Who is talking now? Role expectations and role materializations in interpreter-mediated healthcare encounters

Short title of the Article (for running head): Who is talking now?

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Who is talking now? Role expectations and role materializations in interpreter-mediated healthcare encounters

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Abstract

Complex layers of meaning accompany conversations about illness and medicine in medical encounters. The complexity multiplies in multilingual healthcare interactions when interpreters are asked to bridge the cultural communities of the provider (and medicine) and the patient, not only by interpreting the languages used, but also by taking on different roles, coordinating talk and facilitating answers to questions that providers and patients raise as they communicate with one another. A sub-set of three segments of interpreter-mediated authentic interactions (n = 392) are presented, to explore the provider and healthcare interpreter's responsibilities and challenges in constructing and co-constructing meaning in conversations about healthcare information. Findings suggest that interpreters do not volunteer to take on roles above and beyond that of interpreting. Instead, they are instructed to take on other roles which may not necessarily be aligned with their background or professional practice (e.g. explore medical history, explain the value of ratings on a pain scale). This study has implications for providers

and interpreters in regards to responsibility and ethics when communicating with patients who do not use societal languages.

Keywords: agency; coordination of talk; ethics; healthcare encounter; interpreter; responsibility; role

1. Introduction

Patients seeking care, providers supplying it and interpreters brokering communication about it may not share expectations about each other's roles, the encounter and the type of knowledge/information transmitted. In addition, co-participants in a healthcare interaction may not share beliefs and practices related to health, diseases, the body, life or mortality. When they come together for a healthcare consultation, a new and cross-cultural community emerges through communication. One may think that responsibilities and roles in this newly formed cross-cultural community mirror those found in a healthcare encounter in which only two interlocutors take part.

This paper investigates the roles and responsibilities in the co-construction of (mis)understanding among patients, healthcare providers and interpreters (Angelelli 2014). Specifically, it aims to shed light on the issues that arise when providers share control of the medical consultation with the interpreter, causing role shifts and blurring role boundaries. After a brief overview of the research on healthcare interpreter-mediated interactions I present segments of provider/patient interactions that illustrate issues faced by interlocutors who engage in communicating health-related information across languages and cultures. I then discuss issues of roles and responsibilities and their implications.

2. Literature review: Interpreter-mediated consultations

The assumption of interpreter's non-intervention in communication (Dysart-Gale 2005) is challenged by examining the participation of interpreters during interactions. Studies show that interpreting is a special case of coordinated interaction (Wadensjö 1998; Baraldi and Gavioli 2012), a discourse process (Roy 2000) in which interpreters are co-participants who share responsibility in the talk (Wadensjö 1995) by exercising their agency as they make decisions in the context of their work (Angelelli 2004b). Research on interpreting from cognitive, linguistic and sociolinguistic perspectives help us understand this complex communicative event (De Bot 2000; Paradis 2000; Roy 2000; Sawyer 2004; Russo 2011). Well-documented studies of interpreters in the hospital (Metzger 1999; Davidson 2001; Angelelli 2004a), in the courtroom (Berk-Seligson 2002; Hale 2004), in educational settings (Roy 2000; Valdés *et al.* 2003), in the police station (Berk-Seligson 2009) and in the immigration office (Wadensjö 1995; Hsieh and Hong 2010; Arias-Murcia and Lopez-Diaz 2013; Pollabauer 2017) show that interpreters interact with the parties for whom they facilitate communication by deploying a variety of strategies as they do their work (Wadensjö 1998: 106–108).

Angelelli (2004a: 79–103) has studied a series of strategies interpreters use while facilitating talk in the healthcare setting. She also explores the social factors (such as age, ethnicity, gender, socio-economic status, race) triggering interpreters' participation which result in higher and lower degrees of 'visibility' (exercise of agency) of the interpreter in interactions (Angelelli 2001, 2004b: 68–82). Examples of this are interpreters perpetuating or brokering power differentials between patients and providers, exploring answers, sliding messages up and down the register scale, bridging cultural gaps, expressing affect as well as content and, in some cases, even replacing monolingual interlocutors (e.g., when the doctor tells the interpreter to

explore the patient's pain or engage in medical history taking rather than to interpret). As visibility increases, the interpreter's role becomes highly consequential, as it impacts the quality and quantity of information communicated during an interpreted communicative event (ICE) (Angelelli 2004a: 78). It also impacts the provider–patient relationship.

Research also shows that providers and patients have expectations about the interpreter's role: 'For healthcare providers, the interpreter is the instrument that keeps the patient on track; for the patient the interpreter is a co-conversationalist' (Davidson 1998). In a cross-linguistic medical encounter, healthcare interpreters are responsible for facilitating talk between patients and providers who do not share a language or culture.

The difficulties in constructing reciprocal understanding between patients and providers may become magnified when working with linguistically diverse patients. As we will see in the examples below, responsibilities may not always be assumed, role shifts may occur and sometimes are even requested.

3. Data and method

The three ICEs studied here are a subset of a corpus consisting of 392 Spanish/English interpreter-mediated consultations (audio-recorded and transcribed) that were collected at California Hope (all names of organizations and persons are fictitious, to protect the identity of the participants) for an earlier study (Angelelli 2004a). The data were collected in accordance with the tradition of ethnography (Fetterman 1998), and as the sole researcher I was responsible for this and for interaction with participants during observations and interviews. I gained entry to the site and the confidence from the participants by spending a significant amount of time (nine months) getting acquainted with the site and the participants, shadowing interpreters, meeting

providers and patients and building trust. All permissions for data collection and protocols for the protection of human subjects were sought and approved both at the field site and the university I represented (see Appendix for transcription conventions).

Ten Spanish/English medical interpreters, together with Spanish-speaking patients (representing female and male, elderly, adults and youngsters – including children), English-speaking healthcare staff (representing physicians, nurses, lab technicians, diabetic educators, to name just a few) and hospital administrators (managers, receptionists) took part in this study. The interpreters are staff members at CH. To be employed, interpreters had to pass a test of medical vocabulary, memory and interpreting skills designed by the Interpreting Service manager. They work eight-hour shifts and interpret face-to-face and over the telephone.

At CH, patients and providers are used to remote interpreting services. The rule is that interpreters work remotely from their cubicles in the Language Services Unit and providers or patients can request to have face-to-face interpreting through bookings. From the corpus, 97% of the ICEs are remote. Even though the interpreters were physically present in the hospital (they worked from a trailer on the campus), the high percentage of remote ICEs is the manager's strategy to optimize the use of interpreting. The segments selected for this analysis allow us to explore how control over the information requested/provided during the medical encounter is, or is not, retained by healthcare providers during the interpreted medical encounter. Observing, recording and transcribing these encounters, we may identify behaviors such as giving directives to the interpreter to do or not to do something (e.g. 'ask her about chronic illnesses, diabetes, all that...') rather than communicating directly with the patient and having the interpreter do his/her job. In this example the unpacking of 'all that' is done by the provider for the interpreter, rather than by the interpreter himself; the questions generated by the provider would be meaningful in

his/her exploration of the situation, rather than expecting or relying on the interpreter's educated guess. The segments from the encounters exemplify typical provider/patient interactions during the exploratory phase of a medical encounter (Heritage and Drew 1992; Teas Gill and Maynard 2006) at CH. They also align with other reported studies in medical settings (e.g. Wadensjö 1995; Metzger 1999; Bolden 2000; Davidson 2000; Baraldi and Gavioli 2012; Meyer 2012; Gavioli 2012).

4. Data analysis

This section discusses three segments of medical interviews. They are typical of interpreted-mediated encounters at CH.

4.1. Medical-history taking (Segment 1)

Segment 1 comes from an interview between an elderly Spanish-speaking female patient (P) of Mexican origin and a middle-aged female Caucasian nurse (N) who are face to face in a cubicle with a speakerphone. They are joined remotely by Vicente (I), a staff interpreter from the Language Services Unit at the hospital. Vicente was born in Peru, but had lived for most of his life in Romania, where he became a physician, and at the time of the encounter he had been a staff interpreter at CH for15 years. In Excerpt 1, the nurse needs to find out if the patient has any chronic illnesses. She does not ask the question directly to the patient. Instead, she asks the interpreter to find out the information for her. The request does not contain specific information. Vicente agrees to do so. None of the questions asked by Vicente are given to him by the nurse.[1]

Excerpt 1: I = Interpreter; N = Nurse; P = Patient

1	N:	Can you ask her about chronic illnesses, diabetes… all that?
2►	I:	*Ahá. Señora Mesa, ¿alguna vez dijo el doctor, aunque sea veinte años atrás, aquí o allá, que tenía usted diabetes*? (Mrs. Mesa, has a doctor ever told you even twenty years ago here or there that you had diabetes?)
3	P:	No.
4►	I:	*¿Que tenía la presión alta?* (That you had high blood pressure?)
5	P:	No
6►	I:	*¿Que tenía alguna enfermedad al corazón?* (That you had heart disease?)
7	P:	Noooo
8►	I:	*¿Que era enferma del hígado?, ¿De los riñones? ¿Del estómago?* (That you suffered from liver problems? Kidney problems? Stomach problems?
9	P:	No
10►	I:	*¿Alguna vez la operaron, la internaron? ¿Allá o aquí?* (Have you ever been operated on or hospitalized? Here or there?)
11	P:	Noooo
12►	I:	*¿Nunca ha estado usted enferma?* (You have never been sick?)
13	P:	*Esteeee si estuve enferma pero… es deeee depresión nerviosa, no de otra cosa* (Well… I was sick but ….it was de…nervous depression…I did not suffer from anything else)
14►	I:	*Okay… y la internaron por la depresión nerviosa?* (Okay, and were you hospitalized for nervous depression?)

15 P: *Sí…*

(yes)

16 I: *¿Allá o aquí?*

(Over there or here?)

17 P: *Esteee…emmm…en Azusa…*

(hmmm..in Azusa)

18 I: *¿en dónde?*

(Where?)

19 P: *Azusa… cerca de Los Angeles*

(In Azusa, near Los Angeles)

20► I: Ya…she is saying that she denies diabetes, denies cardiovascular disease, denies blood pressure, denies eh… problems with her stomach and her liver…she said that she was… denies surgery…she was admitted once eh… close to Los Angeles…ehmm… for depression

21 N: Okay.. but she does not take any medicine now?

22► I: *Señora ¿está usted tomando alguna medicina estos días?*

(Ma'am, are you taking any medicine these days?)

23 P: No

24► I: *¿Alguna medicina que compró sin receta?*

(Any over-the-counter medicine?)

25 P: No

26► I: *¿Que trajo de allá, que le dio la comadre Juana?*

(that you brought from there, that Comadre Juana gave to you?)

27 P: *No, nada*

(no, nothing)

28► I: Negative…negative

29 N: Okay, all right… sounds just like she has the blues… her lungs are clear, she is breathing fine and her color looks good I'm gonna check her oxygen saturation and then probably send her home with advice and give her the number to call…

30 I: *Okay…Señora dice nuestra enfer*

[

*(*Okay…our nurse says

31 N: [I'll be right back

32 I: *[mera que le ha escuchado los pulmones y suenan bien…*

*(*that she has heard your lungs and they are fine…)

33► P: *Síiií*

(Yeees*)*

34 I: *Dice que su color está bien… que . . . le va a medir el oxígeno de la sangre*

(that your skin color looks fine …that… and that she will measure the oxygen in your blood)

35► P: Okay

36► I: *Eso no duele… le va a poner una lucecita en uno de sus dedos solamente por un minuto y después la manda a su casa con unas recomendaciones.*

(That doesn't hurt…and she will put a little light in one of your fingers during one minute and then she will send you home with advice)

37 P: Okay

(Extract taken from Angelelli 2004a: 94–96)

The nurse does not retain control of the encounter when she addresses the interpreter rather than the patient and directs him to ask the patient about chronic illnesses, diabetes and 'all that' (turn 1). Vicente, the interpreter, not the nurse, does the exploration of the medical history. At turn 2 he starts by addressing the patient by her name and asking her to think back to conversations she has had with her physicians over the last 20 years, both in the US or in Mexico. Vicente does not translate the term 'chronic illness' (turn 2) as '*enfermedad crónica*' but gives a couple of examples to the patient, such as diabetes (turn 2) and high blood pressure (turn 4). Then Vicente shifts register and continues to explore chronic illnesses by naming illnesses after organs that may be affected, such as '*enferma del hígado, de los riñones, del estómago*' (liver problems? Kidney problems? Stomach problems?, turn 8). In his exploration, the interpreter inquired about hospitalization and surgery, and he specifically asked if this has taken place in the country or *allá*', meaning where the patient is coming from or going back to (turns 10, 16). He also asked about medicine intake, expanding from prescribed medicine to over-the-counter or traditional/folk medicine (turns 24, 26). We can see the interpreter unpacking the term 'chronic illnesses' and breaking it down into parts for the patient. The one-line question asked by the nurse in turn 1 is answered with a summary of illnesses and hospitalization (turn 20) and then on medicine intake (turn 28).

Interpreters may or may not be familiar with the protocol used by nurses to explore chronic illnesses; or, an interpreter may be a physician in his own country (as Vicente is) and in following this directive from the nurse, he may ask questions that could be similar or different from the protocol at CH (resulting in unintentional changes to the standard protocol for exploring chronic illnesses); or the interpreter may take an unnecessarily long time, and then report a summary that may not justify the time involved as the nurse is not informed about the details

expressed during the many turns in which she did not participate. These potential outcomes have implications and raise the questions: Who is in charge of obtaining the information? Who is responsible for framing the questions to obtain it? Who is responsible for communicating it to the patient?

It would be tempting to hold the interpreter accountable for stepping out of role (turns 2–20, 24 and 26), taking over the interview or accepting a responsibility that he should not have (turns 32–38). A more mindful look and a more critical approach would turn the tables and see the provider as the party who steps out of role (turns 1 and 21) to become a spectator rather than an actor, using the institutional power she holds (Fairclough 2013) to give directives to the interpreter either explicitly (turn 1) or implicitly (turn 21). Another reading would raise the question of which of the two approaches (i.e. exploring or not exploring the geographic displacement (turns 2 and 10) or the alternative medicine intake (turns 24 and 26), would elicit the required information for the case in hand. Regardless of the approach, in the instances discussed, both the interpreter and the provider (not the patient) share responsibility in how they organize the talk (turns 1, 2–20, 21, 22–28 and 29–36).

4.2. The explanation of a procedure (Segment 2)

Excerpts 2 and 3 come from a meeting between Ramira (P), a 39-year-old Mexican female who is in her second month of pregnancy, and Ellen, the genetic counselor (N) who is here to inform Ramira about the different tests available for a pregnant woman of her age. Annette (I), the Spanish-English middle-aged female interpreter, is working remotely. She has been at CH for six months and previously worked as court interpreter. The interview has a total of 207 turns and

lasts 35 minutes. In Excerpt 2, we join the conversation at turn 21, as Ellen explains to Ramira why she was referred to genetic counseling.[2]

Excerpt 2

21	N:	OK. The reason why Ramira was referred to see me ehmmm it's because of her age of 39 years
22	I:	El porque que le recomendaron que se viera con la señorita esa es debido a la edad de usted de 39 años */The reason why you were advised to see this lady is that due to your age, 39 years/*
23	P:	Sí… así es . . . */yes, that is so/*
24	N:	OK. For all women who are 35 years and more, we offer certain genetic testing to see if the baby could have . . . a problem such as down syndrome or… mongolism . . .
25	I:	Dice para todas las mujeres que sean de 35 años y mayor (sic), que estén embarazas, ofrecemos varios estudios para verificar . . . si sus hijos . . . que esté encargando, verdad. . . */She says that for all women who are 35 or older, who are pregnant, we offer several studies to verify . . . if the children . . . that you are expecting. . . right. . . /*
26	P:	Sí */yes/*

27 I: puedan tener posibilidades de sufrir de síndrome de Down, o sea de mongolismo y algunos otra . . . cosas que . . . suceden por la edad

/may suffer from down syndrome, that is mongolism, and some other things that are caused by age/

28 P: Sí… esteee…… precisamente…. Ayer el doctor de allá de Monroe… me mandó a hacerme… a que me sacaran para hacerme el estudio para el mongolismo

/yes. . . ehmm. . . precisely . . . yesterday the doctor in Monroe . . . sent me to . . . so that they would draw from me to have the study on mongolism done/

29 I: OK Pero. . . ¿fue de sangre o de qué m'hijita?

/OK but . . . was it a blood test or what kind of test my dear?/

30 P: De sangre

/blood/

31 I: OK She said yesterday her doctor sent her for a blood test for that

32 N: OK. The blood test and this test are two completely different things. The blood test is only what we call a screening test…ah… and it is called the AFP blood test

33 I: Dice, estos estudios son completamente diferentes. Dice el estudio de sangre es un estudio que se llama la prueba fetal de proteína alfa, ¿verdad?… que es para determinar si hay proteínas… niveles de proteínas producidos por el feto en exceso de cierta cantidad

/She says that these are two completely different studies. She says that the blood test is a study called alpha protein fetus test, right? And it is to

determine if there is protein, the level of protein produced by the fetus over a certain amount/

34 P: S…

35 I: Go ahead

36 N: OK. So, I'm here right now to offer her this amniocentesis test, because this test is accurate. This tells you for sure if the baby could have a chromosome problem or not

37 I: En este momento ella está ofreciéndole el estudio amniosintesis porque es un estudio que le puede decir claramente si su bebé vaya a tener síndrome de Down o no

/At this time she is offering you an amniocentesis test because it is a study that can clearly tell you if your baby is going to be a Down syndrome or not/

38 N: So, what I'm gonna do is explain the whole test to both her and her husband … her husband's here…and… then they need to let me know whether or not they'd like to have this test today

39 I: Y lo que ella va a hacer ahora es explicarle a ustedes, a usted y a su esposo, que está también presente, ¿verdad?/

/And what she is going to do now is explain to you, to you and to your husband, who is also here, right?[

40 P: Sí[

/yes/

41 I: [cómo va este estudio y para qué, … y entonces ustedes pueden decidir si quieren hacer el estudio hoy o si no. ¿Está bien?

/what this test is about, what is the purpose, so that you can decide if you want to have this test or not. Okay?/

42 P: Sí, está bien

/yes, that is fine/

43 I: Go ahead

Unlike the previous example, in this interaction the provider seems to be responsible for the information offered to the patient. But, as Ramira shares the information she has received previously about these tests (turn 28), the pattern starts to change. Annette does not relay that information to Ellen directly for her to explore further. Instead, she decides to interrupt Ramira and asks for specifics (turn 29). The way in which Annette addresses Ramira ('my dear', turn 29) shifts from interpreter to co-counselor. Ellen regains control of the interview and explains the differences between the blood test and the amniocentesis test (turns 32, 36 and 38). Ellen divides the information into smaller units and checks for comprehension on the part of the patient. This forces Annette, the interpreter, to stay close to Ellen. The counselor continues with the explanation of the amniocentesis test that she started atturn 36 and makes clear it is optional (turn 38). In Excerpt 3 the conversation begins to break down when the needle is mentioned (turn 49).

Excerpt 3

44 N: OK. The way we do this test is first we do an ultrasound so see how many months pregnant you are and to find a safe place to insert the needle

45 I: Primero, la primerita cosa que hacen es un estudio ultrasonido, ¿verdad?[

/First, the first thing to do is an untrasound, right?/

46 P: [Sí

/yes/

47 I: [para determinar cuántos meses tiene usted de embarazo[

/to determine how many months you are into the pregnancy/

48 P: [Sí[

/yes/

49 I: [y para ver en qué posición es mejor insertarle la aguja

/*and to know exactly the position into which the needle has to be inserted/*

50 N: Now… she's shaking her head…she doesn't need to have the test but I just need to explain it to her

51 I: Dice. . . usted no tiene necesidad de recibir el estudio… lo que ella sí tiene obligación de explicarle

/She says . . . you don't have to have this test done. . . but she has to explain it to you/

52 P: Sí

/yes/

53 N: OK. When we insert the needle… I … don't know but they are trying to say something… I don't know what that is

54 I: ¿Qué fue?

/What's that?/

55 P: Es que lo que pasa es que me está mostrando aquí en una… en un dibujo[

/What happens is that she is showing to me on one. . . drawing/

56 I: [Aja?

57 P: [este. . . uno que le están metiendo la jeringa al bebé

/ehmm. . . it is a drawing where they are inserting the syringe to the baby/

58 I: No es al bebé. . . pero parece[. . . Yo sé cómo dice

/no, it is not to the baby, but it looks like it, I know what you mean/

59 P: [O sea. . . es a la matriz. . . o sea dónde está él

/I mean… to the womb . . . or where the baby is/

60 I: Sí. . . es para sacar un poco de líquido que le rodea al bebé

/yes, it is to get some of the liquid that surrounds the baby/

61 P: Aja… entonces yo le pregunté al doctor de allá de Monroe… entonces como yo he tenido problemas con los demás embarazos… de que se me caen a los dos meses y medio

/aha, so I asked the doctor from Monroe, that because I have had problems with the other pregnancies, that I lose them after two and a half months/

62 I: [Mhm

[

63 P: [el doctor me dijo…esteee… me dijo que no me conviene que me hicieran este…este estudio…

/The doctor told me that this study is not convenient for me/

64 I: Bien, me permite un momentito entonces, señora….momento eh…

/All right, just a moment ma'am, one moment please/

You may not want to go any further with this because she has had problem pregnancies, the doctor and she have discussed this particular study. She said that she's been told by the doctor because she has in the past lost pregnancies,

that…emmm…. It wasn't a good test that she should have…. It's not something that he would recommend

65 N: OK. She told me that she had three miscarriages, all at about two and a half months, is that right?

66 I: Yes, that's just what she was just saying

67 N: OK. Ever find a cause for those miscarriages?

At turn 50, Ellen tells Annette that Ramira is shaking her head and emphasizes that Ramira does not have to have the test, but she has to be given the information about it. Annette explains this to Ramira, who seems to understand (turns 51 and 52). When Ellen hears '*sí*' (yes, turn 52), she continues discussing the place where the needle can be inserted using a diagram. Ellen turns to the interpreter for help (turn 53) as she notices a disruption in communication. Between turns 54 and 63, the interaction is between the interpreter and the patient. At turn 67, Ellen wants to explore the causes of previous miscarriages and puts Annette in charge from turns 68 to 80. In Excerpt 4, Annette answers at turn 82 and Ellen continues with the explanation required by protocol.

Excerpt 4

81 N: OK. So they haven't done any studies, that's what I just wanted to know

82 I: No, they have not

83 N: OK. I'm just gonna briefly explain this test of the amniocentesis and if they don't want to have it, that's fine. . .but

[

84 I: [Excuse me. . .I know you know your business much better than I [

85 N: [aha

86 I: [but. . .I think it'll just make her a little bit more uncomfortable because she has already, as you've noticed shaken her head

[

87 N: [No

[

88 I: [and said she's discussed it with her doctor and really doesn't feel comfortable talking about it

89 N: Oh. . . she told you she doesn't want to talk about it

90 I: That's why she keeps shaking her head no. . .that she doesn't want the study… she doesn't want to go further

91 N: Ok. She only shook her head NO one time

92 I: Okeyyyy:

93 N: OK? Umm

94 I: I'll ask her if she wants you to discuss it with her

95 N: Please do

96 I: ¿Señora?

/ma'am?/

97 P: Sí

/yes/

98 I: Usted quiere que ella siga hablando refiriente a ese procedimiento o prefiere que no?

/do you want her to continue talking to you about the procedure or would you rather not?/

99 P: Pues, ¿el de la jeringa?

/well, the one with the syringe?/

100 I: Aja

/aha/

101 P: ¿La jeringa en el … estómago?

The syringe into the stomach?/

102 I: Aja

/aha/

103 P: esteee pues la verdad . . . o sea yo les agradezco que me traten de ayudar pero. . . este. . . en este caso… yo no quiero hacerme ese. . . estudio… o sea… quiero que me hagan por ejemplo el. . . el ultrasonido

/ehmmm well, truly, I mean, I appreciate that they are trying to help me, but, ehmmm, in this case do not want to have that study done, I mean I want to have for example the . . . the ultrasound/

104 I: Sí

/yes/

105 P: De. . . eso. . .sí. . .pero el estudio este. . . de las jeringas. . .no

/of. . .that. . .yes. . . but this study. . .of the syringes. . . no/

106 I: Es muy razonable. . . me permita (sic)?

/it is very reasonable. Would you allow me?

107 P: Sí

/yes/

108 I: She said she'd rather not go into further discussion with the particular surgery involving the needle. She said she is very grateful that you are offering her this assistance

109 N: OK

110 I: She appreciates it…. She said she would like to go ahead with the ultrasound if that will be at all possible/

111 N: /aja/

112 I: /but she really doesn't want to deal with the needle procedure at all

113 N: OK, that's fine. I need her to sign the refusal now. . . that she doesn't want to have the amniocentesis test. . .

114 I: Bien, ¿señora? Ella necesita que usted firme una hoja diciendo que no quiere tener ese estudio con la jeringa

/Okey, ma'am? She needs you to sign a piece of paper saying that you don't want to have this study with the syringe/

115 P: Sí, así es

/yes, that is right/

116 I: She said that's fine. She'll sign it.

Unlike the patient in Segment 1 (Section 4.1), Ramira contributes more actively to role shifting. We see Ramira interacting with Annette as her co-conversionalist (turns 54–64). Instead of requesting information from Ellen or expressing her fears of losing her pregnancy to her, Ramira shares with Annette her decision to have the ultrasound and asks Annette to thank the provider

for all her help. Annette accepts the role of co-conversionalist (turn 94) and the request to explain Ramira's decision (turn 98) and advocate for Ramira by advising Ellen not to pursue the explanation of the test (turn 108). Annette thus steps out of role. Ellen tries to regain control and communicate directly with Ramira with Annette's help. Instead, Ellen ends up facing an alliance (turns 84–114) constructed between Ramira and Annette.

4.3. The use of pain-rating scale (Segment 3)

The following segment comes from an interview between a middle-aged Spanish-speaking female patient (P) of Mexican origin and a middle-aged female Caucasian nurse (N) who are face to face in a cubicle using a speakerphone system. Mario, a male staff interpreter (I) born in Mexico with eight years of experience at CH, interprets remotely. The patient is complaining about pain in her abdominal area, close to the belly button. In Excerpt 5 we join the conversation as the nurse begins to explore, localize and measure her pain.

Excerpt 5

1	P:	Ah, poquito arriba del ombligo
		(*Uh, a little above the belly button*)
2	I:	Okay, y es, ah, a la derecha o a la izquierda?
		(*Okay, and it's, uh, to the right or to the left)*
3	P:	Es casi de dirección del ombligo
		(*It's almost in direction of the belly button)*
4	I:	Ajá, para arribita
		(*Uh-huh, a little upwards)*

5 P: Sí, arriba

(*Yes, above)*

6 I: Uh, it's above the belly button.

7 N: Okay, nothing below the belly button?

8 I: No

9 N: Okay, okay from a scale one to ten, ten being the worst, is it a ten?

10 I: ¿Señora?

(*Ma'am?*)

11 P: Sí

(Yes)

12 I: ¿En una escala del cero al diez, siendo cero nada de dolor, el diez un dolor que se muere…

(*On a scale from zero to ten, being zero no pain at all, the ten a pain that you almost die from it*)

13 P: Ajá

(*uh-huh)*

14 I: ¿En qué número pondría usted el dolor?

(*In what number would you place your pain?*)

15 P: El dolor nada más, me, me, me pegaba poquito como con nauseas y se…[

(The pain only, I, I, I, had a little like nausea and it)

[[

16 I: [Okay, pero ¿más o menos cuánto?]

(Okay, but more less, how much?)

17 P: Ahh, no mucho, era poquito el dolor.

(*Uh, not much, it was a little pain*)

18 I: Pero en una escala del cero al diez, siendo cero nada de dolor y el diez un dolor que se muere, ¿En cuánto pondría usted el dolor?

(*But on a scale from zero to ten, being zero no pain at all and then a pain that you die, Where would you place this pain?*)

19 P: Como un ocho yo creo.

(*About and eight I think*)

20 I: She said an eight

21 N: An eight, okay.

Once it is confirmed that the pain is not below the belly button (turns 7–8), the nurse applies the pain scale (turn 9) to assess its intensity. The nurse does not direct the interpreter to broker the pain scale for the patient, and the interpreter does not focus on answering the nurse's initial close question ('is it a ten?'). Instead, the interpreter takes ten turns (turns 12–21) to broker how the scale works and produces a rating of an eight (turn 21). The nurse does not claim her place in the interaction and accepts the rating co-constructed by the interpreter and the patient without questioning how they arrived at a rating instead of an answer to the 'is it a ten?' question. And, as shown in Excerpt 6 immediately following, the pain rating of 'eight' does not hold.

Excerpt 6

22 P: Porque no'mas (sic) era poquito y me [apretaba el estómago

(Because it was just a little and I would press on my stomach)

23 I: [Entonces señora, ¿si es poquito no es mucho verdad?]

(Then ma'am, if it's a little bit is not a lot, right?)

24 P: No, eh, eh, o sea na'mas (sic) me apretaba el estómago y repetía

*(No, uh, uh, I mean I would just press on my stomach and repeat***)*

25 I: ¿Qué repetía? ¿Usted quiere decir eruptaba?

(*What did you repeat? Do you mean you burped?*)

26 P: Ajá

(*Uh-huh*)

27 I: Okay

28 P: Sí,

(*Sí)*

29 I: Pero, o sea, entonces no, ¿es ocho o menos de ocho?

(*But, I mean, then is not, is it eight or less than eight?*)

30 P: No, es menos de ocho porque se me quitaba luego.

(*No, it's less than eight because it would go away afterwards*)

31 I: Okay, ¿Como cuánto más o menos? ¿E.. era poquito?

(*Okay, how much more less? Was it a little?*)

32 P: Sí, era poquii.. (sic)

(*Yes it was liiitl…*)

33 I: ¿Un tres, un cuatro?

(*A three, a four?*)

34 P: Por ahí, sí, sí, porque un ocho no… es mucho

(*Somewhere there, yes, yes because an eight, no, that's a lot*)

35 I: [Okay, okay, Pat?]

36 N: Yes? Uh-huh

37 I: It's not eight

38 N: Oh!, which one?

39 I: Uh, she says a little bit, uh, it's around three or four

40 N: Oh, okay, mild then

41 I: Yes, uh, she said at, uh, she had a kind of a gasses (sic), um, that when she was applying pressure she was burping.

42 N: Okay.

43 I: And the, the, the symptoms were a relief.

44 N: Okay, you know, uh, she needs to get a thermometer to check her temperature, okay, this is very important.

45 I: Señora [dice] la enfermera que tendría que tener un termómetro para chequearse la temperatura porque es muy importante tenerlo.

(*Ma'am, the nurse says that you should have a thermometer to check your temperature because it's very important to have it.*)

46 P: [Sí], uh-huh

47 N: Okay, because otherwise, you know what I'm thinking is that she might not even need to come in. It sounds like it's the stomach flu to me. Did she have abdominal cramping also?

48 I: ¿Señora tiene como cólicos?

(*Ma'am, do you have cramps?*)

49 P: Mmmm, no

50 N: Okay and she, uh, was not exposed to anybody that had the stomach flu?

51 I: ¿Señora, ha estado cerca de alguna persona que tenga el flu de estómago?

(*Ma'ma, have you been near someone who has the stomach flu?*)

52 P: Sí

(Yes)

53 I: ¿Ha estado?

(*You have?)*

54 P: Sí, es que a mi, a mi cuñada también así le pegó diarrea, así dice que le dolía el estómago.

(Yes, that's because my, my sister in law had diarrhea, she says that her stomach hurt like this)

55 I: Okay, she said yes, uh, her brother in law had the diarrhea, too.

56 N: Okay, is the pain, um, worse when you move, when she moves or when she coughs?

57 I: ¿Señora el dolor se le pone, se le empeora cuando se, cuando se mueve o cuando tose?

(Ma'am does the pain get, does it get worse when you move or when you cough?)

58 P: Ehh, no, casi no toso.

(*Uh, no I don't really cough*)

59 I: No she doesn't []

For the last thirteen turns (turns 47–59) the nurse regains control of the conversation, still exploring the pain as the patient moves or coughs. Segment 3 illustrates another pattern of role shifts. Unlike the provider in Segment 1, this provider tries to retain control of the interview by addressing the patient directly (turns 7 and 9) and directing the interpreter to seek an answer (a rating on the pain scale, turn 56). In his search for the answer, Mario does not keep both parties in direct communication (e.g. turns 22–35). Instead, he does the exploring as the main interlocutor by engaging in 39 consecutive turns (turns 10–38) with the patient and reports the rating back (turns 39) to the provider. The provider does not attempt to recover control of turn taking or of information. She accepts the conversational dynamic as set by the interpreter.

5. Discussion and conclusion

The data presented depict typical behaviors observed in provider/patient interactions mediated by an interpreter in this particular hospital context. The segments illustrate the fluidity of roles within segments, and even within turns, which result in role shifts. These shifts impact the construction of mutual understanding among interlocutors, the teamwork required in the patient/provider/interpreter effort to achieve goals in a relationship-centered interaction and the parties' constructions of roles.

Consequently, these shifts also raise questions of responsibility and ethics in talk. Interpreters are not solely responsible for role shifts: responsibility in conversation is shared among co-participants (Hill and Irvine 1993, Solin and Ostman 2012, Sarangi 2012). The three parties to the conversation take part in turn-taking/receiving/assigning/appropriating (Clyne

1996: 91). Control and power are not monolithic constructions. There are no strict rules followed and role shifts occur frequently.

As evident from the segments presented, when providers relinquish control of the interview and ask interpreters to take over, the communicative goals are less predictable than when providers retain control of the medical discussion and guide interpreters in helping them achieve their goals. The same holds true for the patient and the interpreter. When the patient is able and willing to provide information and answers, or can communicate with both interpreters and providers (e.g. his/her non-familiarity with the pain scale) the conversation may be constructed jointly by the three parties and everyone may be aware of who is saying what to whom.

When interpreters do not play roles perceived as belonging to others (e.g. engage in medical history taking on their own, even when requested by a provider, or accept a responsibility that may jeopardize mutual understanding, even when requested by the patient) and they focus on contributing their renditions to the interpreted-communicative event, mutual understanding and co-construction of meaning is protected. It appears that mutual understanding and co-construction can be achieved if every party to the conversation stays within the expected role.

However, role expectations and materializations appear not to always align in interpreter-mediated provider/patient interactions. The findings in this study align with characterizations of interpreters as gatekeepers, co-conversionalists and advocates, among other roles, and with characterizations of providers who differ in how they maintain control of interviews or transfer control to interpreters. Further research in other language combinations or settings is necessary to shed light on the shared responsibility in construction of understanding or misunderstanding

during talk caused by role shifts. This research has implications for the education of interpreters and healthcare providers.

Notes

1. The transcript of this interpreter-mediated encounter was previously used to study (1) the role of the interpreter (Angelelli 2004a) and (2) power and solidarity in interpret-mediated interaction using critical discourse analysis (Angelelli 2011).
2. The transcript of this interpreter-mediated encounter was previously used to analyze distance and closeness between interlocutors in culturally diverse healthcare communication (Angelelli and Geist Martín 2005).

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