28 Intercultural Communication[1]

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> And again and again the language …
>
> Kogoi 2011: 260

Abstract: The introduction critically examines the concept of culture which is often invoked to explain differences that are in fact considerably more complex or have other, namely communicative, causes. This is followed by a discussion of general challenges arising in multilingual doctor-patient communication. The following section (§ 28.3) presents a range of institutionalised approaches to addressing these challenges, outlining their respective advantages and limitations. Particular attention is paid to the acquisition and practical application of so-called 'intercultural competence' as well as to the use of professional and lay interpreters. The challenges and potential dangers posed by insufficient interpreting practices are illustrated with detailed analytical examples. The concluding section (§ 28.4) provides a brief overview of technology-mediated approaches to lay interpreting.

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1 This chapter is based on the German version (from 2018) by our colleague Florian Menz, who passed away far too early. As editors, we would like to express our sincere thanks to his family, for kindly granting us the publication rights. We would also like to thank Regina Geisler-Knünz, who revised, translated, and updated the chapter.

28.1 Introduction: Cultural differences or language barriers?

Linguistic and cultural diversity has increased considerably worldwide in recent decades, including Europe's nation states. This development can be attributed primarily to (economic) globalization and the resulting migration processes. Multilingualism is a widespread and enduring phenomenon, particularly in large cities, yet it is still insufficiently accounted for in the healthcare sector. Discussions often focus on the additional effort required to provide care and on poorer therapeutic outcomes for patients with migration backgrounds; differences, particularly cultural ones, are frequently interpreted as deficits, shortcomings, or failures on the part of patients (Kutalek 2011). It is often overlooked, however, that all communication between doctors and patients is embedded in culture, and that the most widely practiced form of medicine in the West − evidence-based medicine − is itself culturally shaped (Napier et al. 2014).

However, reducing culture to a taxonomy of differences often does not go beyond anecdotal reports and "more or less clichéd cultural differences" (Meyer 2003: 164, translation by Regina Geisler-Knünz). For example, it is sometimes claimed that Turkish patients tend to describe depressive symptoms as gastrointestinal complaints, whereas Latin Americans emphasise ‘headaches’, Arabs report ‘heart complaints’, and Chinese patients mention ‘lack of energy’ or ‘boredom’ (Machleidt, Callies 2009). Statements that describe Mediterranean and Muslim people as having a more collectivist orientation and seeing illness as a consequence of external influences rather than individual behaviour (Kogoi 2011) strike a similar chord. Other institutions, such as the "Amsterdam Declaration towards Migrant Friendly Hospitals in an ethnocultural diverse Europe", also highlight the risk that stereotypes may be reproduced, rather than shedding light on the underlying causes of cultural differences (European Commission project "MFH - Migrant friendly hospitals": The Amsterdam Declaration, point 3).

Let us first look at the following example (E 28.1) (Reisigl 2011). After the doctor has spent two and a half minutes explaining how to take various painkillers towards the end of the conversation, he switches to organizational questions and then moves on to the conversation end (line 14). There, the conversation takes a surprising turn:

E 28.1		Communication problems
01	D	That means you will come for a check-up at the end of September
02	P	End of September, aha
03	D	There are already appointments. You can make an appointment at the intake office at the front
04	P	Now?
05	D	Yes, you can make an appointment for a check-up at the end of September.
06	P	Okay
07	D	And then continue with this headache calendar, though
08	P	Go on? Okay
09		*[Omission]*
10	D	When registering: appointment for the end of September • and headache calendar.
11	P	Yes, okay
12	I*	And you'll be back at the end of September.
13	P	Okay, thanks
14	D	Good?
15	I	Okay. And what medication am I taking?

*Interpreter

The question in line 15 clearly indicates that the patient has not understood the preceding explanations. This is evidently a case of communicative difficulty arising from limited language proficiency. However, whether so-called cultural differences also play a role here cannot be asserted without further evidence.

Caution is therefore advisable when using the concept of culture and the term intercultural communication (Menz et al. 2013). For this reason, a number of critical remarks should be made at this point. First, it is not permissible to causally attribute communicative problems of various kinds to a single 'cultural' factor when differing levels of language proficiency are involved. Not every misunderstanding involving individuals with limited proficiency in the societal language is culturally determined (Dimitrova, Sehouli 2023). Rather, it should be emphasised that a certain 'foreignness' (e.g. with regard to healthcare institutions or access to relevant information) is generally a major factor contributing to unequal or disadvantageous outcomes. However, 'foreignness' is not

limited to a different linguistic background or 'culture'; it also exists within a single language community or nation and may arise, for example, from social milieus or gender (Blasch et al. 2010, Bührig, Meyer 1998, Menz, Lalouschek 2005).

Other factors that may impede communication include the topic itself or the structure of healthcare institutions, as well as the patient's medical history or environmental conditions such as limited space and time resources. The individual's personality traits (e.g. extroversion or introversion) and their state on a given day may also play a role (Engel, Hoffmann 2003).

Secondly, 'cultures' are historical: medical concepts of health and illness change over the course of history, as do definitions of illness itself, as they are not exclusively defined biologically, but also socially, politically and culturally (Kutalek 2011, Hsieh 2022).

Thirdly and finally, culture-related categories such as 'cultural identity' and 'cultural membership' are not fixed or pre-existing communicative entities; rather they are produced, reproduced, transformed, and rendered relevant – or problematised – by the participants within the interaction (Menz et al. 2013, Walter, Matar 2018, Hsieh, Kramer 2021).

It therefore seems advisable to begin by examining more closely at how language barriers are sustained in medical communication, as the language of medicine in German-speaking countries is still predominantly German. In the following, we will first describe these language barriers – specifically, the difficulties faced by patients with limited proficiency in German) and then consider possible solutions. However, it should be stated in advance that, since the issue concerns communication and relationship building (§ 3.2), there can be no one-size-fits-all solution or universal remedy. Rather, it will – and must – always involve developing solutions that are appropriate to the specific situation and context.

Ideally, the aim is therefore, on the one hand, not to invoke culture prematurely as a monocausal explanatory factor for differences and problems, but on the other hand, not to disregard it where it is relevant.

28.2 General problems of multilingual doctor-patient communication

Studies show (cf. e.g. Roberts et al. 2005, Bigi, Rossi 2020) that specific forms of misunderstandings can occur at all levels of the language system and interaction when there is little knowledge of the doctor's language. On the phonological-phonetic level, this concerns pronunciation and word stress as well as intonation and speech reproduction, on the syntactic-lexical level grammar and vocabulary, and on a pragmatic level the lack of contextual information.

Above all, however, the presentation style of complaints and symptoms reveals consequential differences. Presentation style has a decisive influence on misunderstandings, as it may subvert physicians' expectations and thus give rise to comprehension difficulties (Meeuwesen et al. 2010). Many patients who are unfamiliar with Western healthcare systems, for example, are surprised by its focus on symptoms, which runs counter to the learned patterns of initiating contact and building relationships through forms of small talk at the beginning of a conversation. Such differing forms of self-presentation in medical consultations are much more often responsible for communicative problems than, for example, culturally specific notions of illness and recovery (Roberts et al. 2005). Above all, however, the patient-oriented discussion strategies increasingly demanded in Western societies very often contradict the expectations of the doctor-patient relationship of patients with a different cultural background. In such cases, providing additional guidance and information about procedures (Roberts 2006) tends to complicate communication rather than facilitate it. Therefore, a key factor for improvement lies in increased awareness-raising and the promotion of attentiveness in training on such presentation strategies. Conventional communication training based on monolingual speakers is inadequate, as it fails to address precisely these problems of differing self-presentation and expectations or assumptions regarding consultation.

In addition, there is evidence that doctors' role expectations and communicative tasks when interacting with patients who do not speak German as their first language are shifting: for instance, towards addressing more non-medical questions and a higher proportion of administrative rather than medical issues (Valero-Garcés 2002). Equally significant, however, are structural contradictions arising from the bureaucratic organization of the healthcare system (Roberts 2006), such

as the increasing demand for documentation and the use of standardised computerised procedures. These are primarily designed for monolingual speakers and disadvantage patients with limited proficiency in the language of care, who are often unfamiliar with the required procedures.

28.3 Approaches to enhancing understanding in multilingual communication

Comprehensive explanation and provision of information are essential prerequisites for successful medical communication and are, not least, legally mandated as an obligation of healthcare institutions to provide such information and guidance. Meeting these requirements is naturally more complex when interlocutors do not share a common language than in monolingual communication settings. Various approaches can be employed to reduce such problems, although they are not all equally effective. Some of these approaches will be discussed below in terms of their advantages and disadvantages.

28.3.1 Intercultural competence

When communicating with patients who have limited proficiency in German, it is particularly important to consider some basic parameters, sometimes summarised as *intercultural competence* (Deardorff 2009); however, this term can be misleading in that, as argued above, it primarily concerns communicative behaviours. The key point is a willingness to recognise and accept differences in communication strategies and habits as a matter of principle. This involves developing sensitivity to the fact that one's own expectations regarding communication patterns (e.g., the concise description of symptoms in a particular order) are not automatically shared by the patient. Such willingness − also described as the ability to differentiate − entails reflecting on one's own ideas, expectations, and orientation systems, and acknowledging that these are not the only valid frameworks (Peintinger 2011, Schmidhuber 2022, Ilkilic 2023). Importantly, this reflective ability can be practiced

and trained[2] and should not be mistaken for a permissive '*anything goes*' approach.

Intercultural awareness, however, makes it possible to address differences explicitly and is not limited to multilingual communication; rather, it is inherent in virtually any interaction, including those between speakers of the same language. Being mindful of this can help avoid the trap of 'ethnicization' (Groenemeyer, Mansel 2003). Ethnicization refers to the reduction of individuals to their cultural or ethnic background – that is, the premature explanation of misunderstandings solely in terms of membership in a particular ethnic group, without considering other factors. In this understanding, 'intercultural competence' corresponds to a communicative disposition that acknowledges the inherent vagueness and underdetermination of communication. It is thus an individual attitude or mindset. Some strategies for developing and fostering cultural competence are summarised in Box 28.1.

Box 28.1 Key points on the concept of intercultural competence

- Cultural competence is not a fixed end point, but rather a learning and experiential process throughout one's professional career
- No one can be competent in all cultures. Asking questions and addressing uncertainties is therefore permissible and advisable, for example:
  - Questions about communicative practices ("Do you mind if I shake your hand?")
  - Questions about sociocultural background ("Where were you born and raised?")
  - Questions about personal interpretation of illness
  - etc. (Kogoi 2011, Kropiunigg 2011, Peintinger 2011, Dimitrova et al. 2022)
- As a general principle, culturally specific knowledge is less important than one's overall attitude, (including demonstrating respect, taking time, providing explanations, ensuring thorough examinations, and involving patients in decision-making)

[2] An example of such structured training is the IPIKA programme developed at Charité Berlin in 2016, a transprofessional curriculum aimed at strengthening intercultural competencies in clinical practice (Dimitrova, Sehouli 2023).

A significantly different setting for addressing interactive problems in multilingual and multicultural encounters is involvement of *interpreters*. Given the extensive literature, this section will focus on studies that pursue linguistically oriented approaches − a research strand within interpreting studies that has been gaining increasing attention (Bolden 2000, Bührig 2001, Bührig, Meyer 2004, Pöchhacker, Shlesinger 2005, 2007, Hsieh, Ma 2024, Hsieh 2024) Two main types can be distinguished in so-called community interpreting: professional interpreting and interpreting by family members. These represent the extreme poles of different contexts within mediated multilingual communication.

28.3.2 Professional interpreting

Discourse-analytically oriented studies on professional interpreting occupy the intersection between the field of interpreting − which remains strongly shaped by professional norms of interpreting − and applied linguistic paradigms that foreground conversational needs. The contradictions arising between role-specific mandates and ethical guidelines of interpreting associations on the one hand, and actual interactive practices on the other, lead to interactional dilemmas (Angelelli 2004, 2019). For example, interpreter training programs still generally require that interpreters should not appear as independent personalities within the interpreted situation but rather remain 'invisible'. However, Angelelli's analysis of nearly 400 interpreted communicative events demonstrates that a number of linguistic actions indicate the visibility of interpreters: interpreters introduce themselves as participants in the interaction; they verbalise interactional rules (e.g., turn-taking conventions); they paraphrase technical terms or concepts; they shift register up or down (e.g., translating more informally than the original utterance); they filter information; and they adopt the perspective of one party. Beyond these individual linguistic utterances, however, interpreters' interactive participation is also shaped by their understanding of the purpose of the consultation, and not solely by the goal of translation. Interpreters are not passive participants in the interaction; rather, their translations are strongly influenced by the medical perspective. Interpreters share the normative orientation of physicians toward presenting biomedical information as objectively as possible. This orientation manifests not only in the amplification of information they consider relevant (e.g., eliciting a comprehensive account of symptoms), but also in the suppression of

patient-provided, subjectively oriented information on socio-psychological issues (Bolden 2000).

While Bolden here observes, in line with Mishler (1984), that interpreters' involvement tends to reinforce the 'language of medicine' (§ 10.2), other studies arrive at more nuanced conclusions. In their analysis of only three interpreted consultations, Merlini and Favaron (2005) found that interpreters took up an independent position, mediating between the perspectives of physicians and patients. An examination of certain linguistic features (prosodic elements such as intonation and emphasis, turn-taking, interruptions, etc.) highlights the interpreters' active engagement in the interaction as a defining characteristic of this mediating role, albeit with strong inclusion of the patients. Similar findings are reported by Sator (2013) and, in a more recent study, also by Bolden (2020), who demonstrates that interpreters' actions are shaped by the demands of the interactional and medical activities they are engaged in.

Moreover, many studies indicate that migrants consider the use of professional interpreters important (Borde, David 2005), even though professional interpreters are more commonly employed in hospitals than in outpatient settings. This section will therefore briefly outline some key parameters for the effective use of interpreters, not least to facilitate patient-centred communication. Furthermore, the aspects discussed below are also relevant for the far more frequent practice of ad hoc interpreting by laypersons (§ 28.3.3). As a general principle, the following points should be observed when working with professional interpreters (Box 28.2); they fall within the responsibilities of the physician as a member of the institution.

Box 28.2 Key points for the use of professional interpreters

- Interpreters should be 'booked' in advance.
- It is advisable to brief the interpreter beforehand on the physician's purpose in speaking with the patient.
- Seating arrangements should allow eye contact between all parties.
- The interpreter's gender should be appropriate for the patient.
- Open-ended questions should be used whenever possible, in order to assess the patient's comprehension.
- Medical jargon (§ 10.5, 27) should be avoided where possible, and technical terms should be explained.
- Despite the interpreter's presence, the patient should always be

addressed directly.
- Contributions should not be too long, so that the interpreter can translate accurately.
- Nodding should not be interpreted as a sign of understanding; other explicit checks for understanding should be used.
- It is not the interpreter's role to advise the patient, decide what is important, offer help, analyse or interpret information (from the physician or patient), or calm the patient. These conversational tasks remain with the physician conducting the consultation, even in interpreted encounters.

A particular form of professional interpreting is the provision of written information (Wesselmann et al. 2004). Certain types of content are especially well suited to this format because they consist of standardised information. This applies in particular to organizational information about procedures in the practice, as well as lists of organizations and institutions that provide support – of which there is now a considerable number. The use of pictograms can also be helpful in this context (Parmakerli 2010), which is particularly relevant given varying literacy levels.
With regard to technological tools, the development and use of digital solutions to overcome language barriers are increasing. However, the effectiveness of such tools is often limited by translation accuracy, accessibility, usability or ethical concerns (Kreienbrinck 2025, Schouten et al. 2023).

28.3.3 Lay interpreting

Conversations involving lay interpreters pose additional, and often serious, communication challenges. The term *lay interpreter* refers to individuals who act as linguistic mediators without having received formal academic training in interpreting. They are likely to be far more common in medical settings than generally assumed (Pöchhacker, Kadric 1999, Führer, Brzoska 2020). Broadly speaking, lay interpreters fall into two groups, which differ considerably in terms of their competences. The largest group consists of family members or friends of the patients who accompany them to consultations and are expected to serve as interpreters. When these individuals are (minor) children, such triadic constellations can raise major ethical concerns, not least because in

children, in addition to emotional involvement, cognitive skills are often not yet sufficiently developed to provide reliable interpreting services.

The second group consists of members of medical and health-care professions who possess multilingual proficiency and are employed as interpreters (for example in hospitals but also including medical office assistants). In some pilot projects, this group receives training in order to carry out mediating tasks competently (Meyer 2003, Wesselmann et al. 2004). As the studies cited show, the proficiency of two or more languages alone does not guarantee satisfactory interpreting performance. The major advantage lies in the fact that they are generally familiar with institutional procedures and have a medical background.

With family members, the translation of medical terminology often poses particular problems during the conveyance of information in diagnostic consultations. These difficulties are sometimes compensated for through specific procedures, such as repeating the term in the source language (e.g., the German medical term in Portuguese) or replacing it with paraphrases (Meyer 2004). Pointing gestures to affected body parts or to information in brochures, as well as word-for-word translations into the target language, are also used as support strategies. The latter often give rise to comprehension problems, so that interpreted consultations frequently fall short in quality, and the information conveyed is less accurate and complete than in monolingual consultations (Bührig, Meyer 2004, Meyer 2004).

Several other differences between consultations with professional interpreters and those with lay interpreters are also relevant for communication quality. Professional interpreters typically translate all the physician's questions and rarely add new ones. Family interpreters, however, translate only about 14% of the questions, answer approximately 50% of the questions directly themselves (for example, a spouse), and also introduce significantly more new questions (Valero-Garcés 2002, 2005).

Above all, certain qualitative differences and similarities stand out. Conversations interpreted by laypersons, due to the relatively limited linguistic competence of the interpreter, also show changes in adherence to communicative conventions. Although, similar to non-interpreted conversations, lay-interpreted interactions typically feature communicative strategies for ensuring understanding – such as frequent requests for clarification, repetitions, and reformulations – these differ from professional interpretations in important ways. In lay interpretations, the interpreter often assumes multiple roles, frequently tak-

ing on the questioning functions of the physician or providing answers to the physician's questions directly, without translating them. When the interpreter addresses one of the parties directly, these passages remain untranslated for the other party, a situation that never occurs in professional interpretations (Sator 2013). Ad-hoc interpretations provided by family members are therefore associated with a high risk of misunderstandings. Professional interpreters, in accordance with association guidelines, also employ the first person in their translations, whereas lay interpreters usually use the third person, often in conjunction with reporting verbs (e.g., "she says"). Similar findings regarding therapy sessions are reported by Bot (2005), who, however, does not consider the perspective shift resulting from third-person usage in translations as problematic to the extent often assumed in the literature; rather, she interprets it as an adaptation to the interactive reality of the encounter.

An example of problematic lay interpreting

The following example illustrates several problematic aspects of lay interpreting. The example was analyzed in detail by Sator (2013) and is here presented in an abridged form. The material under analysis consists of an initial consultation and four follow-up appointments with a Turkish-speaking patient at a headache clinic in Vienna.[3] The patient speaks very little German and is interpreted during the initial consultation by her pregnant daughter. During the course of the conversation, an inpatient admission for analgesic withdrawal is arranged. However, the patient does not attend the hospital stay as scheduled but instead travels to Turkey for a family visit. It thus appears that the patient, for reasons unknown, was not compliant; indeed, the physician even speculates in an informal interview that this might be related to a generally lower sense of commitment among Turks.
The following transcript excerpt (E 28.2) illustrates the moment in the initial consultation when the inpatient admission is 'negotiated'.

[3] The diagnosis is migraine without aura and medication-overuse headache.

E 28.2		Problematic lay interpreting
01	D	(I) mean, I don't know what would be more appropriate for you or more suitable for you? ((1s)) So, to do the whole thing as an outpatient or/or umm as an inpatient. You umm have to decide that.
02	P	((1.5s)) Ahh
03	I	İki hafta burda mı yatmak istiyon yoksa ...
	I	*Do you want to stay here for two weeks or ...*[4]
04	P	((3s)) Ne zaman?
	P	*((3s)) When?*
05	I	When will she be admitted if she ...
06	D	Uh, basically I would/I would now call, uh, one of the war/ wards, uh, and would just ask. That means that... Uh, just from a feeling, I would say that it could happen relatively quickly. That one could have an appointment, and they could/could come. Right? Would that be the/ the option that you want? ((1s)) So, to be admitted and then come back on an outpatient basis?
07	P	Ne zaman?
	P	*When?*
08	I	Ya ne bilim ne zaman yer olursa.
	I	*What am I supposed to know, whenever a seat is free?*
09	P	((2.5s)) Sen doğururken olmasın ((4s)).
	P	*((2.5s)) It should not be when you give birth ((4s)).*
10	*[Omission: It is clarified that the admission date would be BEFORE delivery]*	
11	D	Huh?
12	I	Hangisini istiyon?
	I	*Which one do you want?*
13	P	Huh?
	P	*Huh?*
14	I	Hangisini istiyon?
	I	*Which one do you want?*
15	P	Ne diyo?
	P	*What does he say?*
16	I	Ya burda yatcan iki hafta diyo yada hap falan yazim eve git diyo.
	I	*He says you'll either stay here for two weeks or I'll prescribe you pills and you'll go home.*

[4] Translations of the Turkish passages are set in italics for ease of reading.

17	P	Hm • • şimdi hap yazsın. • • bi deneyim. • • olmazsa gerçek yatacam annem hm?
	P	*Hm, he should prescribe tablets now. I'll give it a try and if it doesn't work, then I'll really stay here.*
18	I	Zaten seni hastaneye alırlarsa - - - - Mid - - Mid-July.
	I	*If they admit you to the hospital, in the middle/ middle of July anyway.*
19	I	So, when she is admitted, around mid-May, right?
20	D	Ahmm, I can... I'll call upstairs. Then let's see, shall we?
21	*[The doctor phones the ward and makes an appointment for inpatient detox in mid-May]*	

Viewed from the perspective of the physician, who does not understand Turkish, and considering only the German-language passages, the patient appears non-compliant, failing to adhere to an agreement in favour of a visit to Turkey.

A closer examination of the corresponding passage in the initial consultation, however, leads to a different conclusion. In line 1, the physician briefly presents the two options − an inpatient admission or outpatient analgesic withdrawal − and leaves the decision to the patient. The patient consults with her daughter to ensure she can attend the birth of her grandchild, which the physician confirms (lines 2–10). In lines 11 to 16, the daughter summarises the two alternatives in a very abbreviated form and urges the mother to make a decision. The patient expresses a preference for outpatient medication withdrawal, which the daughter does not translate. Instead, she reconfirms that the admission would take place in May, well before the expected birth at the end of June. The physician promises to clarify this by phone (line 20) but immediately schedules an appointment, contrary to his announcement (“Then let's see, shall we?”).

It can therefore be seen that the patient expresses a clear preference for outpatient medication withdrawal, which is, however, insufficiently interpreted by the daughter. The doctor, in turn, does not sufficiently back up *his* assumption of a decision for an inpatient stay, but (hastily) organises a hospital bed (Sator 2013). The daughter's interpretation is incomplete in both directions (the patient's decision for outpatient withdrawal is *not* interpreted, for example), and it also remains unclear whether she is not pursuing her own interests. The physician’s attempts to ensure understanding are also insufficient, and the interpre-

tation is poorly coordinated, as he does not insist on a complete translation. This – not uncommon – conversation exemplifies the shortcomings repeatedly observed in family-mediated interpretations.

The consequences are considerable: the decision for hospitalization is made over the patient's head, resulting in a discussion *about* the patient rather than a dialogue *with* her (Sator, Gülich 2013).

Conclusions for the practice of lay interpreting

The complexity of the communicative prerequisites in interpreted interactions increases exponentially. While a dyadic monolingual situation essentially involves two constellations (the physician speaking to the patient, and the patient speaking to the physician), the presence of an interpreting third party increases this to 15 documented participation configurations (Sator, Gülich 2013), depending on which language is used, which participant is primarily addressed, and how reference is made to the non-addressed third party − whether someone is spoken to, about, or on behalf of another person.

In view of the findings of these studies, it must be assumed that lay interpreting does not meet the standards applied to monolingual medical communication (Reisigl 2011, Sator 2013). Moreover, the competencies of lay interpreters are generally insufficient, and systematic training is difficult to implement except for in-house institutional staff. Therefore, other measures are advisable, which are outlined below (Box 28.3):

Box 28.3 Key considerations in the use of lay interpreters

- It is the responsibility of the physician to manage the organization of interpreting in a triadic encounter, as lay interpreters generally lack the relevant competencies. This includes a brief orientation phase at the beginning of the consultation covering the language abilities of all participants − including the interpreters −, an explicit agreement on how the interpreting will be conducted, and the patient's concerns and expectations (Sator 2013, Sator, Gülich 2013).
- It is the physician's responsibility to consistently coordinate the interpreting throughout the interaction (i.e., to invite or require family members to translate) (Menz 2011), and to employ additional

measures to ensure understanding (drawings, sketches, increased clarification requests, backchannel signals, etc.) (Reisigl 2011).
- It is important to segment the conversation into small units, to avoid side conversations, to ensure that patients also refrain from such parallel talk, and to instruct lay interpreters accordingly (Meeuwesen et al. 2010).
- Finally, studies have shown that interpreted consultations do not necessarily take more time; they are more complex qualitatively, but not quantitatively (Menz 2013).

28.4 Outlook and further information

In summary, it must be noted that communication with patients who have insufficient command of the physician's first language entails significant disadvantages in medical care. Such patients not only receive less affective support (Schouten, Meeuwesen 2006), but also have reduced access to essential information. In German-speaking contexts, it is still largely regarded as the patient's responsibility to ensure adequate communicative competence and to facilitate the necessary exchange of information. Accordingly, the measures discussed in this chapter for reducing these disadvantages need to be complemented by broader societal interventions. Training and continuing education opportunities for physicians should be expanded to ensure that lay interpreting situations – which are particularly frequent in outpatient settings – can be managed satisfactorily and efficiently for all participants, particularly the practitioners themselves.

In addition, better dissemination of information – particularly in medical practices – about existing support structures and migrant networks is required (Flubacher 1999). A further structural measure would be to significantly increase the number of physicians with first languages other than the majority language, as their proportion remains far below the demographic average.

Another option is the use of video interpreting tools. This allows the doctor and patient to communicate via a professional interpreter connected to an electronic device. Such projects have already been successfully tested in Switzerland and Austria and are increasingly being used in hospitals as well as in private practices (Kletecka-Pulker 2013, Pöchhacker 2014). Since video interpreters do not need to be physically pre-

sent and can therefore be organised more easily, video-mediated interpreting has the potential to become a form of mediated communication that provides the advantages of professional interpreting while mitigating the drawback of limited availability. Recent research also indicates that while video interpreting tools can enhance efficiency and emotional distance, interpreters experience technical difficulties and challenges related to the lack of physical presence (Klomfar et al. 2025).

Ultimately, a medium-term shift in political perspective is necessary – one aligned with 'best practice' approaches that recognise migrants not as a problem but as a group contributing to economic growth, positive demographic developments, and cultural enrichment (Baldaszti 2003). Such a change in attitude would also benefit other disadvantaged groups 'without a migration background', whose unequal treatment within the healthcare system has been well documented (e.g., Menz, Lalouschek 2005).

For further reading, the edited volume by Michael Peintinger and its accompanying practical guide, which address a range of linguistic and non-linguistic aspects of intercultural communication and are specifically designed for medical practitioners, are recommended (Peintinger (ed.) 2011). Gillessen et al. (2020) provide a multidisciplinary account of intercultural communication in medical settings and develop practice-oriented recommendations for culturally sensitive doctor-patient interaction, while Schmidhuber (2022) focuses on intercultural competence in hospital settings, including communication with patients with dementia and their relatives.

More linguistically oriented questions are explored in Apfelbaum and Müller (eds.) (1998) and Bührig and Meyer (2015), as well as in Hsieh and Kramer (2021), who reconceptualise culture in health communication through the lens of social interactions as intercultural encounters. A forthcoming volume by Crichton and Martin (2026) will similarly address intercultural communication in healthcare contexts.

Detailed interactional-linguistic analyses can be found, for example, in Menz (ed.) 2013).

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Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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