Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications

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BACKGROUND Patients in inner-city areas come from increasingly diverse language and cultural backgrounds. Neither communications training modelled on local English speakers nor the provision of interpreters offer adequate solutions.

AIM To identify how patients with limited English and culturally different communication styles consult with general practitioners (GPs) in English, and to develop training strategies from both good practice and observed misunderstandings.

METHODS Randomly selected routine and emergency surgeries in 19 inner London general practices were video-recorded. The videos were viewed independently by 2 discourse analysts. Key consultations, across a wide range of English language ability, were selected and transcribed to analyse misunderstandings resulting from language/cultural differences.

RESULTS Of the 232 video recordings that were made, 20% were with patients with limited English and contained major and often extended misunderstandings.

QUALITATIVE ANALYSIS Four main categories of patient 'talk' contributing to misunderstandings are identified: (1) pronunciation and word stress; (2) intonation and speech delivery; (3) grammar, vocabulary and lack of contextual information; and (4) style of presentation. The importance of different styles of self-presentation by patients as the reason for misunderstandings is highlighted. On only 3 occasions were culturally specific health beliefs raised.

CONCLUSION It is routine for GPs in inner London practices to manage consultations with patients with culturally different communicative styles from their own. Specific training in identifying these problems and preventing/repairing them in the consultation is essential. This level of awareness-raising is more crucial than general discussions of culturally different health belief models.

KEYWORDS referral and consultation standards; communication; multilingualism; cultural diversity; physician–patient relations; London/epidemiology.

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INTRODUCTION

Multilingualism is part of everyday urban life in most countries, and Britain is no exception. For example, 300 different languages are now spoken in London.[1] It is commonplace for people to manage aspects of their lives with limited English or to use a variety of English influenced by their first language. Teaching and learning about diversity, highlighted in recent policy documents,[2,3] is no longer the poor relation of medical education. Most innovations are concerned with raising awareness, changing attitudes and community activities.[4] To date, there has been less focus

Overview

What is already known on this subject

Medical teaching and training increasingly emphasises communication skills.

Training is usually modelled on consultations with fluent English-speaking patients.

Needs of patients with limited English/culturally different styles of communicating have not been systematically researched.

What this study adds

Language/cultural differences caused misunderstandings in 20% of consultations.

Four categories of 'patient talk' caused misunderstandings: pronunciation, speech delivery, grammar/vocabulary and culturally specific presentation styles.

Communicative style is a more important factor than culturally specific health beliefs.

More GP communication training needed.

Suggestions for further research

Similar research in other multilingual, multiethnic areas of the UK, and with other health professionals.

on specific communications strategies when consulting with ethnic and linguistic minority patients, and modules on diversity in the undergraduate curriculum are often taught separately from those on communication, and in abstract terms. However, the more general themes related to cultural values, respect, understanding and interpersonal relations need to be harnessed to specific consulting skills if patients from diverse backgrounds are to be fully involved in treatment decisions and if treatment is to be optimised.

Ideally, every patient would see a general practitioner (GP) who shared their dominant language[5] or would use an interpreter, but these options are limited by availability and cost. Even when available, the interpreter-mediated consultation can produce its own misunderstandings[6] and some patients prefer to communicate directly with their doctor.[7,8] What issues do doctors face when consulting directly with patients with limited English?

First, the effect of the 'language barrier' itself has to be understood. The issue of English language ability has been treated as an either/or matter, i.e. you either speak English or you do not.[9] Yet patients who do not speak a local or standard variety of English may be anywhere along a continuum of ability in terms of their accuracy, fluency, structuring of explanations and presentation of symptoms.[10] We need to understand how these 'language barriers' affect the consultation, but the available literature is conflicting. Some research is emphatic about language problems[6,11] while other research downplays them.[12] Practitioners may find consultations with limited-English speakers hard work. Language difficulties can lead to negative judgements and stereotyping,[13] as GPs view patients as 'difficult' through the prism of language difference.[14]

Secondly, the effect of culture is important. In the past, there was a tendency to discuss 'culture' in terms of static, culturally specific health beliefs separate from language. This position is now critiqued widely in both the medical and the socio-linguistic literature.[15–17] Despite some evidence of different health beliefs, research shows that western models of medicine predominate.[18] Rather than fixed health beliefs, it is the language/cultural issues concerned with relating to and representing illness to the GP[10,19] which cause misunderstandings.

A dynamic notion is needed which, first of all, aligns culture with language: 'culture and language are wired in together'.[20] In spoken encounters it is not possible to separate ways of talking from cultural assumptions: for example, how direct to be, how much background detail to give before the main point, whether interrupting someone is rude or friendly or what topics are permissable to discuss. These are matters of discourse or rhetoric which affect the whole climate of the consultation and are crucial to styles of self-presentation, which is the focus of this study. 'Language/culture' needs to be understood as *part of* action and interaction rather than standing outside them. Differences and similarities arise out of the encounter as it happens. It is not helpful to assume that just because a patient and a GP are from a different language and/or cultural background that

the consultation is, necessarily intercultural. Patients and GPs either 'talk themselves into an intercultural encounter'[21] or interculturality is simply not attended to.

We need to understand more about how these language/cultural differences combine to cause misunderstandings in the consultation, the consequences of such misunderstandings and how doctors and patients develop strategies for understanding each other. This study used discourse analysis of videos made of inner London GPs' consultations to identify ways in which patients, with different levels of ability in English and culturally different styles of communicating, managed the interaction. In particular, we aimed to identify the type and extent of misunderstandings that occurred as a basis for developing ways of training doctors to both prevent and repair them.

METHOD

Setting

The study was carried out in 4 inner London (one single-handed) practices, in Lambeth, South London.

Data collection

We video-recorded a random selection of 232 routine and emergency general practice consultations ($n = 19$). Where patient consent allowed, we recorded consecutive consultations in a morning or evening surgery. Patients' details were noted and patients were asked about their understanding of the consultation immediately afterwards. GPs viewed and gave feedback on selected videos. These data were used to inform the discourse analysis of the video recordings.

Analysis

All video-recorded consultations were viewed independently 3 times by 2 authors (CR and BM) and all identified misunderstandings, their causes, prevention and management were discussed, using categories developed for an earlier European study on language use by minority ethnic workers.[22] Thirty-seven consultations (16%) were transcribed, using transcription conventions from Interactional Sociolinguistics (see Fig. 1). These key consultations were selected from a range of language abilities and communicative styles, where significant misunderstandings had arisen. This paper focuses only on *patients'* talk and its potential for contributing to miscommunication.

RESULTS

We approached 294 patients, and 232 were filmed. Thirty languages other than English were reported as patients' first or dominant language. Thirty-one per cent of all consultations (71 of 232) contained clearly identifiable misunderstandings. Of these, just over two-thirds (52/71) were with patients with limited English. This means that over 20% of *all* consultations were with patients with limited English and contained major and often extended misunderstandings. There were only 3 references to culturally determined health beliefs.

Figure 1 Transcription conventions.

[word]	Simultaneous talk, when more than one person is speaking at a time
word =	Latching (one speaker following another with no pause)
(.)	Micro pause, less than one second long
(2.0)	Estimated length of pause of one second or more, to nearest 0.5 of a second
wor:d	Lengthening of a syllable
wor-	Word/syllable cut off before completed (e.g. false start, interruption)
{ }	Inaudible speech; brackets left empty
{word}	Unclear speech; brackets contain a guess at/approximation of what was said
((laughs))	Non-verbal communication
(word)	Talk overlaid by nonverbal communication
word	Stressed syllable
/word/	Non-standard pronunciation by patient represented in standard orthography

Misunderstandings

Misunderstandings occur whenever there is insufficient understanding for both parties to continue, or where there is the illusion of understanding which is only revealed as such later on, or where there are unresolved ambiguities. We also include social discrepancies where problems of sustaining social interaction lead to uncomfortable, disruptive or confusing moments – the notion of 'trouble' in interaction.[23] In these cases, there are no explicit misunderstandings but there is interactional evidence that the consultation did not go smoothly and/or either side was not able to convey their intentions clearly.

Our study does not include misunderstandings that only surface in *post-hoc* interviews with patients and doctors. Recent studies of misunderstandings in general practitioner consultations have focused on the unvoiced agendas[24] and on unknown and conflicting information[25] which was elicited after the consultations. This study examines problems of understanding and interactional mismatches which are evidenced in the consultations as they are happening.

Misunderstandings were much less frequent in consultations with local/standard English speakers. They tended to relate either to medical jargon or simple 'slips of the ear' and were usually cleared up within one turn of talk. A few less easily resolved problems with local/standard English speakers were with the confused elderly, depressed patients, patients with learning difficulties or drug users.

In consultations with patients with limited English, misunderstandings often led to protracted negotiations or either side 'glazing over' as words passed them by. They were usually caused by problems on several levels as in example 1:

Example 1: Passport

A Bangladeshi patient has come to ask his GP to sign his passport form.

1	D	black pen and this is for you M isn't it
2	P	yeah M B's my name
3	**D**	**how long have I known you B**
4		**(1.5)**
5	**P**	**my name**
6		**(..)**
7	**D**	**how long (0.5) how long do I know you for how many years**
8	P	oh:um (..) e::h 9 years (..) {come to the re-} I come to this country
9		in er (.) 1990(.) but [then I am]
10	D	[I saw you] in ninety: six
11	P	96
12	D	(0.5) ((counts on fingers of left hand)) 5 years I've known you
13		(.)
14	P	really

The misunderstanding and its resolution, in bold in this text, is clear from the patient's lack of relevant response in line 5. It may have been caused by a number of problems occurring simultaneously. First, at the phonological level, the basic processing of sounds: 'known' and 'name' were perceived as the same word (lines 2 and 3). Secondly, at the grammatical level, there was difficulty processing the form of the verb, 'have known' vs. 'do know' (lines 3 and 7). Thirdly, the expression 'how long?' is often confusing to limited English speakers because it encodes a metaphor of space (the idea of time as a long line of events) in a question about time. Fourthly, at the level of common-sense assumptions, a question such as 'How long have I known you' is relatively unusual outside bureaucratic contexts. Fifthly, at the level of institutional knowledge, the patient may well not appreciate that in order to sign the passport the GP must have known him for a minimum period. If, as in this example, this knowledge is not made explicit, then the patient has to make a large inferential leap to grasp the GP's motivation for asking the question. The location of the GP's question, immediately after he had established whom the passport was for and the patient had confirmed his name, tended to discourage any new inference. The patient was still in the frame of reference to do with naming and identity, whereas the GP had shifted to a new topic. In this example, the GP attempts to repair the misunderstanding by reformulating the question (line 7). He starts by repeating the question then hesitates and restarts, reformulating the verb form.

He then reformulates the question form so that the spatial metaphor is reworked more explicitly in terms of time (how many years). The patient then responds with a relevant answer. The patient's misunderstanding may have been caused by any or all of the factors mentioned above, in combination. However, the doctor deals with the patient's immediate problem of not being able to process the question term 'how long' and the present perfect form of the verb 'have known' because he needs an answer to this particular question.

Although any misunderstanding may be multicausal, as in example 1, for the sake of clarity, the different causes of misunderstandings are discussed separately. In real consultations, difficulties occur when there are a constellation of causal factors, and their occurrence, prevention and management need to be seen in this light. Also misunderstandings, like all interactions, are jointly produced. Although the misunderstanding may be initially experienced by one side, as in example 1, it has arisen out of their joint difficulties in negotiating meaning and its possible repair will involve work on both sides. But, again, for analytical clarity, we distinguish between misunderstandings which GPs face (the focus of the rest of this paper) which stem from what the patient has said, and those which patients face.

Four main categories of patient talk leading to misunderstandings by GPs were found: (1) pronunciation and word stress; (2) intonation and speech delivery; (3) grammar and vocabulary; and (4) style of self-presentation. We will illustrate categories 1 and 2 and then focus on the last of these.

Category 1: pronunciation and word stress

Pronunciation

In the following consultation with an Albanian patient there is confusion between /mit/ and 'meat'; /mince/ and 'mice'; /cow/ and 'coal'. She tries to explain to the doctor what she thinks is causing the rash:

Example 2: skin rash

A young Albanian woman has had a skin rash for several months and thinks it might be an allergy:

1	P	I think from /meat/ because
2	D	milk
3	P	/meat/
4	D	mit what is mit

Example 2: Continued

5	P	/meat/ ((laughs)) I don't know /meat/ erm
6	D	er
7	P	/mince/ I think
8	D	mice
9	P	yeah
10	D	like rat
11	P	yeah
12	D	you have mice at home
13	P	what do you – /mince/ no but/meat/ you know to eat erm I can't say in English
14	D	can you draw it
15	P	no I don't know how to /write/ this er
16	D	is it a food
17	P	eah food food I think from er from /cow/ you know
18	D	from
19	P	/cow/
20	D	coal?
21	P	no no /cow/
22	D	cow from cow
23	P	yes
24	D	ah beef
25	P	beef yeah
26	D	ah beef ah

Both sides work hard to understand the other but on three occasions, the different ways of pronouncing vowels: the short and long 'i' sound (mit/meat), the short 'i' sound and the /ai/ sound (mince/mice) and the different sounds of 'o' as in /au/and /ou/ (cow/coal) lead to quite a protracted clarificatory sequence. This includes a further misunderstanding at lines 14 and 15 when the doctor tries to repair the confusion by asking the patient to draw what she thinks is the cause of the rash.

Differences in word stress can also cause as many misunderstandings as pronunciation. This is particularly the case in patients' English, which is influenced by syllable-timed languages such as French, many West African languages and Caribbean Creoles. This means that each syllable occurs at regular intervals rather than in local or standard English where each stressed syllable occurs at regular intervals. For example, a patient from The Gambia speaks about bathing in Dettol, stressing each syllable equally and the GP does not immediately understand the reference. Differences between stress-timed and syllable timed languages also affect the rhythm and intonation of different varieties of English.

Category 2: intonation and other features of speech delivery

The tunes, rhythm and stress in speech help to chunk information into units, distinguish what is important, make the contrast between given and new information and establish speaker perspective. These are all important features of communicative style and differences in style make it difficult to process the other's meaning. One frequent cause of misunderstanding is the difference between the way in which standard/local speakers of English and other speakers of English show emphasis and contrast, to make a point or a correction. In local/standard English this is routinely achieved through contrastive stress, e.g. 'did you go this week?' 'No, last week'. In the next example, there is an ambiguity which is not resolved because the patient's use of contrastive stress is different from the doctor's. The patient's English has many characteristics of Nigerian English.

Example 3: dog bite

1	D	what kind of dog was that (.) it was somebody's (.) [dog]
2	P	[yes] somebody's
3	D	it was a stray dog
4	P	no no it was somebody's dog
5	D	right
6	P	yes I:: made an enquiry they said that – **they they told me**
7		**the dog go to the vet regular**
8	D	right okay
9	P	**but that's what they said**
10	D	right (.) right right so did you know the owner or [did]
11	P	[I] know the owner =
12	D	= oh fair enough (.) so
13	P	**erm:: ((laughs)) (but)**
14	D	did you see any doctor then
15	P	no

The patient was bitten by a dog when on holiday in Nigeria and the GP explores whether a rabies vaccination is necessary (lines 1 and 3). Told that the dog reportedly sees a vet regularly (lines 6–7), and the patient knows its owner (line 11), the GP appears satisfied the evidence is authoritative – he says 'oh fair enough so' (line 12). Later in the consultation he suggests to the patient that a vaccination is not indicated. However, the patient implies that he is not convinced that the dog is free from rabies ('they told me the dog go to the vet regular but that's what they said'; lines 6, 7 and 9). In British English, contrastive stress to convey this suspicion would emphasise the *verbs* 'told' and 'said': 'they told me the dog goes to the vet regular, but that's what they said' (implication: and not what they actually do). Instead, the patient's intonation system focuses on the *agent* (the acquaintance, 'they'), and the *content* of the agent's utterance – the 'what'. The patient hints at his sceptical perspective by using the word 'but' twice and at line 13, by the use of a hesitation marker and laughter. Yet the difference between the participants' intonation systems means the hint is not consolidated categorically and the matter remains unresolved. Just as in example 1, we showed that misunderstandings can be multicausal, we see here that conveying a clear message also relies on a number of features of speech delivery. Words alone do not convey intention. Intonation is central to meaning making. Where different intonation systems meet, misunderstandings and ambiguities may result.

Category 3: grammar, vocabulary and lack of contextual information

- Vague language, juxtaposing key words with little syntactic 'glue', wrong use of pronouns/key words
- Markers of time
- Misleading use of 'yes' and 'no', e.g. 'yes' response to 'You don't mind?

Category 4: style of self-presentation

- Low self-display
- Different ways of structuring information
- Topic overload and recycling
- Overlapping/interrupting talk

We will illustrate this fourth area in more detail. This level of talk caused more protracted, general and unresolved misunderstandings than the other three levels because it was more difficult for the participants to assess where the problem lay. Patients and GPs ended up talking past each other but not knowing quite why. These self-presentation styles resulted from some or all of the first 3 categories above, where basic problems of trying to process meaning can occur, together with different ways of structuring information and managing the interaction. These in turn depended upon different sociocultural assumptions about how to communicate with others. Patients drew on all these resources to make what was, for them, a persuasive piece of self-reporting.[26] However, the conventions patients used may have been at odds with the GPs' expectations.

Style of self-presentation

Low self-display

Some patients said little, but handed over a letter, some pills or even empty bottles and jars to show what their diet is like, and waited for the GP to infer the problem. This behaviour has been noted in other institutional encounters with South Asian participants[27] and may reflect assumptions that the consultation is a hierarchical encounter in which doctors are invested with considerable power, including the power of diagnosis from very little patient-given information. Low self-display may also be part of patients' resourcefulness in trying to prevent misunderstandings by compensating for their limited English with documents and artefacts.

Different ways of structuring information

Long stretches of talk appear loose and not cohesive, and can leave the GP focusing on the words/phrases

Example 4: social security

A Sylheti speaker from Bangladesh in his 60s has come to find out about social security payments while he is on sick leave:

1	D	have a seat (2.5) right
2	P	{see} I'm coming ask er – for er I used to work{ing} part-time
3		(0.5) ((looks at doctor))
4	D	yes
5	P	and er at the moment I couldn't work since last week because I feel very weak
6		(.) and I was loo– er losing blood
7	D	losing blood =
8	P	= yeah and er the toilet was {quite a} long time and I going in to hospital for
9		erm (1.0) er 15 of this month [this is] ((hands letter to doctor))
10	D	[thank you]
11	P	the letter which tells also [doctor M –]
12	D	[why] ah I see so you've been referred to have a
13		test
14	P	and further testing and er it doesn't get any better
15	D	mm
16	P:	you see I don't get any better actually its its still (.) the same
17	D	mm
18	P	I don't have it s– er since 3 days
19	D	mm =
20	P	= and just eating er vegetables you know this water and er {whatsoever I
21		cooked} see from e:r (0.5) our country
22	D	right =
23	P	= s–
24	D	from your home and where is your home (.) where are you [from]
25	P	[er] well from Bangladesh
26	D	right yeah
27	P	so this is er my wife s- she cooks
28	D	she cooks all =
29	P	= and [er]
30	D	[of] the food yeah
31	P:	you know (.) but (.) sometime OK sometime (.) it's worse
32	D	[mm hm]
33	P	[you know] you can {bring different people} food all the time
34	D	I see
35	P	so (.) at the moment (.) I'm really am worried about myself I don't know
		happening =
36	D	= right
37	P	nearly 3 month now
38	D	3 months
39	P	yes [3 months]
40	D	[you've been] = losing blood
41	P	yeah =
42	D	= yeah

that they could understand and ignoring the rest. As a result, irrelevant topics (at least for that consultation) became the focus.

In a study of the opening moments of the consultation, a clear contrast can be seen between local/standard speakers of English and other patients.[26] With the former, the initial self-presentation consists of brief context-setting alongside the description of symptoms. Speakers of other varieties of English often either give no context at all or, as the case with example 4, spend the first few minutes of the consultation setting the context without making clear the main reason for the visit: obtaining a letter from the doctor so the patient is able to claim benefits.

The patient explains that he used to work part-time (line 2), then pauses, apparently waiting for the GP to infer what his problem was and respond. (This is an example of low self-display discussed above as it is the only occasion at which the patient pauses for any length at the end of an utterance until the GP has responded.) But because he has presented very little of himself or the problem, she, in turn, waits for more. He then outlines symptoms and presents his referral letter. Because of the way he structures his self-report, both at utterance level and at the more general level, the GP picks up on the medical theme and on medical words such as 'losing blood' (line 7) and on the 'letter' (line 11) but is no nearer appreciating the reason he has come. The patient stresses the words 'weak' and 'blood' (lines 5 and 6) rather than 'work' which, later, transpires to be his main concern. Doctor and patient then became mired in the background detail of the case and cannot find a mutual way of clarifying the main reason for his visit, because the very language resources they both use only helped to create more uncertainty. Even after two-and-a-half minutes, they are no nearer agreeing the purpose of the consultation. It is not until nearly 3 minutes into the consultation that the patient mentions social security and it is a further 9 minutes before they agree that the form which the doctor has signed is adequate 'proof' for social security that the patient is sick and should be on benefits.

Although there are no explicit misunderstandings, when viewing the video later the doctor indicated that she was quite uncertain as to where this consultation was going and she had difficulty processing the intonation and unusual syntax of the patient whose English was strongly influenced by his first language. There is evidence of these difficulties in the data. There are long linear phases when the patient speaks and the doctor gives minimum listening responses such as 'mm'. She occasionally picks up on items of information such as blood, his country, the cooking. This repetition or restructuring of his words serves as a 'go on' function so he then gives more context. This style of structuring information so that the context or comment comes first and the main point or topic comes later is widely used in South and East Asian languages[28] and contrasts with English and other western languages, where the main point is usually near the beginning and then supported by further context.

Topic overload and recycling

A very different way of managing the interaction also causes problems for GPs. A common pattern in our data was 'topic overload', where the patient brought 4 or 5 topics, many of them apparently unrelated to the consultation. For example, a Portuguese speaker introduced 5 separate topics: blood tests, thinning hair, itching, pain in the palms of her hands and her child's possible urinary infection. It is not uncommon for local/standard speakers of English to bring multiple agendas to the consultation. However, this was a more common occurrence with patients with limited English and it was *how* the topics were introduced and then managed by this latter group which caused difficulties.

Often these topics were introduced with few or no cues that this was a new topic, and before discussion of an earlier complaint had concluded. In some cases this did not cause an overt understanding problem, but it created misunderstandings in terms of what the GP was prepared to cover in the consultation.

Overlapping or interrupting talk

This category is closely associated with the 'topic overload' just mentioned. Speakers often talk at the same time, and this does not always constitute 'interruption'. Sometimes, talk can be 'overlapping', and is used to indicate engagement or agreement by the overlapping speaker. A common pattern in our data was for the GP to begin an explanation or try to offer reassurance, for example, by generalising or normalising the complaint: 'Lots of people get this when…'. The patient would then begin to speak simultaneously, either to start a new topic, or to give a further description of a complaint which the GP had apparently dealt with, or to answer a question asked some way back in the consultation. Example 5 illustrates both the topic overload and the simultaneous (overlapping or interrupting) talk – both indicated by the '[' symbol.

Example 5: dust mites

An elderly Italian-speaking woman has several problems including: thinning hair, a dust allergy and pains in her joints:

1	D	yes so (.) I think the next step is to: get you to see the: skin specialist
2		who deal with problems of the hair (.) [and]
3	P	[yeah]
4	D	em ask their opinion (.) would you be happy to go and see the
5		spe[cial]ist
6	P	[yes] (.) please darling [yeah]
7	**D**	**[yeah] cos [I think]**
8	**P**	**[I– I] sneezes (.) lot I sneeze lot**
9	D	you sneeze a lot (.) (ri:ght)
10	P	((laughs)) cos [er]
11	D 0.	[that's] something different is it

.....

(later in the consultation)

12	D	it's the– to do with the joints
13	P	[ah the joints]
14	D	[and as] we get a bit older they get a bit [worn]
15	P	[gett]ing old too no
16	**D**	**older ((laughs)) but it's erm (.) it's really important to:**
17		**erm (.)**
18	**P**	**and [the– the– (.) listen this this this er]**
19	**D**	**[keep your fingers moving (.) do some exercises]**
20	**P**	**this dust mite is e:r (.) is danger for the house you know**
21	D	it's not dangerous no: it's nothing (.) that will do harm to your h- home

In the first part of the example, the GP begins to explain why she thought a referral to a specialist is needed (lines 1 and 2) and the patient overlaps her in agreement and acknowledgement twice (lines 3 and 6). These overlaps do not lead to any discomfort or loss of information. The patient then interrupts (line 8), with a new topic: sneezing just when the doctor starts her explanation of why it would be useful to see the specialist. The GP acknowledges that this is a new topic at line 11 (that's something different is it) but is unable to finish her explanation. In the second part, the GP begins to explain the importance of exercise for painful joints and again the patient overlaps twice (lines 13 and 15). Her overlap at line 15 when she takes up the theme of getting older means that the crucial notion of joints being 'worn' is not attended to. She then interrupts (line 18), re-introducing the topic of dust allergy and cutting off the doctor's recommendation to exercise her fingers. The 'trouble', therefore, is that the doctor's explanations, suggestions and reassurances never get properly voiced. So, here it is not a matter of patients' unvoiced agendas but of doctors'.

Frequent overlapping speech is considered in some languages and language varieties to be a 'high-involvement' style[29] and to show friendliness and politeness. By contrast, patients may interrupt because they do not understand or see the point of GP explanations and reassurances, particularly if they are expressed in somewhat abstract and general forms. The upshot is that although the patient may have voiced all her agendas, the general practitioner is left not knowing whether the patient understands the reasons for the medical decisions made and the recommendations for self-help.

DISCUSSION

Twenty per cent of *all* the consultations we filmed contained misunderstandings caused by language/cultural differences, where talk itself is the problem. These misunderstandings related to issues of language and self-presentation rather than culturally specific health beliefs. This challenges the literature on culture and ethnicity which exoticises patients from linguistic minorities.

Communication textbooks include sections on how to help patients understand what *GPs* say (usually by avoiding medical jargon), but do *not* deal specifically

with how GPs themselves can understand what *patients* say. In a typical morning or afternoon surgery in Lambeth, South London, a GP may have to consult with 6–8 patients with different language/cultural backgrounds. Many of these patients speak English as a foreign language and their English is strongly influenced by their first or dominant language. Others come from countries where English is an official language and is used as a lingua franca – for example, the countries of West Africa, the Indian subcontinent, Singapore and the Philippines. Their English is often fluent but there are differences in pronunciation, stress, intonation and ways of structuring their talk which GPs may have difficulty processing. The consequences are clear to see in the detail of doctor–patient interaction: simple elicitations can lead to protracted clarification sequences which extend the length of consultations (as in example 2); less easily identifiable differences in communicative style can lead to uncertainty (example 3) and potential frustration on either or both sides (examples 4 and 5). The difficulties in struggling to understand such a variety of patient styles and accents was commented upon by GPs in video feedbacks, and when we presented to GP groups.

Communication textbooks exhort doctors to encourage more talk and to listen better, but such prescriptions are modelled on monolingual, monocultural consultations, where ordinary talk itself is not the problem. GPs need to make rapid assessments of patients' competence in English; they need to acknowledge the difficulties patients may have in communicating in English and the resourcefulness that patients display in attempting to convey their intent in limited English; they also need to accept that patients may have a systematically different way of presenting themselves and relating to the doctor; and they need to develop strategies for preventing and managing misunderstandings. Although there is now much debate and many recommendations relating to working in an ethnically diverse society,[30,31] education and training communication programmes have not developed more linguistically sensitive and culturally flexible approaches for the thousands of consultations, every day, with patients who do not speak a standard or local variety of English.

The conventional wisdom of communication textbooks also focuses too narrowly on GP behaviour without considering how patients can change/challenge the consultation. For example, there is often a focus on how patients may have problems of understanding and/or feel 'disconnected' from their GPs. In our data, the converse is also often true. GPs have difficulties understanding patients, and attempts at 'lifeworld'[32] explanations and social chat become closed down by the patients (as in example 5). These 'looking-glass' experiences, combined with the general feeling that patient and doctor are 'talking past each other', can increase stress for both parties.

General exhortations to listen to and respect patients are not an adequate response to the demands of a multilingual patient population. Interventions which encourage students to work closely with minority community groups are one way of raising awareness and providing a context for developing new skills.[33] A complementary approach, and one which helps students and GP registrars to develop a new analytical language for discussing and developing skills for intercultural communication, is through video analysis. We have produced a video, 'Doing the Lambeth Talk', using examples from our research data (and not simulations or role plays) which provides trigger material for understanding misunderstandings and gives examples of how these can be prevented and repaired. It also gives an opportunity for those who are unfamiliar with the varieties of English which they meet in their practices to 'tune in' to some of the systematic differences in language and style which they may encounter.

This study provides suggestive data indicating that language/cultural issues in general practice are not simple and need to be higher on the agenda in multilingual urban areas. It has also shed light on the range of misunderstandings which doctors can encounter, despite some patients' resourceful attempts to produce convincing self-reports. Finally, the practical implications of widely accepted patient-centred models, based on the assumption that more talk is more patient-centred, may need to be re-examined in the light of this study.

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