**	CsCBT	42.53	39.23	45.83	2.36	–1.94	6.66	1.39	–5.52	8.30
	CsET	44.63	39.99	49.27	2.46	–3.92	8.84	4.59	-2.85	12.03
Secondary outcomes										
Physical role (SF-36)**	CsCBT	4.17	0.95	7.39	5.85*	–1.52	13.22	–1.14	–9.75	7.47
	CsET	1.56	–0.12	3.24	–4.38*	–9.85	1.09	–2.21	–8.68	4.26
Bodily pain (SF-36)**	CsCBT	47.17	39.08	55.26	.87	–3.79	5.53	–3.05	–9.22	3.12
	CsET	52.41	42.36	62.46	–5.50	–10.46	-0.54	–3.09	–9.16	2.98
General health (SF-36)**	CsCBT	54.06	47.90	60.22	1.21	–3.60	6.02	–.80	–6.07	4.47
	CsET	52.55	45.48	59.62	–1.79	–6.83	3.25	2.42	–4.35	9.19
Vitality (SF-36)**	CsCBT	37.50	33.03	41.97	.04	–5.11	5.19	.23	–7.23	7.69
	CsET	43.13	38.25	48.01	1.75	–5.36	8.86	5.88	–2.63	14.39
Social functioning (SF-36)**	CsCBT	45.49	40.93	50.05	2.39	–4.82	9.60	–3.69	–12.25	4.87
	CsET	50.39062	44.48	56.30	3.75	–4.47	11.97	6.25	–5.81	18.31
Role-emotional (SF-36)**	CsCBT	4.63	0.04	9.22	2.84	–6.02	11.70	–7.58	–19.47	4.31
	CsET	12.50	3.93	21.07	.83	–9.40	11.06	5.05	–5.70	15.80
Physical symptoms (GHQ)***	CsCBT	13.61	12.56	14.66	.23	–1.27	1.73	–1.23	–2.92	0.46
	CsET	13.47	12.16	14.78	.95	–0.79	2.69	–1.29	–3.18	0.60
Anxiety (GHQ)***	CsCBT	13.42	12.30	14.54	.87	–0.57	2.31	–.84	–2.45	0.77
	CsET	12.41	11.03	13.79	.54	–1.26	2.34	–.03	–2.02	1.96
Impairment of social functioning (GHQ)***	CsCBT	13.89	12.85	14.93	1.49	0.06	2.92	–.37	–1.93	1.19
	CsET	13.19	11.97	14.41	1.10	–0.48	2.68	–1.18	–3.11	0.75
Depression (GHQ)***	CsCBT	9.06	7.94	10.18	–.91	–2.39	0.57	–.95	–2.78	0.88
	CsET	8.78	7.25	10.31	.72	–1.08	2.52	–1.12	–3.15	0.91
Pain Disability Index (PDI)****	CsCBT	38.96	35.40	42.52	1.35	–3.22	5.92	.60	–4.54	5.74
	CsET	40.72	36.55	44.89	4.98	0.81	9.15	.76	–4.85	6.37

CI = confidence interval; CsCBT = Culturally sensitive cognitive behavioural therapy; CsET = Culturally sensitive exercise therapy

** The percentage scores range from 0% (lowest or worst possible level of functioning) to 100% (highest or best possible level of functioning).

*** Simple Likert Scoring 0-1-2-3 measuring symptoms from ‘not all’ to ‘much more than usual’

**** Scoring 0-1-2-3-4-5-6-7: 0 – no disability, 7 – worst disability

Table 4: Means and standard seviations (SD) of pain intensity on a visual analogue scale (0–10).

Secondary outcomes	**Group**	**Pretreatment**		**Post-treatment**		**12-Month follow-up**	
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Pain intensity (visual analogue scale)	CsCBT	7.38	1.99	7.62	1.60	7.43	1.91
	CsET	7.47	2.12	7.42	1.89	7.50	1.96
	Pooled	7.42	2.03	7.53	1.71	7.46	1.92

CsCBT = Culturally sensitive cognitive behavioural therapy; CsET = Culturally sensitive exercise therapy acy, on the one hand, and patient perception of their own personal benefit, on the other. Given the fact that similar CBT-based interventions have been shown to work well in other populations [45, 47–49, 61] (with one exception [62]), one might consider whether the apparent failure of the intervention had to do with the particular needs of the population under study. We certainly attempted to pay attention to the specific cultural factors of the patient population, mostly from rural Turkey, and adjusted the intervention accordingly. Still, one must consider if more intensive therapy might have yielded better results, although the limited evidence available regarding in-patient treatment of migrant patients suffering from chronic pain, even with a much higher intensity of treatment than ours, has not shown impressive results [63–66].

On the other hand, one might question whether the assessment strategy was conceived in a sufficiently culturally sensitive manner in respect to several dimensions considered below.

Socioeconomic factors

The population under study certainly was unique. In contrast to other patient groups previously described, Turkish-speaking patients in our sample showed a strikingly low quality of life as assessed with the SF-36 [67], and were characterised by very low levels of education and a severe lack of socioeconomic resources. They suffered from a combination of economic stress and many emotional burdens in terms of family stresses, e.g., compromised family members as illustrated in the high percentage of chronically ill spouses (see table 1). Future prospect of work for our patients remained grim: Before acquiring their pain syndrome, they had typically been performing heavy physical work, were unskilled and had poor language competence. During disability and the period of unemployment, they also almost certainly became physically deconditioned. Frequently they sought to improve their financial situation by applying for disability benefits. However, during the period of our trial, the Swiss Court issued a decision that rescinded the previous eligibility of chronic pain as a ground for early retirement disability. If we assume that self-reported evaluations of pain are also expressions of a more general statement of “not being well”, patients may have been reluctant to acknowledge in test results that they were getting better, out of fear of further reducing their chances of disability benefits.

Assessment instruments

We chose questionnaires that had validated in Turkish populations to increase the likelihood of obtaining reliable data. However, these instruments had been validated among samples significantly different from the population that we studied: respondents were much better educated and had a substantially higher socioeconomic status [54]. Assessment instruments for the kind of participants in this study do not yet exist, and it seems very plausible that they might not be appropriate, reliable or valid for this population. Thus it is possible that the global feedback of satisfaction with the programme provided the only reasonably accurate indication of patient perception. In any case, this study highlights the need for development of measurement instruments that can demonstrate properties of validity and reliability for such poorly educated immigrant populations – populations very much a reality in Western European countries.

As one example of disparities regarding our patient sample and others, in terms of levels of health-related quality of life, participants in our study differed from every other comparison group with which we are familiar: All scores on emotional, social and physical role functioning were extremely low [67]. It remains unclear whether the SF-36 is a valid instrument for an immigrant patient group in which one-fifth is illiterate, or whether the SF-36 accurately describes these patients’ state of well-being. Of course, it is possible that the level of despair, despondency and resignation, often enough articulated by patients, were, indeed, reflected by quality of life scores, and that the level of intervention was insufficient to address the enormous adversities of these patients. In any case, until properly validated assessment instruments are developed for such populations, it may be impossible to determine efficacy of interventions or to explore relationships among salient variables in such groups.

In conclusion, our investigation suggests a very incipient state of knowledge in research on immigrants with low educational background who suffer from long-term pain. As a feasibility study, the study was highly successful at motivating participants to attend, and they appeared genuinely satisfied with a six-month programme of culturally sensitive cognitive-behavioural intervention. Nevertheless, our findings cast doubt over aspects of validity and reliability of outcome measures in this population. Our results may also call into question the adequacy of psychotherapeutic intervention as the sole strategy to help immigrants with chronic pain. Since the life challenges of this population are often so overwhelming, a far broader approach may be necessary that includes far greater efforts to integrate such individuals into their host society and workforce. Perhaps only then may CBT or alternative interventions begin to show positive results. Finally, despite our lack of positive findings, this intervention trial will hopefully stimulate further efforts to address a problem that saps both the human spirit and societal resources.

Table 5: Means and standard deviations of healthcare utilisation (estimated yearly costs in Swiss Francs).

Secondary outcome	**Group***	**Pretreatment**		**Post-treatment**		**p**
		Mean	**SD**	**Mean**	**SD**	
Healthcare costs**	CsCBT	8,112	17,412	8,592	19,040	
	CsET	2,156	2,604	2,996	6,720	
	Pooled	5,444	13,344	6,088	15,048	0.704

CsCBT = Culturally sensitive cognitive behavioural therapy; CsET = Culturally sensitive exercise therapy

* Estimated yearly healthcare costs based on 3 months before intervention and 3 months after intervention.

**Costs were calculated according to Tarmed (health cost scale of Swiss Medical Association)

Implications of this research: Given the fact that we observed no changes at all, even no pooled effects, the lack of findings cannot be attributed to our employment of an active control intervention procedure. Additionally, given the absence of even tendencies toward effects of treatment, it is hard to argue that an increase in the number of participants (and hence the power of the analysis) might have been beneficial for detection of reliable treatment effects. One possibility is that our choice of assessment instruments did not target the underlying problem of these patients? Perhaps more fundamentally, one might wish to question, in the first place, whether such an immigrant population with chronic pain suffers ‘pain’ from the cultural understanding defined by a Western taxonomy, or whether the term “pain” refers more to a fundamental sense of ‘ill-being’ that simply cannot be addressed by a pain-oriented treatment program.

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Figures (large format)

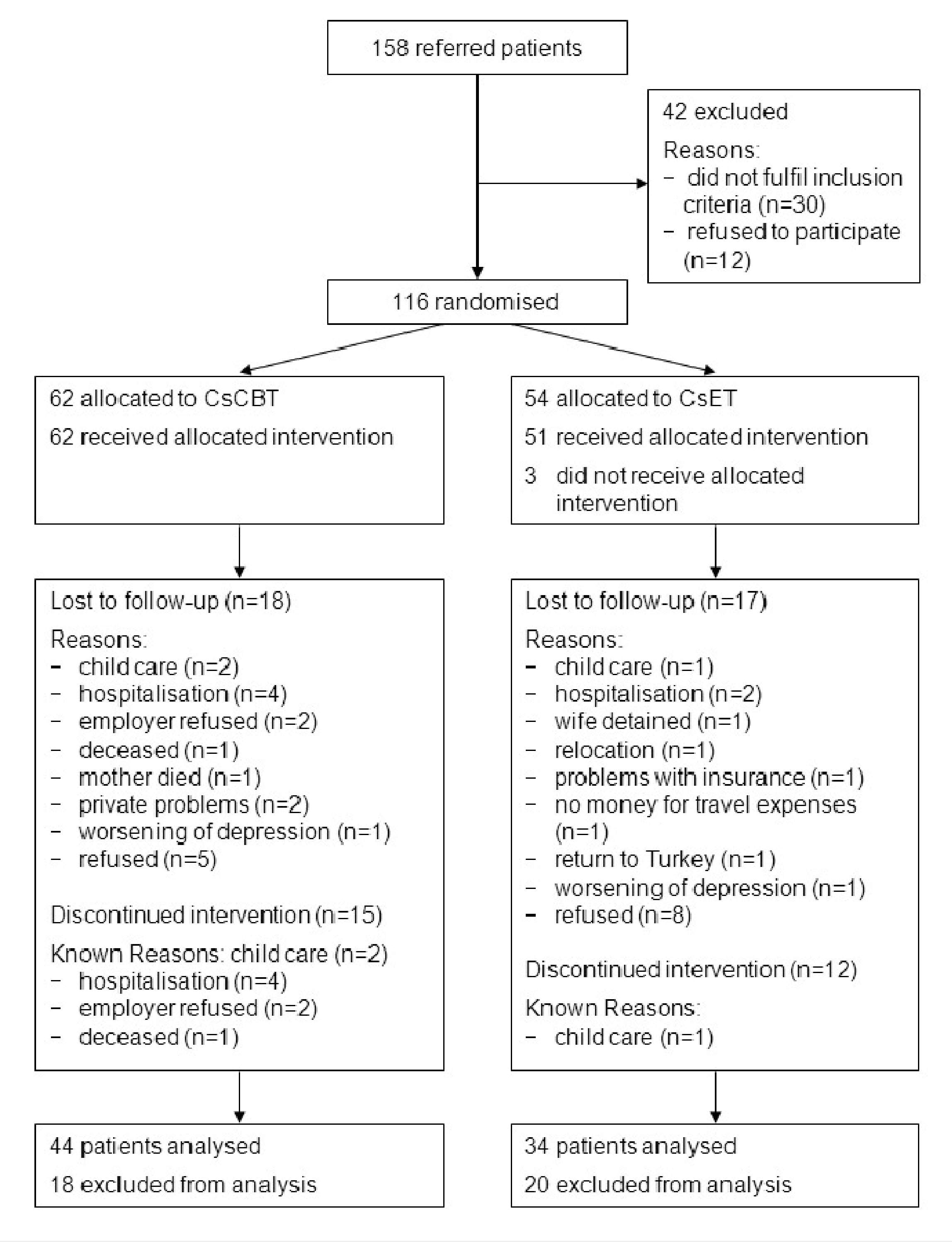

Figure 1

Flow chart of participants.

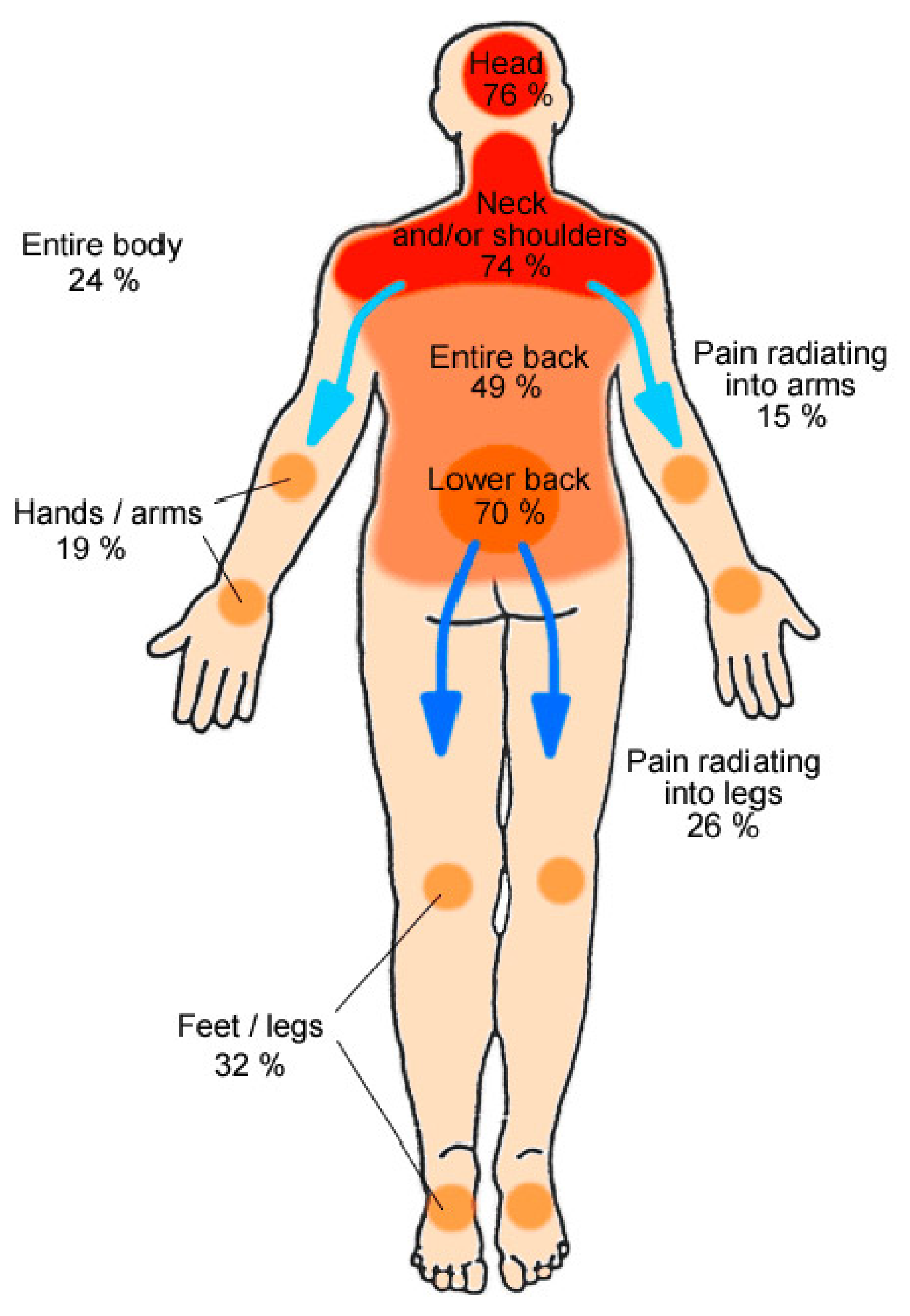

Figure 2

Graphical display of pain localisation, reported by the patients on a sketch as shown. Multiple responses were allowed (n = 114).

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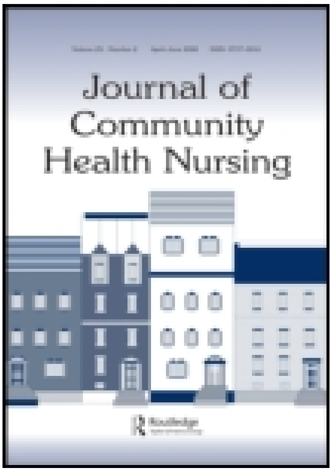

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The Role of the Health Care Interpreter in a Clinical Setting—A Narrative Review

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Objective: To examine published models of health care interpretation and associated roles, expectations, and outcomes. Methods: A literature search was conducted using the key words *interpreter/translator, communication*, and *role* and their combinations in PubMed, CINAHL, PsycINFO, and PSYNDEXPlus. References mentioned in articles identified with these search terms were then checked by hand in corresponding publications and books. We excluded articles if they were dealing with concepts of interpretation, role definitions etc., without presenting any empirical evidence to support their recommendations. Thirty-four of 1,121 references that investigated the role of professional interpreters in health care were found to meet inclusion criteria. Results: Out of 34 articles, only 2 recommend strict adherence to the conduit model in which interpreters are faithfully and exclusively transmitting information; the interpreter's role is in 32 studies defined in broader terms as the role of a cultural broker ($n = 18$), a manager or clarifier ($n = 22$), a patient advocate ($n = 13$), or a mediator ($n = 6$). Conclusion: There are no commonly accepted understandings of the interpreters' role; empirical data are lacking. Practice Implications: The interpreter's function must be explicitly clarified before a health care encounter is conducted. There should be an agreement of some basic rules.

The use of interpreting services is increasingly advocated in health care systems. Noncongruent language and different cultural background have been identified as significant barriers to mutual understanding (Bischoff et al., 2003; Kale & Syed, 2010; Ngo-Metzger et al., 2003; Woloshin,

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Schwartz, Katz, & Welch, 1997). Language barriers have been associated with worse interpersonal care, lower patient satisfaction, and longer length of hospital stay (Lindholm, Hargraves, Ferguson, & Reed, 2012; Ngo-Metzger et al., 2007). Patients, in general, consider the availability and the quality of interpreting services as very important; the use of the interpreter and the perceived quality of the interpreter's translation are strongly associated with the quality of care overall (Baker, Hayes, & Fortier, 1998; Dang et al., 2010; Green et al., 2005; Kline, Acosta, Austin, & Johnson, 1980; Kuo & Fagan, 1999; Lee, Batal, Maselli, & Kutner, 2002; Moreno & Morales, 2010; Ngo-Metzger et al., 2007).

However, there is no consensus among health care providers, patients, and interpreters about the role interpreters have in health care settings (Fatahi, Hellstrom, Skott, & Mattsson, 2008; Fatahi, Mattsson, Hasanpoor, & Skott, 2005; Ngo-Metzger et al., 2007; Shannon, 1997). Recently, a Swiss organization active in the training and distribution of interpreting services issued a brochure on professional behavior of interpreters in health care settings (INTERPRET Schweizerische Interessengemeinschaft für interkulturelles Uebersetzen und Vermitteln, 2011). This brochure holds that professional interpreters should function as brokers of patients' interest, as mediators between health care professionals and patients, and in helping professionals and patients understand cultural differences. This definition of the interpreter's role goes far beyond the first role definition The interpreter is a conduit transmitting information without distortion between sender and receiver (Shannon, 1997). Many interpreters, and most health care providers, recognized merit in the conduit model: Within this model the interpreter serves as a neutral and almost invisible *language vehicle* (Fatahi et al., 2008; Fatahi et al., 2005; Hale, 2007; Rowland, 2008).

However, almost at the same time as the conduit model was being propagated, other authors noted that a broader understanding of an interpreter's function was mandatory: Bloom, Hanson, Frires, and South (1966); Brislin (1976); and Ingram (1978) held that interpreting is not simply a transfer of a linguistic code from one language into another; communication includes the exchange—and transfer—of multiple, interwoven layers of information.

Many recent publications reiterate the early critique against the conduit model as focusing on the linguistic message only, and as disregarding its social and cultural construction (Hsieh, 2006, 2007; Watermeyer, 2011). Interpreters, themselves, frequently reported significant professional and ethical difficulties in their practice attributable to their ambiguous role understanding (Fatahi et al., 2005). The latter, in turn, determines which communication strategies they use (Hsieh, 2008). From this perspective, the definition of interpreting errors, so often reported in numerous studies (Aranguri, Davidson, & Ramirez, 2006; Butow et al., 2011; Flores et al., 2003; Laws, Heckscher, Mayo, Li, & Wilson, 2004; Pham, Thornton, Engelberg, Jackson, & Curtis, 2008; Vasquez & Javier, 1991), might also be seen as a consequence of a lack of coherent understanding of the interpreters' role.

Given the aforementioned conceptual inconsistencies, this article gives a narrative review of the literature, focusing on the different role definitions of an interpreter, taking into account articles that analyze these questions from the perspective of expert interpreters, patients, and health care providers. Furthermore, we explore to what extent a preference for one of these models is based upon empirical evidence, namely comparing different role understandings within a given setting.

METHODS

The results are presented in a narrative format (Moore, Rivera Mercado, Grez Artigues, & Lawrie, 2013; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). We used online databases (PubMed, CINAHL, PsychINDEX, Cochrane Library), and searched for further eligible literature through references in scientific articles and books. In total, we generated 1,121 references from all data sources.

Inclusion/Exclusion Criteria

We included all articles that met the following inclusion criteria: (a) articles in English and German (b) that contained empirical data about the role of professional health care interpreters in typical clinical situations. The key words *interpreter/translator, communication*, and *role* were used in different combinations (see Figure 1).

We excluded, without further review, articles in which the title and/or abstract showed that the focus was not on health care interpreters. Studies examining the role of only ad hoc or family interpreters were also excluded. For the 211 articles for which it was unclear from the title and abstract whether the article contained data regarding the role of professional health care interpreters, we reviewed the full text of the article and had to exclude an additional 177 articles, because they did not present empirical data that supported a definition or preference for a certain role of health care interpreters.

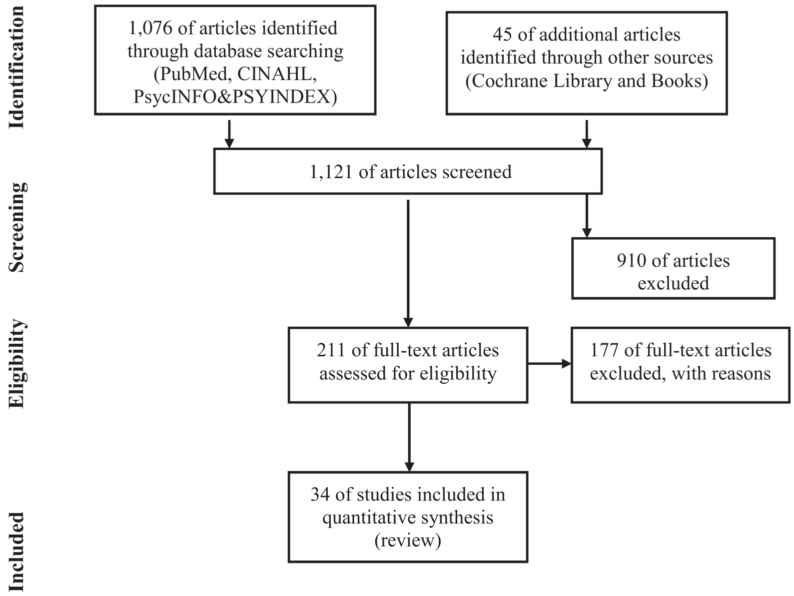

FIGURE 1 Flow Diagram of Narrative Review Strategy and Outcomes.

Abstraction of Included Articles

The remaining 34 articles were independently assessed by two investigators. Information was collected on number and characteristics of participants, geographic location of the research, study design, methods, statistical analyses, and main study finding about interpreters' role in a health care setting. Any disagreement was resolved by discussion and consensus between the review authors.

Because health care interpreting is not yet a universally licensed and referred field the definition of a *health care interpreter* and his/her training varies widely in the published literature. We define a professional health care interpreter as any individual paid and provided by the hospital or health care system whose task it is to facilitate interpretation between a health care provider and a patient. In our review, we kept the term *formal versus informal* professional interpreter, if this differentiation was made in the original article. It usually referred to the difference between interpreters with an officia certificat versus interpreters trained otherwise.

For the presentation of the results, we decided to organize the data according to the population under study; thus, articles categorized under the heading of *interpreters* contain data about the interpreters' perception of their role in the health care setting, and likewise with *health care providers* and *patients*. Studies investigating the perception of different groups of participants are categorized as *combined* articles.

RESULTS

Of the 34 articles included in the study, 12 focused on the interpreters' perception of their own role in the health care encounter (see Table 1), 2 studies investigated the clinicians' perception of the interpreters' role (see Table 2), 1 studied the patients' perception of the interpreters' role (see Table 2), and 19 compared perceptions of different speakers (see Table 3). The most often investigated combination was that of health care provider and interpreter ($n = 10$), followed by the combination of all three participants ($n = 6$). Two studies compared interpreters' and patients' perceptions of the interpreters' role, and one study compared health care provider and patient.

Geographical Origin of Articles

The majority of studies ($n = 14$) were conducted in the United States, followed by five studies from Canada. Three studies each came from Australia, South Africa, Sweden, and Switzerland. One study each reported data from Austria, Spain, and the United Kingdom.

Setting of the Investigation

Half of the data ($n = 18$) were collected from in-hospital settings, three from psychiatric institutions, and five from primary care. Three studies gathered their data from an interpreter service and another three combined a primary care setting or a hospital setting with interpreter services. Two studies did not report on the setting of their investigation.

TABLE 1
Interpreters' Perception of Their Role in a Health Care Setting

Study/Data Source	*Country/Discipline*	*Practice/Setting*	*Sample*	*Design/Test*	*Results*
PubMed (Butow et al., 2010)	Australia/Psychology	Hospital oncology	Thirty interpreters with formal training in interpretation. Three languages.	Qualitative/Audiotapes	Conduit role is clear, but broad dilemmas.
CINAHL (Messias, McDowell, & Estrada, 2009)	USA/Nursing	Health departments, hospitals	Twenty-seven interpreters: 13 formal, 14 informal. Two languages.	Qualitative/Audiotapes	Conduit role is impractical and sometimes impossible.
Book (Ortega Herráez, Abril-Martí, & Martin, 2009)	Spain/Research group of the university	Public, private, and third sector institutions	Twenty-f v health care and social interpreters: 8 formal, 17 informal. Nine languages.	Quantitative/Self-administered questionnaire	Interpreters in 'helpers' role: edit more speakers utterances explain procedures/cultural differences don't inform about their intervention
PubMed (Dysart-Gale, 2007)	Canada/Concordia University	Hospitals, an urgent care facility and gynecological clinic	Thirty-two formal interpreters. Ten languages.	Qualitative/Field notes and audiotapes	Transmission model is not enough. Semiotic model with expanded roles facilitate mutual understanding.
PubMed (Rowland, 2008)	USA/Ohio State University	Student dental clinic	Three formal interpreters. Two languages.	Qualitative/Field observation and audiotapes	Obligation to provide a precise, word-for-word translation of every comment. No advocacy role with patients
Book (Angelelli, 2004)	USA/Ethnography	Public hospital California Hope	Fourteen interpreters,1 interpreting services manager Spanish	Qualitative, quantitative/fiel notes and audiotapes	Interpreters are visible as: – detectives – multi-purpose bridges – diamond connoisseurs miners
Book (Slatyer, 2005)	USA, Canada, Mexico/Linguistic	Health care centers	Ninety-seven health care interpreters Compared with 107 conference interpreters and 89 court interpreters Spanish and other languages	Quantitative/Questionnaire IPRI	Health care/community interpreters perceived themselves significantl more visible than the other 2 groups.

(*Continued*)

TABLE 1
(Continued)

Study/Data Source	*Country/Discipline*	*Practice/Setting*	*Sample*	*Design/Test*	*Results*
PubMed (Fatahi, Mattsson, Hasanpoor, & Skott, 2005)	Sweden/Göteburg University	Primary health care	Eight formal interpreters: 4 languages.	Qualitative/Focus-group interviews with interpreters	Interpreters should pass information as correctly as possible. Information shortage because of lack of time.
PubMed (Avery, 2001)	USA/Human services	Refugee and immigrant services	Interpreters No information about languages	Qualitative/Focus-group meetings	Interpreters as conduit and manager of the cross-cultural mediated clinical encounter
Reference (Bolden, 2000)	USA/Linguistic	Urban hospital	One formal interpreter in Russian	Qualitative/Audio- and videotapes	Interpreters are active: pursue issues they believe to be diagnostically relevant.
Reference (J. M. Kaufert & Koolage, 1984)	Canada/Medicine and anthropology	Two urban hospitals	Eight interpreters No information about languages	Qualitative/Audio- and videotapes	Interpreter as language translator, cultural broker and advocate
CINAHL (Hsieh, 2007)	USA/Social science and medicine	Interpreting agencies and local hospitals	Twenty-six formal interpreters. Eighteen languages.	Qualitative/Audiotapes	Interpreters are active as codiagnosticians

TABLE 2
Health Care Providers' and Patients' Perception About the Interpreter's Role in the Health Care Setting

Study/Data Source	*Country/Discipline*	*Practice/Setting*	*Sample*	*Design/Test*	*Results*
PubMed, CINHAL, PsyIndex (Fatahi, Hellstrom, Skott, & Mattsson, 2008)	Sweden/Health care and social science	Primary care	Eight general practitioners. Four languages.	Qualitative/Audiotapes	Interpreters are neutral acting literally as a pure *interpreting machine*
PubMed, CINHAL (Rosenberg, Leanza, & Seller, 2007)	Canada/Medicine	Primary care	Nineteen physicians and 24 patients. Eight languages.	Qualitative/Videotapes	Physicians expect from interpreters cultural brokerage
PubMed (Hadziabdic, Heikkila, Albin, & Hjelm, 2009)	Sweden/Health science and social work	Health care centers	Seventeen patients from former Yugoslavia: Serbo-Croatian	Qualitative/Audiotapes	Patients expect literal translation and professional and neutral attitude.

TABLE 3
Combined Studies About the Interpreter's Role in the Health Care Setting

Study/Data Source	*Country/Discipline*	*Practice/Setting*	*Sample*	*Design/Test*	*Results*
PubMed (Watermeyer, 2011)	South Africa/Human and community development	HIV pharmacy clinic	Two pharmacists and patients of the clinic Setswana	Qualitative/Field notes and videotapes	Conduit role is inappropriate, but flexible approach based on patients preferences and communicative needs
CINAHL PubMed (Hsieh, 2008)	USA/Ethnography	Interpreting agencies	Twenty-six interpreters, 11 health care providers, 5 patients. Eighteen languages.	Qualitative/Shadowing and audiotapes	Roles played by interpreters: – conduit – advocate – manager – professional
CINAHL (Penn et al., 2010)	South Africa/ Communication	Community rehabilitation clinic	One audiologist, 6 formal interpreters, and 6 care givers IsiXhosa	Qualitative/Audio- und videotapes	Caregivers see interpreters as cultural brokers. Interpreters see their role as *counselor, friend*, or *patient advocate*.
Book (Blignault, Stephanou, & Barrett, 2009)	Australia/Medicine	Health care interpreter service	Eighteen interpreter service personnel, 18 interpreters. Twelve languages.	Qualitative/Audiotapes	Cross-cultural skills and sensitivity as a *core business*
Unpublished paper for Swiss Federal Office of Public Health (Hagenow-Caprez, 2008)	Switzerland/Educational assistance	Hospitals	Nine administration officers 31 interpreters, 11 educational institutions, 10 experts	Qualitative, quantitative/survey, interviews, focus group meeting.	Interpreters have an active role. Not verbatim translation, Intercultural mediation
PubMed CINHAL (White & Laws, 2009)	Boston, USA Latin American health institute	Pediatric outpatient clinics	Health care providers Patients (mothers of the children) Interpreters: 2 formal, 4 informal Spanish	Qualitative/Audiotapes Analytic method by Laws et al. (2004)	Assuming the provider's role, taking the patient's role, engaging in other non-interpretive roles. Interpreters' behaviour not transparent.

Book (Hale, 2007)	Australia	NR	Twenty health care practitioners Twenty-three interpreters	Quantitative survey	Health care practitioners: – expect interpreting everything directly and accurately; – indicate a mistrust of interpreters when they openly take on the „mediator“ role. Interpreters facilitate: communication, cultural understanding Agents of social justice.
Book (Pöchhacker, 2007)	Austria interpreting sciences	Health care and social institutions of Vienna	Six-hundred and thirty health care providers Sixteen interpreters	Quantitative survey	Health care providers expect: – discretion and neutrality – indicating misunderstandings – helping patients to complete formulars – clarifying patients' information through direct check – explaining medical terms – reducing and summarizing. Interpreters: – clarify patients' information through direct check – indicate misunderstandings – summarize – cultural broker.

(*Continued*)

TABLE 3
(Continued)

Study/Data Source	*Country/Discipline*	*Practice/Setting*	*Sample*	*Design/Test*	*Results*
PubMed (Rosenberg, Seller, & Leanza, 2008)	Canada medicine	2 primary care clinics of Montreal	Nineteen physicians Twenty-four patients Fifteen interpreters: – 7 female – 8 male – 6 formal – 9 informal Eleven languages.	Qualitative/Audio- and videotapes	Formal interpreters are active participants and facilitate patients' diagnosis, treatment and recovery.
PsyIndex PubMed (Goguikian Radcliffe & Suardi, 2006)	Switzerland psychology	Etnopsychiatric consultation	Eight psychotherapists Five interpreters	Quantitative Comparison of means from both groups A self-developed enquiry for the evaluation of the interpreters' role	Psychotherapists expect cultural brokerage and mediation. Interpreters remain neutral, but also provide a cultural brokerage.
PubMed (Greenhalgh, Robb, & Scambler, 2006)	UK social science and medicine	Consultations in primary care	Eighty-three participants: – 18 service users – 26 interpreters (17 formal, 9 informal) – 13 GP's – 15 primary care nurses – 8 receptionist – 3 practice managers 12 languages.	Qualitative/Audiotapes Narrative analysis by Muller (1999)	Clinicians expect from interpreters conveying their agenda to the patient and working toward their expected outcome. Interpreters: – interpersonal mediator – system mediator – educator – advocate – link worker
PsyIndex PubMed (Dysart-Gale, 2005)	USA communication	Urban hospital settings	Seventeen interpreters Two physicians Seven languages	Qualitative/Audiotapes, field notes	Conduit role is not adequate.

PubMed (Leanza, 2005)	Switzerland/Canada psychology	Pediatric outpatient clinic in Switzerland	Eight pediatric residents Four formal interpreters Two languages	Qualitative/Audiotapes Content analysis using N'Vivo software	Residents' comments: – Invisible role or allied with the clinician is the strongest one. – Teaching professional and serving as a two-way cultural informant. Interpreters: System, integration, community and linguistic agent
Reference (Singy & Guex, 2005)	Switzerland	5 medical institutions, Department of Adult Psychiatry, Lausanne	Six-hundred and seventy-three somatic physicians, nurses and psychiatrists interpreters Thirty-five immigrant patients	Quantitative/Qualitative Questionnaires addressed to health care provider (HCP); focus groups with interpreters and HCP; individual interviews with patients.	Professional translators as active participants improving communication by bridging the gap (linguistic and cultural). Most physicians and patients do not share the view of translators.
Reference (Davidson, 2001)	USA ethnography	Riverview General's General Outpatient Clinic	Participants of 100 interpreted patient visits Two languages	Qualitative Observation of 100 patient visits during 6 months; audiotapes of 20 patient visits	Interpreters not as neutral agents nor as *advocates* but as additional gatekeepers.
Reference (Davidson, 2000)	USA sociolinguistic	Riverview General Hospital's General Medicine Clinic, outpatient unit	Participants of 100 interpreted patient visits Two languages	Qualitative/Quantitative Observation of 100 patient visits during 6 months; audiotapes of 20 patient visits	Interpreters not only as *advocates* or *ambassadors*, but rather as informational gatekeepers.

(*Continued*)

TABLE 3
(Continued)

Study/Data Source	*Country/Discipline*	*Practice/Setting*	*Sample*	*Design/Test*	*Results*
PsyIndex (Drennan & Swartz, 1999)	South Africa ethnography	Western Cape psychiatric Valkenberg Hospital	Twenty-eight clinicians nursing staff administration staff interpreters and their coordinator One language	Qualitative/Quantitative Semistructured interviews and questionnaires; weekly recordings of the total number of patients in each ward; archival data from the hospital records of patients admitted during the period of the questionnaire study.	Contradictory expectations: – language specialist’ in psychiatry – culture specialist – patient advocate – institutional therapist
PubMed (J. Kaufert, 1998)	Canada/USA medicine	Individual encounters with terminally ill patients at Winnipeg hospital	Participants of 12 patient encounters, involving a professional interpreter, number of participants not indicated.	Qualitative analysis Audiotapes of 12 cases; follow-up interviews conducted with participants; single case study.	Interpreters as mediators
PubMed (Hatton & Webb, 1993)	USA nursing sciences	County health department	Twenty-two nurses: – 6 bilingual – 15 interpreters	Qualitative research method of grounded theory and dimensional analysis Audiotapes of semistructured interviews with nurses and interpreters	The interpreter as: – a voice box: translation word for word – an excluder: the interpreter, took over’ – a collaborator: nurse and interpreter were colleagues.

Study Design and Methods

The majority of studies ($n = 24$) were designed as a qualitative study applying different methods like open interviews with interlocutors; analyzing transcripts from focus group meetings; qualitative analyses of video or audiotaped encounters; and field notes recorded during observation of clinical communication and interpretation. Five studies used a mixed-methods approach, combining qualitative data and questionnaires. Further five studies were designed as quantitative studies, applying questionnaires developed by the authors; of these only one used a validated questionnaire (Angelelli, 2004).

Number of Participants

Across 26 studies, a total of 516 interpreters, 1,537 health care providers, and 322 patients were involved. The number of participants in eight further studies was not indicated. From 516 interpreters, 174 (33%) are described as having formal training, 74 (14%) had no such training, and information about training of the remaining 268 interpreters was not provided.

Numbers of participants ranged from 1 (Bolden, 2000) to 673 participants (Singy & Guex, 2005) per study for one group. Eleven studies (32%) examined a sample ranging from 1 to 19 participants, another 11 (32%) a sample from 20 to 59 participants and 4 (12%) a sample of 60 or more participants.

Models of Health Care Interpretation

The conduit model was in 16 out of 34 studies defined as the main role that interpreters have to follow, two of them claimed that the conduit is the only acceptable role (Fatahi et al., 2008; Rowland, 2008), the remaining 14 also included other roles. Thus, a total of 32 studies ascertained the importance of extending the interpreters' role to further functions including that of a cultural broker ($n = 18$), a manager/clarifier ($n = 22$), patient advocate ($n = 13$), or mediator ($n = 6$). In eight studies, interpreters actively 'edited' information provided by patient or health care provider, often haphazardly e.g. to save time and without informing the health care provider.

The conduit role in the interpreter's practice was explicitly described in eight studies (Bolden, 2000; Davidson, 2001; Dysart-Gale, 2005, 2007; Hagenow-Caprez, 2008; Messias, McDowell, & Estrada, 2009; Rosenberg, Seller, & Leanza, 2008; Watermeyer, 2011) as impractical, inappropriate, or even impossible. Dysart-Gale suggested, for instance, that rather than attempting to subsume the conduit role and the more interactive advocate, clarifier, and cultural broker roles all together under the idealizations of the transmission model, interpreter theorists could articulate the various interactive roles in accordance with more suitable communication models. Interpreters would then have the choice between a number of theoretically sound, clearly articulated roles, each with its own notions of ideal practice that provide ethical guidance. However, she states that these other interpreter roles have not yet been based on standards robust enough to provide ethical guidance in interpreter practice.

Perceptions of Interpreters, Patients, and Health Care Providers

An examination of the findings from the perspective of the different agents demonstrates differences in the perception of roles especially between health care provider and interpreter.

Contrary to interpreters themselves, health care providers expect from the interpreter first of all impartiality and invisibility. If health care providers wanted an extension of the interpreters' role, they were primarily interested in them serving as a cultural broker or as a person actively indicating overt misunderstandings.

In the only study (Hadziabdic, Heikkila, Albin, & Hjelm, 2009) that exclusively investigated patients' expectations of the interpreter, patients were reported to expect "a literal translation" (p. 462) without any value judgment, strict confidentiality, and a neutral attitude toward them. However, patients also perceived that the interpreter had an important role in helping them to find the right way to gain access to the resources of the health care system.

DISCUSSION AND CONCLUSION

Discussion

The findings of this review suggest that a uniform and consistent model for the health care interpreter is lacking. Health care interpreters follow many different roles beyond the conduit model. Furthermore, it becomes clear that each party in an interaction has different expectations concerning the interpreters' role.

The sample sizes of studies are appropriate for their mainly qualitative research design. No article reported on a procedure that prevented a sampling bias, e.g., using a random inclusion or assignment of participants.

Most studies under review hold that the transmission model of interpreting (conduit) is insufficient and needs to be complemented by other functions.

It is interesting to note that the more extensive models of interpreting come from studies that focus on the interpreters' perspective.

Different roles of interpreters sometimes can be traced back to explicit requests brought forward by health care professionals. On the one hand, interpreters are requested to interpret everything and only what has been said; on the other hand and in practice, they are encouraged to keep the interview short and to keep patients 'on track' (Davidson, 2000). In one study from the United States, professionals were frankly mentioning material they would not dare say in front of a native English speaker, acting as though the patient was invisible (Messias et al., 2009). In this case, the interpreter apparently was not supposed to translate every word literally. Another source of role conflict for interpreters can be attributed to providers who expect interpreters to disclose personal opinions ("Do you think he's mentally ill? . . . What do you think he has?"; Messias et al., 2009). There is no empirical evidence comparing the outcome of different interpreting models in a given clinical setting.

This review has some limitations: In general, some studies include a very small number of participants. From the papers reported herein, it remains unclear to which professional characteristics the term *interpreter* is referring: The amount of formal training was either not stated (20/34 studies), formally defined (9/34 studies), or both (5/34 studies). Furthermore, any information with regard to training of health care professionals is missing completely.

Future research should, first of all, support with empirical data any recommendation of a certain model of interpretation in the health care setting. Such research must include the perspectives of all three interaction partners. As far as patient care is concerned, nurses and physicians never know to what extent an interpreter will translate the content of a consultation, whether information is added or omitted. Therefore, before a consultation they must stress the importance of a precise and complete translation of what is said. As there is apparently no agreement on the role of interpreters in health care that is shared by professional organizations of interpreters and health care providers, let alone of patient representatives, we recommend that, first of all, a consensus must be reached. In order to advance the level of concept development and go beyond the mere exchange of theoretical concepts, we need reliable and valid data. Only then could professional organisations of interpreters re-define the goals of formal training and then start evaluating empirically whether their members actually practise what they were told.

Conclusion

Even though the importance of language problems in health care is widely acknowledged, there are no commonly accepted understandings of the interpreters' role; empirical data are lacking

Practice Implications

As long as there is no commonly accepted understanding of an interpreter's function, health care providers and interpreters must explicitly clarify their mutual expectations before they start conducting a health care encounter. Furthermore, some basic rules should be agreed upon. Professionals cannot assume that interpreters share their understanding of interpretation; they should be aware of the fact that they will be held responsible for the content of the consultation. Both doctors and nurses will find it difficult to take on the role of someone who is responsible for the very process of communication and not just for the content of what is being said. However, given the unpredictability of the interpreter's role understanding, we strongly recommend that they address any problems with interpretation directly, e.g., when they have the impression that much less or much more is interpreted than had been said during the consultation.

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Wie verstehen Dolmetscher ihre Rolle in medizinischen Konsultationen und wie verhalten sie sich konkret in der Praxis?

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Zusammenfassung

Fragestellung: Die Dolmetscherrolle im Behandlungssetting ist in der Literatur nicht klar definiert. Ziel dieser Studie ist es, zu untersuchen, welche Rolle Dolmetscher sich im Gespräch selbst zuschreiben und welche Rolle sie in der Praxis tatsächlich einnehmen.

Methode: Im quantitativen Teil der Studie haben sich Dolmetscher im Gesundheitswesen in einem Fragebogen zu ihrem Rollenverständnis geäussert. Im qualitativen Teil wurde anhand von gedolmetschten Videoaufnahmen die Rolle der Dolmetscher in der Praxis analysiert.

Ergebnisse: 373 Fragebögen und 19 gedolmetschte Konsultationen wurden analysiert und verglichen. Während im Fragebogen eine neutrale Dolmetscherrolle bevorzugt wurde, ist in der Praxis ein aktives Verständnis der Dolmetscherrolle zu beobachten.

Schlussfolgerung: Da Selbst-Beschreibung und beobachtetes Verhalten stark divergieren, müssen Fachpersonen und Dolmetscher vor jedem Gespräch miteinander klären, was sie voneinander erwarten.

Schlüsselwörter: Dolmetscher, fremdsprachige Patienten, Dolmetscherrolle, Kommunikation

What do interpreters understand as their role in a medical consultation and how do they carry it out in reality.

Abstract

Objectives: In the literature the role of an interpreter in the clinical setting is not yet clearly defined. The aim of the study is to explore, which role the interpreters assign to themselves and which role they actually take in the clinical setting.

Methods: In the quantitative part of the study, the interpreters evaluated their role in the clinical encounter through a questionnaire, whereas in the qualitative part the interpreters' role was assessed by analysing videotapes of the clinical encounters.

Results: 373 questionnaires and 19 videotapes were collated and analysed. According to the results of the questionnaire interpreters seem to prefer a neutral role in the clinical encounter. This was in contrast to what was observed in practice, as seen in the videotapes. In reality, they take in an active role while interpreting.

Conclusions: It is important that medical professionals and interpreters discuss their roles and expectations before every clinical consultation.

Keywords: Interpreters, foreign-language patients, interpreters' role, communication

1 Einleitung

Kommunikationsbarrieren zwischen Behandlern und fremdsprachigen Patienten sind mittlerweile gut untersucht und ihre negative Auswirkungen auf die Qualität der Behandlung sind erwiesen [1-10]. In westlichen Ländern gehört deshalb der Einsatz professioneller Dolmetscher zunehmend zum klinischen Alltag [1,6,11-13]. Besonders das Dolmetschen in psychotherapeutisch-medizinischen Gesprächen ist eine grosse sprachliche Herausforderung, die eine umfangreiche Kenntnis medizinischer Terminologie(n) in beiden Sprachen voraussetzt. Nicht nur die Sprachkenntnisse sind bei einer Dolmetschleistung wichtig, sondern auch das Rollenverständnis der Dolmetscher ist wesentlich für den Gesprächsverlauf. Eine Übersicht der einschlägigen Literatur zeigt, dass die Frage, welche Rolle ein Dolmetscher in einem Gespräch einnehmen soll, kontrovers diskutiert wird [14-19].

In der Literatur wird die wesentliche Rolle des Dolmetschers als „conduit“ beschrieben, womit gemeint ist, dass der Dolmetscher als möglichst neutraler Zwischenträger Inhalte von einem Sprecher zum anderen transferiert. Weitere Rollen des Dolmetschers, die ihm oder ihr in der Literatur zugeschrieben werden, sind die des kulturellen Vermittlers, Managers, Anwalts des Patienten und im psychotherapeutischen Setting gar des Co-Therapeuten [20-31]. Bemerkenswert ist, dass medizinische Fachpersonen die Dolmetscherrolle eher limitiert im Sinne des „conduit“ definieren [32], während Autoren, die selber im Bereich der Dolmetsch-Wissenschaften arbeiten, ihre Rolle umfassender definieren. In einem kürzlich erschienenen Review-Artikel wurde darauf hingewiesen, dass die unterschiedlichen Rollenzuweisungen kaum durch empirische Daten gestützt werden. Von insgesamt 211 Artikeln, die sich mit der Rolle von Dolmetschern auseinandersetzten, enthielten 177 ausschliesslich theoretische Erläuterungen, die die bevorzugten Modelle und impliziten Annahmen der Autoren widerspiegelten [19]. Nur 34 Arbeiten haben sich in vorwiegend qualitativen Studien die Rolle des Dolmetschers im Gespräch untersucht. Diese grosse Lücke zwischen Theorie und Praxis veranlasste uns, die Rolle der Dolmetscher im medizinischen Kontext von zwei Seiten aus zu beschreiben: zum einen im Selbstverständnis von Dolmetschern und zum anderen in der Analyse ihres konkreten Verhaltens. Es bietet sich an, gleichzeitig mit Indikatoren für das Rollenverständnis von Dolmetschern auch die Qualität der Dolmetschleistung zu evaluieren.

2 Methoden

2.1 Studiendesign

Die hier präsentierten Daten wurden im Rahmen einer multizentrischen Studie gewonnen. Die Studie wurde als „Mixed-methods-Untersuchung“ geplant, in welcher quantitative Daten mit qualitativen ergänzt werden [33]. Wir haben uns für diese Methode entschieden, um das theoretische

Selbstverständnis der Dolmetscher, welches durch einen Fragebogen abgebildet wird, dem in der Praxis ersichtlichen Rollenverhalten gegenüberzustellen.

2.1.1 Quantitative Daten

Instrumente

Die Literaturrecherche ergab einen einzigen auf Englisch validierten Fragebogen, der das Selbstverständnis zur Rolle von Dolmetschern in einem medizinischen Gespräch mit hoher interner Reliabilität abbildet (Crohnbach alpha=0.9; [34]): Das Interpreter's Interpersonal Role Inventory (IPRI) von Angelelli erfasst die Einstellung der Dolmetscher bezüglich ihrer interpersonellen Rolle im Gespräch [34], das Inventar wurde auf Grund von Pilotuntersuchungen, Feedback von Fachpersonen und Seminarteilnehmern entwickelt (S. 53 in: [34]). Dabei beschreibt die Autorin dieses Fragebogens einerseits Elemente einer aktiv gestaltenden („visible") Funktion, andererseits im Verhalten nicht erkennbare („invisible") Elemente im Rollenverständnis des Dolmetschers. Gemäss Angelelli beinhaltet die aktiv gestaltende Rolle des Dolmetschers mehrere unterschiedliche Dolmetschleistungen, die in der folgenden Tabelle aufgeführt und im Fragebogen untersucht werden. Die Fragen werden auf einer Likert-Skala von 1-6 beantwortet (1= Lehne voll und ganz ab, 2= Lehne deutlich ab, 3= Lehne ab, 4= Stimme zu, 5= Stimme deutlich zu, 6= Stimme voll und ganz zu). Zusätzlich werden im IPRI sozio-demographische Charakteristika der Teilnehmer erfragt.

Tabelle 1 hier

Im Einverständnis mit der Autorin wurde die IPRI-Originalversion wie von Beaton empfohlen ins Deutsche übersetzt [35]: Zuerst erfolgte eine Übersetzung vom Englischen ins Deutsche durch zwei Experten mit medizinischem Hintergrund und fundierten Kenntnissen in beiden Sprachen. Differenzen zwischen den beiden ersten Übersetzungen wurden mit einer Linguistin diskutiert, bis Übereinstimmung erzielt wurde. Anschliessend wurde der Fragebogen drei Mal in kleinen Gruppen von Dolmetschern (8 bis 10 Personen) pilotiert. Ihre Rückmeldungen wurden bei der endgültigen Festlegung der Formulierungen berücksichtigt, um möglichst grosse Eindeutigkeit und Verständlichkeit zu erreichen.

Statistische Analysen und Reliabilität von IPRI

Die Ergebnisse der Fragebogen-Untersuchung wurden zunächst mit Hilfe einer Faktorenanalyse auf das Vorhandensein der von Angelelli vorgegebenen Skalen untersucht; die identifizierbaren Faktoren wurden mit Hilfe von Cronbach's Alpha auf interne Konsistenz überprüft. Alle Analysen wurden mit Statistica 6.0 durchgeführt. In der deutschsprachigen Version liessen sich vier Skalen sichern, die mit einem Cronbach $\alpha \geq 0{,}7$ im akzeptablen Bereich lagen. Die fünfte Skala „Establishing Communication

Rules during the Conversation“ liess sich nicht sichern und wurde deshalb in der deutschen Version nicht weiter berechnet. Im Ergebnisteil werden Mittelwerte ± SD berichtet.

Stichprobe

Wichtige Anbieter von Dolmetschleistungen in der Deutschschweiz (HEKS Linguadukt beider Basel, HEKS Linguadukt Kantone Aargau und Solothurn, comprendi? Berner Vermittlungsstelle für interkulturelle Übersetzerinnen und Übersetzer, Verdi – Interkulturelles Übersetzen in der Ostschweiz, Caritas Dolmetschdienst Zentralschweiz, Medios Interkulturelles Dolmetschen Zürich) wurden gebeten, den Fragebogen an die bei ihnen beschäftigten Dolmetscher zu verteilen. Zusätzlich wurden im gleichen Zeitraum (November 2011 bis Dezember 2011) auch die angestellten Dolmetscher des Universitätsspitals Zürich und Teilnehmender von Weiterbildungsprogrammen des Instituts für Übersetzen und Dolmetschen der Zürcher Hochschule für Angewandte Wissenschaften angefragt.

2.1.2 Qualitative Daten

Für die Erhebung von qualitativen Daten wurden von Dezember 2011 bis Mai 2012 gedolmetschte Konsultationen auf Türkisch und Albanisch in den Universitätsspitälern von Basel, Bern und Zürich auf Video aufgenommen. Alle Gesprächsteilnehmer waren mit der Aufzeichnung einverstanden, das Studienprotokoll war von den Ethikkommissionen der jeweiligen Kantone genehmigt worden. Je eine Konsultation kam aus der Onkologie, der Anästhesie, Gutachtenstelle, Diabetes-Beratung, 5 Konsultationen fanden in der Medizinischen Poliklinik, 7 in der Psychiatrischen Poliklinik und drei in der Psychosomatik-Ambulanz statt. Kein Patient war akut psychotisch, es wurde keine Psychotherapiesitzung aufgenommen, sondern Abklärungsgespräche oder Standortbestimmungen. Qualitative Daten wurden durch ein interdisziplinäres Analyseteam (klinische Psychologin (MS), Linguisten (GH; ME), Internist und Psychosomatiker (WL))analysiert (s.u.).

Transkripte

Alle Videoaufnahmen wurden transkribiert und die Transkripte ins Deutsche übersetzt, wobei wir uns an einer für die gesprochene Sprache entwickelten Transkriptionskonvention orientierten [36,37]. Die Transkripte wurden von diplomierten Dolmetschern angefertigt und übersetzt, die nicht an der Erstellung der Videos beteiligt waren. Falls die Übersetzungen nicht verständlich waren, wurden die entsprechenden Abschnitte einem zweiten Dolmetscher vorgelegt. Wenn immer noch inhaltlich unklar war, was mit einer Aussage gemeint sein könnte, wurden diese Äusserungen durch einen sehr gut Deutsch sprechenden türkischen Arzt resp. einen zweisprachigen Albanisch und Deutsch sprechenden Psychologen ein drittes Mal revidiert und mit dem Team diskutiert, um eine endgültige

Version zu erreichen. Die verschiedenen Ebenen der Transkription und der Analyse waren: Die Äusserungen von Medizinischen Fachpersonen (MFP) und Dolmetschern auf Deutsch wurden nur transkribiert, die Äusserungen der Patienten und Dolmetscher auf Türkisch oder Albanisch wurden transkribiert und ins Deutsche übersetzt.

Qualitative Analyse der Transkripte
Für die qualitative Analyse wurden die in Tabelle 2 aufgeführten Kategorien eingesetzt [38-40]. In diesen Kategorien wird zum einen die Qualität der Dolmetschleistung bewertet (z.B. ungenaue oder sinnwidrige Wiedergabe des Gesagten) und zum anderen beurteilt, ob Dolmetschende einen nicht explizit mitgeteilten Rollenwechsel vollziehen.

Tabelle 2 hier

Die Transkripte wurden entsprechend den Vorgaben von Laws et al. in Gesprächseinheiten unterteilt, wobei eine Gesprächseinheit einen Gesprächsbeitrag von Patient oder Fachperson in der Ausgangsprache und die dazugehörige Übersetzung in die jeweilige Zielsprache [39] umfasst. Der Dolmetscher kann in dieser Definition im Gespräch keine neue Gesprächseinheit auslösen, weil er nicht als (aktiver) Gesprächsteilnehmer gilt, sondern jeweils nur dolmetscht, was die anderen äussern.

Bestimmung der Interraterreliabilität
Die Interraterreliabilität wurde insgesamt in drei kurzen (2 Minuten) und in einem längeren Textabschnitt (8 Minuten) gemessen. Die Textabschnitte wurden von einer nicht mit der Durchführung der Studie involvierten Drittperson zufällig ausgesucht. Die Mitglieder des Analyseteams werteten diese Ausschnitte getrennt aus und diskutierten anschliessend allfällige Diskrepanzen bis zur Einigung auf eine der unter Tabelle 2 genannten Kategorien. Dabei wurden prototypische Beispiele für die einzelnen Kategorien erstellt, mit denen in der Folge der gesamte Datensatz analysiert wurde. Die Interrater-Reliabilität in den ausgewählten Textbeispielen wurde mithilfe von Gwet’s AC und prozentualer Übereinstimmung auf akzeptablem Niveau gemessen (Koeffizient= 0.83 -0.92 respektive 0.85-0.93) [41].

3 Resultate

3.1 Quantitative Daten

Insgesamt wurden 373 von 451 verteilten Fragebögen zurückgeschickt. Dies eintspricht einer Rücklaufquote von 82.7%. Die Angaben sind nach Auskunft von Leitungspersonen von Dolmetschervermittlungsstellen (z.B. HEKS oder Caritas) repräsentativ für das Dolmetscherkollektiv im Gesundheitswesen in der Schweiz. Nur ein kleiner Anteil von Dolmetschern (9.1%) hat ein Übersetzerdiplom. Die Hälfte besitzt ein Zertifikat des Nationalen Dachverbandes des interkulturellen Dolmetschens ‚Interpret' (http://www.inter-pret.ch/ausbildung-zertifizierung-und-qualitaetssicherung.html). Weitere Beschreibungen der Stichprobe sind der Tabelle 3 zu entnehmen.

Tabelle 3 hier

Die Ergebnisse der Auswertungen zur Dolmetscherrolle gemäss dem IPRI-Fragebogen sind in Tabelle 4 dargestellt. Die Dolmetschenden lehnen bei drei von vier Skalen Rollendefinitionen ab, die über die eng definierte „conduit"-Funktion hinausgehen (Vertrauen zwischen den Parteien aufbauen, Partei ergreifen, Gefühle erklären). In der vierten Skala (Vermitteln von Kultur) liegen ihre Bewertungen zwischen Zustimmen und Ablehnen.

Tabelle 4 hier

3.2 Qualitative Daten

Insgesamt wurden 19 Konsultationen mit einer Gesamtdauer von 865 Minuten (14 auf Türkisch, 5 auf Albanisch) auf Video aufgenommen. Die Dolmetscher sind direkt in den beteiligten Spitälern oder bei Dolmetschervermittlungsstellen angestellt. Zehn Konsultationen wurden von Ärzten, vier von Psychologen und fünf von Pflegefachleuten durchgeführt.
Die soziodemographischen Daten von Fachpersonen, Dolmetschern und Patienten sind in Tabelle 5 aufgeführt.

Tabelle 5 hier

In den Transkripten liessen sich 3866 Segmente unterscheiden, die jeweils auf das Vorliegen der in Tab. 2 aufgeführten Qualitätsmerkmale analysiert wurden.

Wie aus Tab. 6 ersichtlich ist, sind Auslassungen, Hinzufügungen und ungenaue Wiedergaben von Informationen am häufigsten.

Tabelle 6 hier

Beispiele zu einzelnen Kriterien

Im Folgenden werden prototypische Beispiele zu einzelnen Kriterien aufgeführt. In den meisten Beispielen wären neben der demonstrierten Zielkategorie auch noch andere zu nennen, diese werden aber der Klarheit wegen nicht hervorgehoben.

Kürzel und Transkriptionszeichen in den Auszügen sind wie folgt zu verstehen:

MFP - medizinische Fachperson

PAT – Patient/Patientin
DOLM – Dolmetscher/Dolmetscherin
(.) Pause von weniger als 0:2 Sekunden
(-) Pause zwischen 0:2 und 0:5 Sekunden
[v] verbale Aussage
[nv] non-verbale Kommunikation
[UE] Übersetzung durch Dolmetscher

Auslassungen

Auslassungen kamen in unterschiedlichen Gesprächskontexten vor: Beim Austausch von Informationen zur Diagnose und zur Therapie, bei nicht-faktischen und häufig meta-kommunikativen Äusserungen, die dem Gesprächsfluss dienen (‚ich habe noch eine Frage'; ‚als Nächstes möchte ich') und bei phatischen Äusserungen, in denen eine persönliche Ebene angesprochen ist (‚Mein Neffe feiert eine Hochzeit'; ‚Meine Ärztin ist sehr gut').

Die folgende Tabelle 7 zeigt das Beispiel aus einer gutachterlichen Exploration, in dem die Auslassung bei der medizinischen Fachperson (MFP) den Eindruck erweckt, dass der Patient nicht weiss, welchen Beruf sein Bruder hat.

Tabelle 7 hier

Hinzufügungen und Rollenwechsel

Hinzufügungen treten oft gemeinsam mit Rollenwechseln auf, da Dolmetscher ihre neutrale Rolle verlassen, sobald sie etwas in den Diskurs einfügen, was von den Gesprächsteilnehmern nicht geäussert wurde. In den Beispielen finden sich daher Erklärungen (‚es ist nicht die Absicht der Ärztin, jetzt einen Bericht zu schreiben'), Präzisierungen (‚was war nicht gut? Das hat sie dich gefragt') oder Wiederholungen, vor allem, wenn der Dolmetscher vermutet, dass der Patient nicht verstanden hat, was die Fachperson wollte. Ebenfalls unter diese Kategorie fallen Äusserungen, in denen der Dolmetscher selber Fragen beantwortet oder bei Unklarheit nachfragt – jeweils ohne diese Äusserung der Fachperson zu dolmetschen (‚aber die Dinge, die die Frau [MFP] jetzt sagen möchte, hängen wahrscheinlich mit Ihrer eigenen Pflege zusammen, ist es ok?`). Das folgende Beispiel zu beiden Kriterien in Tabelle 8 zeigt, dass der Dolmetscher anstatt „nur" zu dolmetschen selber interveniert und im eigentlichen Sinne das Gespräch lenkt.

Tabelle 8 hier

Ungenaue Wiedergabe

Diese Kategorie kam oft dann vor, wenn Dolmetscher von sich aus präzise Angaben vereinfachten oder verallgemeinerten (‚nach einer Minute des Telefonierens spüre ich den Arm nicht mehr' anstatt ‚wenn ich am Telefon spreche, nach einer Minute fangen von hier aus kleine Taubheiten an bis zu den kleinen Fingern'; oder,am Morgen' anstatt ‚in dem Moment, in dem ich aufgewacht bin').

In der folgenden Gesprächssequenz (Tabelle 9) führt die ungenaue Wiedergabe dazu, dass der Sinn der Aussage der medizinischen Fachperson verändert wird.

Tabelle 9 hier

Falsche Wiedergabe

Vergleichsweise selten beobachtet wurde ‚falsche Wiedergabe' – im Sinne einer Steigerung der semantischen Ungenauigkeit, die bis hin zur Übersetzung des Gegenteils vom ursprünglich Gesagten reichen kann. Am meisten wurde bei klinisch relevanten Informationseinheiten falsch gedolmetscht, wie bei der Symptombeschreibung (‚nervös' anstatt ‚wütend' oder ‚ich ha nit chönne ligge' anstatt ‚ich habe gar nicht geschlafen'), bei Zahlenangaben (‚am achten Januar' anstatt ‚am achten des siebten Monats' oder ‚halb zehn' anstatt ‚halb nüni') oder bei eindeutigen Angaben zur körperlichen Lokalisation (‚auf der rechten Seite' anstatt ‚mit dem linken Arm' oder ‚an den Schultern und an den Beinen' anstatt ‚auf der Rückseite meiner Beine bis zum Knie und hier an meinem oberen Teil').

Im nächsten Beispiel (Tabelle 10) wird durch die falsche Wiedergabe dem Patienten ein anderes Konzept vermittelt. Die Intention der Ärztin ist es, aufzuzeigen, dass der Patient (noch) nicht weiss, wie er mit dem Schmerz umgehen soll. In der Übersetzung wird jedoch vermittelt, dass man nichts gegen Schmerzen machen könne.

Tabelle 10 hier

Probleme mit der Terminologie

Unter diese Kategorie fallen häufig falsch wiedergegebene Namen der Medikamente oder Präparate (‚Novorativ' oder ‚Novor' anstatt ‚NovoRapid'; ‚Letomir' anstatt ‚Levemir'; ‚Beruhigungsmittel' anstatt ‚Benzodiazepine'), ungenau gedolmetschte oder umschriebene Symptombezeichnungen (‚Fiebergefühl' anstatt ‚Hitzewallungen'; ‚Behinderung' anstatt ‚Lähmung'; ‚mit einer schlechten Stimmung' anstatt ‚Morgentief'; ‚so ein Erbrechen in deinem Magen' anstatt ‚Übelkeit'), nicht präzise wiedergegebene Körperteile (‚Rücken' anstatt ‚Wirbelsäule'; ‚Beine' anstatt ‚Oberschenkel'), sowie allgemeine ungenau gedolmetschte medizinische Begriffe (‚Geburtsdauer' anstatt ‚Schwangerschaftszeit'; ‚untersucht' anstatt ‚geröntgt'; ‚eingestellt' anstatt ‚verordnet'). Im Vergleich zu den oben genannten ‚ungenauen Wiedergaben' lag hier die Ungenauigkeit in der inadäquaten Übersetzung eines bestimmten Fachbegriffs.

Das nächste Beispiel (Tabelle 11) zeigt, dass zum einen dem Patienten eine Absicht unterstellt wird, die er in diesem Abschnitt nicht geäussert hat und dass der terminus technicus ‚Operation' durch den Begriff ‚Spritzen' ersetzt wird.

Tabelle 11 hier

4 Diskussion

Die multizentrisch angelegte Studie untersuchte einerseits das eigene Rollenverständnis von Dolmetschenden mittels eines Selbstrating-Fragebogens (IPRI), anderseits an transkribierten gedolmetschten Gesprächen, wie es um konkrete Verständnis der Dolmetscherrolle steht und wie die Qualität der Dolmetschleistung im Sinne einer korrekten Wiedergabe des Gesagten zu beurteilen ist. Die Hauptresultate zeigen, dass Dolmetschende in der Schweiz ihre eigene Rolle eher konservativ im Sinne eines „conduit"-Modells sehen: Sie lehnen ausser dem eigentlichen Übersetzen zusätzliche Funktionen wie beispielsweise das Explizieren von nur angedeuteten Emotionen ab und sind nur hinsichtlich der Aufgabe, zwischen den Kulturen von Patient und Fachperson zu vermitteln, ambivalent. Daher würde man erwarten, dass sie im Wesentlichen das wiedergeben, was sie vom Patienten oder professionellen Helfer in den jeweiligen Sprachen gehört haben; eigene Beiträge sollten nicht hinzugefügt werden.

Allerdings liess sich bei der Überprüfung dieses Befundes in der praktischen Anwendung beobachten, dass das konkrete Verhalten mit diesen Vorgaben oft nicht vereinbar ist: Dolmetscher greifen auf unterschiedliche Art und Weise in den Diskurs zwischen Patient und Fachperson ein, ohne diesen Rollenwechsel der jeweils nicht sprach-kompetenten Seite zu erklären. Sie erklären z.B. dem Patienten, was die Fachperson ‚eigentlich' hätte wissen wollen, ohne der Fachperson zu sagen, dass sie diese Präzisierung oder Klarstellung vornehmen, auch wenn sie vielleicht ja durchaus sinnvoll ist. Sie informieren auf der anderen Seite den Patienten nicht darüber, dass sie seine Aussage umformulieren, vereinfachen oder präzisieren, wenn sie sie der Fachperson auf Deutsch mitteilen.

Man könnte argumentieren, dass diese Interventionen letztlich den beiden Parteien, die sich nicht unmittelbar miteinander verständigen können, zu Gute kommen. Das ist im Einzelfall für einen Aussenstehenden allerdings schwer zu beurteilen; wichtig ist, dass diese Interventionen ohne Absprache mit den Beteiligten geschehen, die davon ausgehen, dass der Dolmetscher genau das wiedergibt, was sie gesagt haben. Zunächst einmal steht diese Abweichung von einer limitierten Rolle des Dolmetschers im Sinne des „conduit"-Modells im Widerspruch zu der in den Fragebogenangaben geforderten Neutralität. Zum anderen könnte man kritisch anführen, dass ein nicht kommunizierter Rollenwechsel im Kern dem entspricht, was Ärzten als paternalistischer

Kommunikationsstil vorgeworfen wurde ((‚the doctor knows best‘), wenn sie Entscheidungen ohne Rücksprache mit dem Patienten getroffen haben.

Ein weiterer Punkt betrifft die eigentliche Qualität der Dolmetschleistung. Hier zeigt sich, dass ungenaue oder falsche Übersetzungen nicht selten sind. Wenn diese auf fehlendes Vokabular zurückzuführen sind, dann spricht dies dafür, die Ausbildung von Dolmetschern im medizinischen Kontext zu verbessern und Problem-spezifische Sprachkompetenz zu vermitteln. Manche Dolmetschervermittlungsstellen haben in dieser Hinsicht bereits diverse Massnahmen getroffen.

Die aufgeführten Beispiele machen auch deutlich, dass ein Teil der Ungenauigkeiten keine wesentliche klinische Relevanz besitzen dürfte. Wir haben die Transkripte lediglich unter Qualitätsaspekten der Dolmetsch-Wissenschaften analysiert und entsprechende Kriterien herangezogen. In einer weiteren Arbeit könnte es darum gehen zu überprüfen, ob die hier berichteten Ungenauigkeiten tatsächlich das Potenzial haben, die Versorgungsqualität des Patienten negativ zu beeinflussen. Schliesslich wäre diese Frage gerade bei der Aufklärung vor Eingriffen oder Gesprächen nach Komplikationen im Hinblick auf die Haftungsfrage von entscheidender Bedeutung; letztlich haftet die Fachperson und nicht der Dolmetscher.

Eine wesentliche Frage ist, inwieweit die hier beschriebenen Defizite in der Dolmetschleistung ausschliesslich dem Dolmetschenden anzulasten sind. In den Videoaufnahmen lässt sich deutlich erkennen, dass sich die Ärzte oder die Pflegefachleute selber ihrer eigenen Rolle und jener des Dolmetschers in einem gedolmetschten Gespräch nicht sicher sind. Sie fragen beispielsweise nicht nach, wenn die Übersetzung unverständlich ist. Sie intervenieren nicht, wenn die Dolmetscher dem Patienten selber Fragen stellen oder wenn klar ist, dass die Übersetzung weit länger dauert als die an sich kurze Frage, die sie gestellt haben. Daher muss eine Verbesserung von Dolmetschleistungen im Gesundheitswesen auch die Schulung von Fachpersonen im Einsatz von Dolmetschern beinhalten.

Die Aussagen der vorliegenden Studie sind in ihrer Gültigkeit insofern eingeschränkt, als dass das klinische Datenmaterial begrenzt ist; ein Selektions-Bias ist sicher nicht auszuschliessen. Die Frage ist allerdings, wie sich ein solcher Bias auswirken würde. Er wäre dann kritisch, wenn die Forderung berechtigt wäre, die Rolle des Dolmetschers unterschiedlich zu definieren, jeweils in Abhängigkeit von der Problemsituation des Patienten. Das ist einerseits im vorliegenden Datenmaterial schwer zu beurteilen, da sich die Problemsituation oft erst im Verlauf des Gespräches herausstellte. Andererseits stellen wir an unserem Datenmaterial fest, dass Dolmetscher einen Wechsel ihrer Rolle nicht explizit kommunizieren. Wenn sie in spezifischer Art und Weise ihre Dolmetscher-Rolle auf die Problematik des Patienten abstimmen sollten, wäre zu fordern, dass sie (noch) häufiger als jetzt beobachtet einen Perspektivenwechsel ihrer Rolle vornehmen und die Dringlichkeit, dies mit der Fachperson abzusprechen, wäre noch grösser als wir jetzt schon konstatieren.

Zusammenfassend lässt sich festhalten, dass die jetzt vorliegenden Ergebnisse Anlass dazu geben, das Rollenverständnis von Dolmetschern kritisch zu hinterfragen, da es eine tiefgreifende Differenz zwischen dem angegebenen und dem praktizierten Rollenverständnis von Dolmetschern gibt. Die häufig kritische Qualität der Dolmetschleistung wirft die Frage auf, wie eine Verbesserung zu erreichen wäre. Diese Bemühungen können sich nicht nur auf die Dolmetschenden selber richten, sondern müssen auch Fachpersonen mit einbeziehen, die sich darüber klar werden sollten, was sie selber vom Dolmetscher erwarten und die dies eindeutig kommunizieren müssten. Letztlich können sie die Verantwortung für ein Gespräch nicht an den Dolmetscher delegieren. .

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6 Tabellen

Tabelle 1

‚Invisible‘	‚Visible‘
Der Dolmetscher transferiert Inhalte als möglichst neutraler Zwischenträger von einem Sprecher auf den anderen	1. Parteilichkeit: Partei ergreifen
	2. Vertrauen: Vertrauen aufbauen und Erleichtern von gegenseitigem Respekt
	3. Gefühle: Gefühle übersetzen/kommunizieren
	4. Kultur: Kulturelle Unterschiede erklären
	5. Kommunikation: Kommunikationsregeln etablieren

Dolmetscherrollen im Fragebogen IPRI

Tabelle 2

Auslassung von Information [38,39]	• Auslassung von Information; Auslassung von Phatischem (v. a. Anfang/Ende), Auslassung von Peinlichem
Hinzufügung von Information [38,39]	• Zusatzinformationen: Extratextuelle Ergänzungen und Präzisierungen • Erklärungen, Nachfragen
Ungenaue inhaltliche Wiedergabe [42]	• Inhaltliche Verschiebungen • Vereinfachungen (von komplexen Inhalten) Zusammenfassungen (von komplexen Inhalten, langen Turns) • Verschiebung der Gewichtung aus dem AT • Syntaktische Mängel, die das Verständnis erschweren. • Nicht-adäquate Wiedergabe von sprachlichen Bildern, Metaphern, Idiomatik (Berücksichtigung sprachlich-kultureller Unterschiede) • Nicht-adäquate Wiedergabe von logischen Zusammenhängen • Nicht-adäquate Wiedergabe von Deixis, Kohäsion, Kohärenz • Änderung des Registers
Falsche (sinnwidrige) Wiedergabe [42]	• Widersprüchliche, unverständliche Inhalte • Sinnverschiebung • Kulturell bedingte Änderungen, z. B. von Zeitangaben (8. Tag des vierten Monats) • Falsche Wiedergabe von Daten, Zahlen, Namen

	- Fehlerhafte/nicht-adäquate Wiedergabe von Fachzusammenhängen
Terminologie: Abweichungen bei der Wiedergabe der Fachterminologie	- Mangelnde terminologische Konsistenz - Unübliche Kollokationen
Rollenwechsel [38,39]	- Nicht gedolmetschte Passagen (allerdings braucht es keine Verdolmetschung, wenn der Patient verstanden hat, solche Fälle werden nicht „geratet“) - Perspektivenwechsel: Wechsel du → Sie, Metakommunikation (fragen Sie Frau B., ob sie …), Wechsel zur 3. Person, indirekte Rede, aktiv → passiv

Detaillierte Beschreibung der Kategorien

Tabelle 3

Dolmetscher (n=373)	
Geschlecht (%)	
Weiblich	74.2
Alter	46.1 Jahre
Ausbildung (%)	
Kein Bildungsabschluss	1.3
Primarschule	19.0
Oberstufe	21.5
Matura	20.1
Fachhochschule/ Universitätsabschluss	35.6
Keine Angaben	2.5
Ausbildung zum Dolmetscher* (%)	
Keine spez. Ausbildung	24.3
Diplomierter Übersetzer	9.1
Zertifikat Interpret	56.0
Zertifikat ZHAW	12.3

andere	19.6
Dolmetschereinsätze /Monat	
Mittelwert	2.1 (1-4)

*Mehrfachantwort möglich

Deskriptive Daten der Stichprobe, die den Fragebogen ausgefüllt hat

Tabelle 4

Skalen	N	Mittelwert	Std.-Abweichung	Std.-Fehler	-95.00%	+95.00%
Parteilichkeit	370	1.77	0.70	0.04	1.70	1.84
Vertrauen	369	2.59	0.79	0.04	2.51	2.67
Gefühle	370	2.77	0.77	0.04	2.69	2.85
Kultur	369	3.75	0.82	0.04	3.66	3.83

Ergebnisse von IPRI; Likert-Skala von 1-6: 1= Lehne voll und ganz ab, 2= Lehne deutlich ab, 3= Lehne ab, 4= Stimme zu, 5= Stimme deutlich zu, 6= Stimme voll und ganz zu

Tabelle 5

Angaben, n (%)	**Medizinische Fachperson (MFP), n=19**	**Dolmetscher, n=19**	**Patienten, n=19**
Alter in Jahren; M (Range)	wurde nicht erfasst	43 (32-52)	56 (34-65)
Keine Schulbildung			2 (10)
Primarschule		3 (16)	4 (21)
Oberstufe		3 (16)	3 (16)
Matura		2 (10)	3 (16)
Fachhochschulabschluss		-	1 (6)
Universitätsabschluss	14 (74)	9 (48)	2 (10)
Keine Angaben	5 (26)	2 (10)	4 (21)
Abgeschlossene Berufsausbildung	19 (100)	7 (37)	8 (42)

Spezifische Dolmetscherausbildung		8 (42)	
Arbeitserfahrung, Jahre (Range) Keine Angaben, n (%)	15 (5-29) 8 (42)	5.8 (1-23) 10 (53)	

Soziodemographische Charakteristika von Fachpersonen, Dolmetschern und Patienten in den Videoaufnahmen

Tabelle 6

Videoaufnahmen, n=19							
Zeit in Min.	Anzahl Gesprächs-Segmente	Auslassung	Hinzufügung	Rollenwechsel	Ungenau	Falsch	Terminologie
865	3866	2148	1781	660	1149	572	315

Ergebnisse der qualitativen Analyse in Zahlen

Tabelle 7

MFP [v]	hmhm hat er *(der Bruder)* einen Beruf?
PAT [v]	(.) ja (.)
PAT [v]	Ja. Şimdi aklıma gelmiyor, söylesem size.
PAT [UE]	Es fällt mir gerade nicht ein, so dass ich es Ihnen sagen kann
DOLM [v]	Er kann sich nicht erinnern
PAT [v]	(.) Tornacı
PAT [UE]	(.) Schlosser
DOLM [v]	Aha (-) so hm, wie ist es, arabayla ilgili değil mi?
DOLM [UE]	Ach so, hm, das hat doch mit den Autos zu tun, nicht wahr?
PAT [v]	Nein, torna
PAT [UE]	Nein, Schlosser
DOLM [v]	Torna nedir?
DOLM [UE]	Was ist Schlosser?
PAT [v]	Ya, işte ondan…
PAT [UE]	Also, das…
DOLM [v]	Es ist schwierig ((lacht)) (-) er er versucht zu erinnern, was für eine Arbeit er macht
PAT [v]	(.) Ya Almancasını biliyordum ama, şu anda…
Pat [UE]	Also nein, ich wusste, wie das auf Deutsch heisst, aber im Moment…

Beispiel ‚Auslassung‘

Tabelle 8

MFP [v]	Ha, ist das gut? OK, gut. Jetzt hätte ich, weiss nicht, haben Sie noch eine Frage, ein Problem, sonst würde ich mal weitermachen.
PAT [v]	İdrarımı tutamıyorum, ilaç yazdı onun için diyorum
PAT [UE]	Ich meine, ich kann mein Wasser nicht halten, deshalb hat sie mir ein Medikament verschrieben.
DOLM [v]	A yok yok şimdi soracağın bir şey var mı, yoksa normal muayeneye devam edeyim. Özel soracağınız bir şey var mı? Nein, keine Fragen.
DOLM [UE]	Ach nein, nein, gibt es etwas, was du jetzt fragen möchtest, sonst würde ich mit der normalen Untersuchung fortfahren. Haben Sie noch eine spezielle Frage? Nein, keine Fragen?
PAT [v]	Yo teşekkür ederim, dank schön. Vielen Dank
PAT [UE]	Nein, ich bedanke mich.

Beispiel ‚Rollenwechsel‘ und ‚Hinzufügung‘

Tabelle 9

MFP [v]	Und ich nehme an, eigentlich ist es wichtig, ein guter Vater zu sein
DOLM [v]	une po thot menoj po thot se asht shum me rënsi me kan nji bab i mirë
Dolm [UE]	Ich, sagt er, ich denke es ist sehr wichtig, ein guter Vater zu sein
DOLM [v]	Entschuldigung, dass er ein guter Vater ist?
MFP [v]	Hmhm dass er ein guter Vater ist
DOLM [v]	Po thot une menoj po thot se ti ke qenë nji bab i mirë. ke qef m'u kon. Ja ja
Dolm [UE]	Er sagt, ich denke, dass du ein guter Vater gewesen bist. Du möchtest es sein. Ja ja
PAT [v]	(.) a po po.
Pat [UE]	(.) a ja ja
MFP [v]	Hmhm, und Sie können das nicht erreichen im Moment aufgrund der Schmerzen, der Nervosität
DOLM [v]	po thot edhe ktë ti, ju tash nuk muni k'ta mu bo po thot shkaku qi jeni nervoz edhe ki dhimt. s'munesh me u bë bab i mir se je i
Dolm [UE]	Er sagt noch das, dass du, Sie können jetzt es nicht werden, er sagt, weil Sie nervös sind und du Schmerzen hast. Du kannst nicht ein guter Vater werden, weil du bist...
PAT [v]	Po po
Pat [UE]	Ja ja

DOLM [v]	Entschuldigung, manchmal i muss mit andere Worte
MFP [v]	Ja ja dann ist gut
DOLM [v]	Kanjiher nuk po munesh m'u bo bab i mirë se nervoz dhimt po ki spo munesh mu kon babë i mirë, edhe pse ki qef edhe pse dëshiron. Ja, ja
Dolm [UE]	Manchmal kannst du kein guter Vater werden, weil nervös, Schmerzen hast du und du kannst kein guter Vater werden, obwohl du das willst und obwohl du möchtest. Ja ja
PAT [v]	Po po
Pat [UE]	Ja ja

Beispiel ‚Ungenaue Wiedergabe‘

Tabelle 10

MFP [v]	Okay gut, ich kann mir vorstellen, von dem was Sie mir so erzählen, dass Sie sich wahrscheinlich sehr hilflos auch fühlen, oder? Weil Sie nicht genau wissen, woher kommen die Schmerzen und was kann ich dagegen machen oder was können die Ärzte dagegen machen.
DOLM [v]	Evet anladığım kadarıyla şimdilik kendinizi yardımsız hissediyorsunuz, doktorlar yardımcı olamıyor, kimse size yardımcı olamıyor, o yüzden kendinizi sanki bir boşlukta görüyorsunuz.
DOLM [UE]	Ja, soweit ich Sie verstanden habe, fühlen Sie sich hilflos, die Ärzte können Ihnen nicht helfen, niemand kann Ihnen helfen. Deshalb spüren Sie eine innere Leere.

Beispiel ‚Falsche Wiedergabe‘

Tabelle 11

MFP [v]	Haben Sie das verstanden? Okay, guet. Okay, jetzt habe ich noch eine letzte Frage: Waren Sie beim Augenarzt?
DOLM [v]	Son sorusu varmış kendisinin göz doktoruna gittiniz mi?
DOLM [UE]	Sie selbst habe noch eine letzte Frage: Sind Sie zum Augenarzt gegangen?
PAT [v]	Hmhm, göz doktoruna geçen sene gittim ama bu sene daha gitmedim
PAT [UE]	Hmhm, zum Augenarzt bin ich letztes Jahr gegangen, dieses Jahr bin ich noch nicht gegangen
DOLM [v]	Also, er het sowieso e bedürfnis zum Augenarzt z gho. Letscht johr isch er gange
PAT [v]	Ameliyat öncesi gittim
PAT [UE]	Vor der Operation bin ich gegangen
DOLM [v]	Vor dem Spritzen

Beispiel ‚Terminologie‘