UNDERSTANDING INTERACTIONS IN INTERPRETED TRIADIC MEDICAL CONSULTATIONS IN PRIMARY CARE

SHUANGYU LI

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The candidate confirms that the work submitted is his own, except where work which has formed part of jointly-authored publications has been included. The contribution of the candidate and the other authors to this work has been explicitly indicated below. The candidate confirms that appropriate credit has been given within the thesis where reference has been made to the work of others.

A small part of the literature chapter is based on the following co-authored paper:

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ABSTRACT

Communication is one of the core clinical skills and has been taught at medical schools in many countries for some 30 years. However, the use of ad hoc and professional interpreters in medical consultations has imposed new challenges on the medical professionals' communication skills and medical education. Traditional communication models have not provided guidance for working with different types of interpreters. Researchers and educators have been striving to develop new communication models to guide education and practice. However, these models are limited in many ways. This research points out that more research is needed to provide a better understanding of interpreted medical consultations, especially of people's verbal behaviour in talk-in-interaction. Based on this, a more effective communication model can be developed to remedy the limitations the current models have. Therefore, the research has two goals: namely, to develop a better understanding of the interpreted medical consultation and to develop communication skills for work with interpreters.

Using conversation analysis (CA) the research investigated 7 naturally recorded GP consultations involving either ad hoc or professional interpreters. Three languages, Slovak, Mirpuri Punjabi and Urdu, were included. GP interviews and focus groups were conducted for member checking and enhancing the validity of the research results.

The research has investigated the turn-taking and turn-design of the interpreted medical consultations and established two theoretical frameworks which provide a generic understanding of the participants' verbal behaviour in the interaction. Based on the frameworks this research has developed 12 communication strategies orienting to behavioural change of the doctor so as to improve the overall communication. The strategies are useful not only for the training of GPs but also other medical professionals and professional interpreters.

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List of Abbreviations

AUPC	Academic Unit of Primary Care
BSP	Bilingual simulated patient
CA	Conversation analysis
CAT	CA transcription
CL	CINAHL
CT	Content transcription
Dr	The general practitioner
DT	Double translation
Int	Interpreter
LEP Patient	Limited English proficiency patient
ML	Medline
P-I entries	Premature and illegitimate entries
PS	Primary speaker
Pt	Patient
SP	Secondary speaker
T	Translation
TRP	Transition-relevance place
WoK	Web of Knowledge

CHAPTER 1 INTRODUCTION—OVERVIEW OF CHAPTERS

1.1 WHY THIS RESEARCH—STARTING FROM THE PRACTICE

This PhD project was inspired by the work of Dr. Sarah Escott and Dr. David Pearson in the Academic Unit of Primary Care (AUPC) at the University of Leeds to teach medical students communication skills for work with limited English proficient patients with or without the assistance of an interpreter. In 2004 a one-day bilingual communication skills workshop was organised for a small group of medical students on their primary care placement in Bradford PCT. Since then this workshop has been organised every year. During these few years this workshop has been well received by the participating students, whose feedback was overwhelmingly positive (Escott et al., 2009). From 2004 to 2006, the delivery of the workshop was increased to cover 40% of the third-year medical students. In 2009, this workshop was moved back to Leeds University and became a mainstream, available to both undergraduate and postgraduate medical students. Because of this workshop Escott and Pearson came to realise the urgent need to improve the teaching of communication skills across language and cultural barriers. Inspired by a talk by an applied linguist, Celia Roberts in 2009, they pointed out that the study of medical communication across cultural and language barriers could be hugely benefited from sociolinguistics. As a result, they decided to set up the current PhD project in collaboration with the School of Education to investigate the education of communication skills taking a linguistic approach.

With many years' work experience as a conference interpreter and language teacher, I have developed a great interest in interpreted discourse. The difficulties of communication across cultural and language barriers have been striking me as something I need to investigate more in order to do my job better. I am always keen on knowing how people speaking different languages can communicate with each other through an interpreter, despite the paramount linguistic and cultural difference they are confronted with. When I was doing my masters in the UK I had the chance to work as a medical interpreter and found that medical interpreting was very different

from conference interpreting. With a passion to deepen my understanding of interpreted discourse, especial in the context of medicine, I started this PhD research. Since then, I have had a very large measure of freedom in designing and conducting the research. I have received ample support from the AUPC, which has given me a lot of opportunities to observe teaching, teach communication modules, enact scenarios as bilingual simulated patients and converse with teachers, students and clinicians.

This project started with an original plan to look at the workshops for communication skills across language and cultural barriers the AUPC has been running. In order to identify the researchable issues and consolidate the research questions, I sat in the workshops with different facilitators and students to observe how the workshops were organised. I also joined the SPUK (Simulated Patients UK) to become a simulated patient myself so that I was able to see more teaching sessions and gain insight into interpreted medical consultations from the perspectives of the patient and the interpreter.

A few months observation revealed a common problem—there is a lack of consistent understanding of how to teach and what to teach. The way each facilitator ran the workshop varied from person to person, depending on what kind of and how much experience the facilitator had in dealing with non-English patients and different kinds of interpreters and how they interpreted their experiences as being positive or negative. Also noticeable is the common confusion between the concepts of *contents* and *skills* as pointed out by Kurtz and the colleagues (2005). There seemed to be a one-sided perception of communication as a matter of whether the right questions have been asked rather than whether such questions were asked appropriately.

These problems then orientated me to review the literature on communication models especially for linguistically and culturally impeded consultations. It revealed that the root of the problems was actually a lack of a good understanding of the interactional mechanisms of the consultations, and a lack of evidence about what can be counted as viable communication skills in such specific contexts (see chapter 2). Based on the

literature review this research shifted from researching the communication workshops to investigating real GP consultations, in which interpreters were involved, in order to understand the orderliness of interpreted consultations and its potential to provide evidence-based skills for teaching and practice.

1.2 Overview of chapters

Chapter 2 is a review of the academic literature. It begins with an introduction to the education of communication skills in medicine and the traditional communication models and then moves on to introduce the demographic change which has problematised the traditional communication models. It then concentrates on studies of interpreted medical consultations and new communication models sourced from those studies in order to establish the arguments that there is a lack of study of verbal behaviour of participants in an interpreted medical consultation and there are the limitations in those new communication models. The chapter ends with two research goals aiming at addressing the two gaps in the literature.

Chapter 3 introduces the methodological approach I have undertaken. It begins with an overview of the worldviews generally held by researchers in designing and conducting research, focusing on the worldview of pragmatism I held in my research. Then it attempts to establish the notion that language is the core of communication and studies of communication and communication skills cannot go far without the study of language. Afterwards it introduces the different linguistic approaches to studying language from phonetics to discourse analysis. This leads to my discussion of the rationale for conversation analysis to be the appropriate approach for this research. The rest of the chapter concentrates on elaborating on the methodological issues in CA and its applications in research on interpreted discourse.

Chapter 4 elaborates on the actual methods I have undertaken for the research. It explains the site selection, recruitment criteria, participant recruitment, ethical issues, data analysis procedures, rigour of research and the methodological limitations.

Chapters 5 to 8 are the findings chapters aiming to fulfil the two research goals. Chapters 5 to 7 report on the findings based on the conversation analysis of seven naturally recorded interpreted GP consultations. Chapter 5 elaborates on the orderliness of turn-taking system of the interpreted consultations. Seven types of turn-taking organisations are identified. Chapter 6 concentrates on pauses and overlaps in the talk. They are the deviant form of turn-taking or in other words, they are the situations when turn-taking is not observed by participants. They demonstrate significant impact on the dynamics of the talk-in-interaction. The benefits of using intra-turn and inter-turn pauses are particularly outstanding and are highlighted in this chapter. Chapter 7 looks at the turn-design in the interaction. It reveals the mechanism of the interrelated turn-design in the interpreted consultations—the current turn is determined by that of the previous turn and determines the design of the next turn. I point out that the interpreter's turn-design (either to translate or talk back to other interlocutors) is the key to the quality of the conversation. I focus on the relationship between the Dr's turn-design and that of the interpreter, attempting to reveal how the former can affect the latter so as to affect the quality of the overall communication. The three chapters fulfil the first research goal to provide a generic understanding of the participants' interactional behaviour, which has shed light on the development of a series of communication strategies.

Chapter 8 aims at fulfilling the second research goal to develop communication skills (which I prefer to call *strategies*). Based on the CA findings and sourcing from my own expertise and the information obtained from GPs, I developed 12 communication strategies. Not only are they based on the evidence of the CA study but they are also enhanced through the discussion with GP trainers in a focus group interview. The chapter also elaborates on the pilot dissemination workshop which I conducted for a group of GPs, who have given positive feedback to the strategies and reassured their usefulness in practice and medical education.

Chapter 9 reviews all the previous chapters, summaries the findings and reiterates the contributions this research has made to the knowledge as well as practice. The whole thesis ends with a vision for more research to come in the future.

CHAPTER 2 LITERATURE REVIEW—INTERPRETED MEDICAL CONSULTATIONS AND COMMUNICATION SKILLS

As discussed in Chapter 1, the research was driven by the pragmatic difficulties the teachers at the University of Leeds have been confronted with in their teaching of medical communication across language and cultural barriers. With the aim to improve the education of communication skills in the new situation, the literature review was conducted so as to provide a better understanding of the problems and issues that language and cultural barriers have imposed on medical communication and its education, identify available solutions to these problems and identify the knowledge gap that this research is about to address. It has also covered a broader range of the literature in order to provide the researcher with the necessary background knowledge about primary care, the education of medical communication and the current demographic change.

This literature review sets its ground in UK primary care. It first reviews the relevant literature in medical communication to establish an understanding of the significance of communication in medicine, the teaching and learning of medical communication skills and the communication models commonly used by medical schools. Afterwards, it reviews the increasing demographic change and the changes and challenges that language and cultural barriers have brought to medical communication and education in wealthy countries including the UK. It then reviews various solutions that have been adopted to tackle the barriers in primary care and general practice. Focusing on using interpreters as an effective solution, it reviews studies in interpreted medical consultations and new communication models for doctors to work with interpreters. Then it attempts to establish the argument that these studies are not sufficient for us to understand people's behaviour in an interpreted medical consultation and the new communication models which are based on these studies are limited in many ways. It points out that more research on people's linguistic behaviour is needed and a new communication model can be established based on a better understanding of the way

people use language in the interpreted consultation. This model may overcome some of the limitations the current new models have. The chapter ends with two research goals: to provide a better understanding of the interpreted medical consultations and to develop communication skills.

2.1 METHODS

This literature review derived from a variety of information sources, from academic database, university library catalogue, Google scholar, to my own experience as a professional interpreter and my personal contact with other colleagues and professionals who are either teaching or involved in multicultural medical communication. A search with databases, Google scholar and catalogue was carried out combining various search strategies, aiming to establish a clear understanding of the current situation of interpreted medical consultations and the teaching of communication, especially in the UK; and to identify the gap of knowledge in the literature.

2.1.1 STRATEGIES FOR DATABASE SEARCH

In order to identify databases to conduct a structured literature review, I did a sample keyword search on MEDLINE, EMBASE, COCHRANE LIBRARY, PsycINFO and Web of Science, to determine the relevance of each of these databases. Three of them were shortlisted for further investigation, one for social sciences (Web of Knowledge (WoK)) and another two for medicine (MEDLINE (ML) and CINAHL (CL)). Based on the topic of this research—Triadic Interpreted Medical Consultations in Primary Care—I conducted a keyword search in title, keywords and abstract in the databases with the following keywords:

BOX 1 KEYWORDS FOR LITERATURE REVIEW (EXTENDED BASED ON (LI ET AL., 2010))

1. Language barrier(s)
2. Medical interpreter/interpreting
3. Interpreter mediated consultation(s)
4. Interpreted consultation(s)
5. Interpreter errors or interpreter mistakes
6. Cross cultural health care or cross cultural medical care
7. Language discordance/discordant
8. Language service
9. Primary care or general practice

The search was then refined to include only peer reviewed, research articles, proceedings paper and editorial materials, which are written in the English language. Publications that are not about *human* were excluded. I did not specify the year of publication so the search included any articles that contain any of these key words. Keywords 1 to 7 were combined by using 'OR' in order to include articles covering all these topics, the result of which revealed 429, 676 and 20959 papers in CL, ML and WoK respectively. All of them were then combined with keyword 9 by using 'AND' to search publications related to the primary care or general practice. As will be discussed later in this chapter, research into the language and cultural issues in medicine has been done across healthcare sectors and all the studies have broad implications that go beyond the specific sectors where they were conducted; therefore, my review was not restricted to studies that were conducted in primary care only. As WoK revealed a large number of papers, I refined the search by using 'Subject Areas' to exclude subjects, such as computing and software, management, tourism, business, etc. and include all the subjects that are related to medicine, such as psychology, public, environmental and occupational health, nursing, paediatrics etc. Finally 788 papers were identified from WoK. 429 from CL, 676 from ML were finalised for manual search. I went through each of the paper title and identified final 223, 241 and 142 from CL, ML and WoK respectively. In addition, I also searched University Catalogue and Google

Scholar and finally some 352 papers, articles, book chapters and books were identified to be relevant to this research.

2.1.2 Supplements

Personal contact is a valuable contribution to the literature review in that the research in this field is still new and there are still many issues coming from the practice that do not have straight answers in the exiting literature. Therefore, I approached doctors, medical staff, educators of communication and interpreters for more information. My own knowledge was also sourced to supplement the writing of this literature review.

2.2 In the context of primary care

Studies of communication across language and cultural barriers have been undertaken in across the health care system, from primary care and general practice to hospital, from psychiatry to paediatrics. Consultation activities across these departments, however, share the most significant characteristics and research findings have such general implications that go beyond any specific department, in which the research was conducted. The current study chooses to focus on primary care not only because most contacts between patients and medical professionals take place in general practice but also because consultations in primary care are so diverse and sophisticated that the findings are likely to have broader implications generalizable across healthcare departments.

About 97% of the British population is registered with a GP. In 2009, 80% of patients have seen their GPs and only 13% are referred to hospital care (Simon et al., 2010). As the primary point of health care GPs not only treat patients but also link them to secondary care and other sectors in the entire healthcare system. With a working knowledge of the whole breadth of medicine, GPs have a wide range of responsibilities from treating minor illness, promoting better health, preventing disease to certifying disease, monitoring chronic disease and referring patients to hospital specialists. This makes the consultation a multi-task procedure (ibid), in which doctors have to apply

both a ‘disease framework’ and an ‘illness framework’ of communication in order to investigate and treat patient’s biomedical problems as well as lifeworld concerns (Bischoff and Hudelson, 2010). To achieve all that, good communication is at the heart of GPs’ ability to provide good service to patients. It is a difficult skill to learn, coming both from excellent medical education and experience. Equally it is a skill which evolves, adapting in the last twenty years to presence of computers in the consultation and increasingly to the challenge posed by language barriers. Consultations in primary care and general practice are especially challenging as presentations are made at the patients request, for any problem, and often for complex non-medical problems. The consultations covering a wide range of topics in medicine as well as in social life provide the best environment where the most sophisticated and valuable phenomena can be found. The outcome of the research based on primary care is of high potential to benefit a wider audience from different healthcare departments.

2.2.1 Communication in medicine and why teach communication

Doctor-patient communication aims to create a good interpersonal relationship between doctors and patients (Thom, 2008, 2009). Ong et al (2005) regard a good interpersonal relationship as the prerequisite for optimal medical care. Another important purpose of medical communication is to exchange information, which involves both the doctor and patient to give as well as seek information (Pöchhacker and Shlesinger, 2005). Doctors need information to diagnose and give treatment and patients need information about ‘what happened to them’ and information ensuring that they are ‘known and understood’ by doctors. Last but not least, communication enables shared decision-making. This concept has come to the fore only in the last two decades before the traditional paternalistic style of decision-making had been questioned in North America and Europe (Hoving et al., 2010). It has changed the dynamics of doctor-patient communication and makes communication much more important.

Communication is not a matter of personality, something that was traditionally considered as irrelevant to the clinicians' ability to provide medical care. However, studies have shown the contrary that communication is a core clinician skill (Kurtz et al., 2005). A usually overlooked fact about communication is that history taking is known to contribute more to making a diagnosis than the examination (Hampton et al., 1975, Peterson et al., 1992). Clinicians' communication skills are immediately related to their clinical performance, which is largely based on finding reasons for patient's attendance, gathering correct and sufficient medical and lifeworld information, explaining the prognosis and diagnosis and planning treatment. Whether the information is communicated between the doctor and patient reflects on the patients' concordance with their medication. Butler et al (1996) have found that an average of 50% of the patients did not take the prescribed medicine or took it incorrectly due to the doctors' inadequate explanation and discussion. In a study carried out in rural south-western Ontario, Canada, over half of the patients reported that doctors were not able to elicit their main purpose of attendance to the consultation (Stewart et al., 1979). Ineffective communication on the part of clinicians also causes legal dispute. Lawyers also identified that physicians' communication and attitudes were the major issues causing patients to pursue a malpractice suit (Beckman et al., 1994).

2.2.2 Can communication be taught and learnt

For a long time communication was not formally taught in medical schools but believed to be something medical students would learn through their experience in practice. This belief was not reliable in that experience can reinforce good habits but also consolidate bad ones. Therefore, their communication skills do not necessarily improve with time and increased experience. Kurtz et al (2005) found that students' ability to communicate deteriorated as they progressed through their traditional medical training, which did not include training in communication skills. They point out that 'communication in medicine is a *series of learned skills* rather than just a matter of personality' (21). These skills can be gained and retained through systematic education. The authors presented the evidence not only from their own research and experience

as educators of communication in medicine but also from the existing literature. The impact of communication programmes has been gaining recognition over the past 25 years. It has been proved in different studies that training did result in students' improved communication and the improvements could be retained.

Although the doubt about whether to teach communication skills has been resolved for a long time, issues about what are communication skills and what should be taught are largely dependent on teachers' own experience. Many of these teachers had no training of communication themselves and may not demonstrate high standards of communication in their own practice. Even if they are good communicators, they may never have analysed what they do and many of them find it difficult to teach. In short, facilitators do not necessarily have better understanding of the subject matter than their students (ibid). That is what Kurtz et al call '*the blind leading the blind'* (ibid: 31).

While the necessity of training is beyond doubt, another issue these authors point out is that it is necessary to provide theoretical basis for teaching and define what communication skills are composed of.

2.2.3 Communication models

To answer the question of 'what to teach' in communication programmes, scholars have built up various models. Many of them delineate the *tasks*, *strategies* and *skills* of a medical consultation (Pendleton, 2003). Tasks describe what is to be achieved in the consultation or in a phase of the consultation. Strategies mean the plans or approaches that the doctor uses to achieve the tasks. And skills are purposeful and clearly observable behaviours, which, therefore, are used as the basis for both teaching and research (ibid). Different authors focus on different aspects. They have proposed theories about medical communication and checklists of tasks of what a medical consultation should achieve and what should be taught in communication skills programmes. Many checklists focus on the tasks and goals. Some of them prescribe the general tasks, which bear the equal importance throughout the

consultation (e.g. Cohen-Cole, 1991, and Mead and Bower, 2000); some list actions according to the sequence they are to be undertaken (e.g. Neighbour, 2005); and some combine both general tasks and sequential actions into one (e.g. Pendleton, 2003, and Silverman et al., 2005). However, in these models there is confusion between tasks and skills to achieve them. This misleads students and even teachers to think that knowing what to do in the consultation (tasks) means knowing how to do the consultation (skills) (Kurtz et al., 2005).

Calgary-Cambridge Guides (Silverman et al., 2005, Kurtz et al., 2005, Kurtz et al., 2003) have been widely used by medical schools. The authors have endeavoured to combine 'content' and 'process' (or in other words, *tasks* and *skills*) into one model, which has resolved the confusion in other models. Communication skills programmes are believed to be able to address three areas: skills, attitudes and issues; however, skill-based approach is the final common pathway for all communication learning (Kurtz et al., 2005). Once skills are mastered, other 'issues and challenges, such as anger, addiction, breaking bad news or cultural issues, are much more readily tackled' (Kurtz et al., 2005: 2). Calgary-Cambridge guides are a comprehensive model, which consists of 70 individual communication process skills, supported with evidence about how each of them can help improve communication.

2.2.4 Old problems, new challenges—A demographic turn

Increasing economic and political migration has brought an increasing number of new residents into North America, Australasia and Europe. Britain is an increasingly multicultural and multilingual society; 8% of the country's total population (some 4.8 million) were migrants originally born outside this country in 2002 (Home Office., 2002). Many do not speak English as a first language and a considerable number speak limited or no English. There are no national statistics on how many people in the UK speak English as a second language nor how many ethnic languages are spoken (CILT, 2009b); however a 2009 survey in London identified some 307 languages, 20 of which have over 2000 speakers (CILT, 2009a).

Where there are language barriers and no common language between a clinician and patient, a professional or ad hoc interpreter must be involved in the consultation to make communication possible. The NHS is committed to providing 'high quality language support and communication services' to everyone that is entitled to the NHS treatment (Department of Health, 2004). However working with interpreters requires new skills, not anticipated within the monolingual communication models which are commonly accepted by medical schools and practiced by medical professionals (Li et al., 2010).

2.2.5 Old models confronted with new challenges

Although the core content and skills to conduct a medical consultation through an interpreter remains the same as one where interpreter is not needed, traditional communication models based on language and culture concordant consultations cannot fully resolve many other issues brought up by the language difficulties, various perceptions of disease and consultation by different cultures and the involvement of a third person as interpreter in an interpreted consultation. Although some of the traditional models, such as Calgary-Cambridge (Silverman et al., 2005), have attended to cultural issues, they hardly address the language barriers. These authors, however, merely emphasise the need to check the extent of the language barrier and incorporate the specific skills to overcome the barriers but only suggest postponing if they are too great.

Studies of interpreted medical consultations started from the mid 1990s. The call for research into language and cultural barriers is raising its voice in recent years. Issues about the inefficient communication of doctors discussed many years ago, are re-emerging and being sophisticated by new problems (Greenhalgh et al., 2007). Jacobs and colleagues (2006) have reviewed peer reviewed academic articles specialising in this area. The majority of the reviewed studies of language discordant medical consultations are quantitative enquiries. They have focused on Spanish-speaking patients in primary care or emergency department settings mostly in the US (60%) as

well as in other countries (40%). They identified articles that involve topics about healthcare access barrier, adherence, cost, interpreter issues (e.g.: error, evaluation, role etc.), patient satisfaction and so on. The review demonstrates that, in general, the quality of care of limited English proficient (LEP) patients was poorer, even if interpreting services were provided. They have identified the following problems:

1. LEP patients are less likely to receive the care they need and less likely to understand the processes necessary to become insured;
2. They are less likely to follow recommendations for treatment and follow-up visits;
3. They are more likely to be admitted to the hospital, to have longer hospital stays and to receive insufficient anaesthesia;
4. They are at risk of receiving unnecessary diagnostic testing and suffering medical errors;
5. They in general are less satisfied with their communication with health care providers;
6. Health care providers are also less satisfied with their interactions with LEP patients.

They authors point out that it is far from enough only to document the problems but more rigorous research is needed to provide better understanding of how language barriers affect health and health care; the efficacy of linguistic access to service interventions, and the costs of language barriers and efforts to overcome them. The reviewed literature, as they noticed, does not provide guidance on which interventions, and under which circumstances, best reduce language barriers. They also point out that more research is needed on the teaching of communication skills for work with interpreters and reduce the obstacles. Similar findings are also reported in other reviews of the literature on the subject matter (e.g.: Karliner et al., 2006).

In practice there exist a variety of means to resolve the problem brought by the language discordance in medical consultations, such as, talking directly to LEP patients

with simple English, using professional or ad hoc interpreters or using telephone interpreting services. Different solutions have their own limits and impose different challenges to the doctors' communication skills. The next section will look at each of these solutions, with a focus on the UK general practice and primary care.

2.3 Exploring solutions

Various methods offer possible solutions to overcome the language barrier. Different GP practices take different solutions according to their specific logistic management of the interpreting service. They would mainly adopt one of the following ways to consult with their LEP patient (Li et al., 2010):

1. Speaking directly with the patients with simple English;
2. Having their own bilingual health care providers to work with the LEP patients;
3. Using professional interpreters (including telephone interpreting) and having routine access to such services;
4. Encouraging patients to bring their family members or friends who can interpret for them in the consultation.

Greenhalgh et al (2007) have found that the type of interpreters or language support the practices choose has to do with their institutional organisation. The authors have identified two types of general practices in this study situated in part of London, namely, the contemporary practices and traditional practices. Staff members in more contemporary practices emphasise efficiency, accessibility, and equity; therefore, they would be more '*routinised*' to provide professional interpreters. In contrast, traditional practices, often single-handed practices, tend to have bilingual health care providers to work with patients from a particular ethnic community in that region or use family members or friends of the patients as ad hoc interpreters.

2.3.1 Using simple English

It is rare that a patient does not speak English at all. Usually they can speak very limited English to manage simple conversations if not a complicated discussion about their disease (Roberts et al., 2005). Therefore, another solution that would be applied by the doctors is to speak with the patients using 'simplified English'. Although this way of communication enables the doctor to establish the direct interpersonal relationship with the patient, it is discouraged due to the commonly reported dissatisfaction of the patients and medical professionals (Flores, 2005). Roberts et al (2005) find that there are majorly four categories of LEP patient 'talk' that contribute to misunderstandings in the communication: pronunciation and word stress; intonation and speech delivery; grammar, vocabulary and lack of contextual information; and style of presentation. Due to these factors LEP patients bring to the consultation, it is very difficult to decide whether the patient has sufficient language even to understand the simply English used by the doctor. How much simplified English can benefit the consultation depends on how much English the patient can speak and understand and how complicated the conversation has to be in order to accomplish the clinical tasks. To make do with simplified English somehow allows doctors to accomplish their work but the risk of miscommunication is high when clinicians are not certain about the patients' understanding and whether their concerns have been fully elicited and correctly understood by the medical professional.

2.3.2 Bilingual healthcare providers

The use of bilingual healthcare providers can improve the quality of medical care. Patients reported high satisfaction and indicated that the consultation is the same as a language concordant one (Flores, 2005, Jacobs et al., 2006). However, the number of bilingual healthcare providers who are confident to consult in a language other than the one they are educated with is much smaller than the number of patients demanding such service, which makes the service not widely accessible for patients (Riddick, 1998, Phelan and Parkman, 1995).

2.3.3 Professional interpreters, ad hoc interpreters

The most effective solution is to have an interpreter who speaks both English and another language to facilitate the communication. Studies have shown the use of either professional or ad hoc interpreters are related to patients' higher satisfaction and improved outcome of health care (Karliner et al., 2006, Flores, 2005). The definitions of professional interpreters vary in different research papers. Some consider only those who have been trained and have qualifications as professional interpreters; while others would call anyone a professional interpreter as long as they are paid by an organisation for doing interpreting. The latter is the kind of professional interpreters involved in this research. They are either affiliated to the NHS PCT or a private language service provider and are paid for providing interpreting service. Most of them have received a certain form of training and all are expected to be abide by the Code of Conduct. The Chartered Institute of Linguists has issued the Code of Professional Conduct[1], which is a standardised regulation to be observed by qualified interpreters in the UK. The Institute also provides training and accreditation and holds examinations leading to the award of qualifications for work in the field of interpreting and translation[2]. Qualified interpreters and translators can be found on National Register of Public Service Interpreters (http://www.nrpsi.co.uk/). The Criminal Justice System has accepted the quality control for public service interpreters offered by the Institute in the form of a qualification called the Diploma in Public Service Interpreting (Institute of Linguists Educational Trust, 2004), yet this is hardly ever acknowledged in the field of Health (Li et al., 2010).

Ad hoc interpreters, by contrast, are all the others who act as interpreters in a medical consultation. They can be family members, friends, untrained medical and nonmedical staff and strangers (Flores, 2005). Not all professional interpreters are trained to do medical interpreting; and likewise not all ad hoc interpreters are untrained.

[1] Accessable through http://www.iol.org.uk/Charter/CLS/CodeofProfConductCouncil17Nov07.pdf

[2] Information obtained through personal contact with Liz Weatherill, manager of NHS Bradford & Airedale PCT Language Services Department

Although the UK National Health Services has committed to providing a professional interpreter to any patient if needed (Department of Health., 2004, Department of Health, 2000), the provision of professional language support is still inefficient. An estimated 50% of GP practices did not use the NHS interpreting service (Greenhalgh et al., 2007). The inefficiency is caused by multiple reasons. One could be because there is no stable interpreting service provider in the region or the practices do not have budgets for it. Another reason is the patients' preference for family member interpreters over professional interpreters (Flores, 2005). Patients opting for family or friends to interpret for them are not unusual as they trust these people better than a professional interpreter they have never met before. Some patients think that the family members or their friends understand them well and can best represent their interests especially in a situation where the patients do not understand the language (ibid). Doctors also find that the participation of family member interpreters allows them to better understand the dynamics of the family relationship so as to establish a relationship with the whole family (Rosenberg et al., 2007, Edwards et al., 2005). That is why family interpreters are also considered as the 'second best' after professional interpreters (Greenhalgh et al., 2006).

The inefficient provision of language services in the UK is also related to politics and GPs' attitudes towards the management of LEP patients. Policy makers and researchers are debating over the issue of language support for migrants who speak little English. People on one side of the debate say that the service is patchy and more is needed in language services in order to ensure the equality of every citizen in accessing health services (Jones, 2007). On another side, people argue that the NHS should curb the spending on interpreters and encourage patients to learn English given the high annual cost in interpreting services (£55 million in 2005(Easton, 2006, Drury, 2008)) and suggest that patients are more likely to suffer from psychologically related health problems from not being able to merge into mainstream society due to a lack of English (Adams, 2007). Before this debate is settled the ongoing controversy will result in a considerable number of practices not using professional interpreters.

Difficult logistic management is another reason pushing some practices away from using professional language services. A professional interpreter needs to be booked in advance, which means more workload for the practices to obtain sufficient information about their patients, such as their nationalities and what languages they speak. Patients should book their appointments in advance in order to allow the practice to book the interpreter for them (Riddick, 1998, Greenhalgh et al., 2007). However, in reality this is not always possible. Patients in general practices can turn up very spontaneously as some of them do not use a booking system for seeing the doctor in their own country (Greenhalgh et al., 2007). In this regard, ad hoc interpreters show their significant advantages of being spontaneous, easy to manage and low cost (ibid).

2.3.4 Telephone interpreting

Apart from the above-mentioned in-person interpreting, telephone interpreting service begins to gain more and more attention nowadays. It is discussed more in the US where the required supporting technology has been matured. There are approximately two types of telephone interpreting services—'remote simultaneous medical interpretation' and 'proximate consecutive interpretation' (Locatis et al., 2010: 346, Riddick, 1998). Simultaneous interpreting is widely used in court and business meetings. Because of its common use in international conferences, it is also known as conference interpreting. A trained interpreter is located in a remote place equipped with headsets that can hear the speakers and talk to the audience. Their interpretation is produced simultaneously with the speaker's speech. This enables the conversation parties to talk with each other as if there were no language barrier. This technique was introduced to medical communication only a little more than a decade ago in the US (Riddick, 1998).

Consecutive interpreting is similar to the triadic in-person interpreting except that the interpreter is not physically present and the conversation parties need to use a phone. Both these language service provision modes require special equipment. At least a

telephone is required. The reviewed studies of remote interpreting services, most of which were from the US, indicate that ideally the GP practices will be provided with the headsets and microphones by the language service provider. For consecutive interpreting a double-handset phone or a speakerphone is used. It is not uncommon in some cases that the doctor and patient have to pass a single handset between each other. To my knowledge, there is no GP practice or hospital using remote simultaneous interpreting in the UK, although in some special occasions an on-site consecutive interpreter may choose to do some simultaneous whispering interpreting when either the doctor or the patient is taking a long turn to speak and the interpreter feels inappropriate to stop them but also the pressure to interpret for the listener. However, consecutive telephone interpreting services are commonly used. It is favoured particularly by practices where the patients speak many languages or patients' spontaneous turn-up is more frequent.

2.3.5 Interpreting services & quality of health care—focusing on face-to-face interpreting

There are a few systematic literature reviews of research on the impact of the use of different types of interpreters or not using them when needed. The following will look at how each kind of interpreting service affects the quality of health care.

2.3.5.1 Professional vs. ad hoc interpreters

Karliner et al (2006) reviewed peer-reviewed articles published in English between 1966 to 2005 and identified 28 articles that looked at the impact of professional interpreters and ad hoc interpreters on the quality of health care. 71% of the reviewed studies were from the US, with 2 from the UK. This review suggests that both professional and ad hoc interpreters increased patients' satisfaction of consultations but professional interpreters were associated with a higher overall improvement of care for LEP patients. They appeared 'to decrease communication errors, increase patient comprehension, equalise health care utilization, improve clinical outcomes,

and increase satisfaction with communication and clinical services' for LEP patients (748).

2.3.5.2 No interpreter & bilingual providers

In addition to the preference for trained professional interpreters, Flores (2005) has reviewed the studies about the situations where interpreters were not provided to the LEP patients when needed and situations where bilingual providers were consulting. It reveals that LEP patients who were not provided with an interpreter but definitely needed one had the lowest satisfaction. The reviewed studies also suggest that bilingual health care providers can eliminate the language barrier and the patients' satisfaction is almost as high as in language concordant consultations. In some studies, patients reported that they found it more comfortable to talk about sensitive issues with bilingual physicians or through bilingual family or friends than with other types of interpreters. This finding is also supported by Edward and colleagues' research (2005) on patients' trust of different types of interpreters. They argue that personal character and trust are also important in good interpreting.

It is worth noting that there are two types of bilingual healthcare providers. One is those who speak a minority language as their first language and another is those who are native English speakers but have learned a second language and use it in their work (Hsieh, 2006). Despite a number of reports of improved quality of care given by bilingual healthcare providers, the caveat should be made that miscommunication may still occur due to the discrepancy of the healthcare providers' linguistic and cultural competence in English and the minority language (Crossman et al., 2010, Locatis et al., 2010). Clinicians should be fully aware of their own limits and call in professional interpreters whenever necessary.

2.3.5.3 Remote interpreting service

Remote interpreting in medicine includes simultaneous and consecutive telephone interpreting and video interpreting. A systematic review (Azarmina and Wallace, 2005) only identified 9 papers related to this topic. Research has documented that people's

overall evaluation of remote interpreting service is lower than face-to-face interpreting (Locatis et al., 2010), except for one research conducted in a US Children's Hospital Emergency Department, which indicates that both telephonic and in-person interpretation resulted in similar concordance in understanding of discharge diagnosis compared with bilingual providers (Crossman et al., 2010). The most reported drawbacks of telephone interpreting are that the phone was distracting, the audio sometimes was poor, it lacked visual contact, body movements and use of hand were restricted by holding the phone. People's complaints about video interpreting is that they lost eye contact as they had to stare at the screen all the time. The GPs I have talked with also said that the use of the phone and the presence of a 3rd unseen person in the consultation seems to affect the interpersonal dynamics and can result in the sensation of a barrier between patient and doctor and the difficulties to establish trust and have in-depth discussions about the patient's problems. They also mentioned that long conversations on the phone can be difficult as there is a need to avoid using long sentences and more difficult to use open-ended questions. Consequently the process can be slow and drawn out and the information elicited can be more limited (Jones and Gill, 1998, Kuo and Fagan, 2007).

In the UK both professional and ad hoc interpreters are widely used throughout the country and across health care sectors. Consecutive telephone interpreting is common in many GP practices but simultaneous and video interpreting are very rare. The complexity of interpreted consultations has imposed a great challenge and high requirements on medical professionals' communication skills, which is what this research is going to investigate.

As these studies show, it is very important to use an interpreter whenever needed. Therefore, it is very important that medical professionals are equipped with relevant skills to work with different kinds of interpreters effectively so as to improve the quality of care. Although telephone interpreting is an important means of language service in the UK, in this research I only investigate the face-to-face interpreting given

the fact that face-to-face conversation and telephone conversation are two very distinctive activities per se and the constraint of a PhD project.

2.4 USING FACE-TO-FACE INTERPRETERS IN UK PRIMARY CARE

In many areas in the UK, ad hoc interpreters such as receptionists have been widely used especially when a more formal service was not available. Due to the high demand for language support and frequent use of ad hoc interpreters, especially the use of medical staff, professional training that leads to a vocational qualification are now available. Taking Bradford where this research is based as an example, in collaboration with the NHS and Bradford College, the University of Bradford gives a three-month training course called Community Interpreting Module, to receptionists from the GP surgeries, which leads to a National Vocational Qualification at level 2-3[3]. The whole course costs £300 plus an examination fee of £50[4]. This course is also open to people who are frequently required to act as ad hoc interpreters. By the end of the course, trainees have a choice to upgrade their qualification to the National Vocational Qualification Level 4 which allows them to be registered with language service providers and become salaried professional interpreters[2]. They can work not only for medical consultations but also in courts and other civil services, where interpreting services are highly demanded. Box 2 includes the contents of this module.

[3] Information obtained through personal contact with Liz Weatherill in 2009.

[4] Information obtained through personal contact with Kasia Kosel in 2010.

BOX 2 CONTENTS OF COMMUNITY INTERPRETING MODULE2

- The Role and Responsibilities of Interpreters
- Working with Public Service Providers
- Cross-cultural differences in interpreting and translation
- Different interpreting styles: first and second person
- Types of interpreting: **consecutive** and simultaneous
- Sight translation
- Basic interpreting process
- Applying skills to the interpreting process
- Note-taking
- Specialist terminology
- Glossaries

Thanks to the NHS' commitment to providing high quality language support, some of the PCTs in the UK have established their own interpreting service departments. A search of 'UK PCT interpreting service' on Google reveals quite a few PCTs that provide this service, such as Newcastle PCT, Westminster PCT, Bristol PCT, Bradford and Airedale PCT, just to name a few. However, for many reasons as discussed in the previous section the use of face-to-face professional interpreters is quite disproportionate across the country.

Having an interpreter in between the patient and doctor in the consultation room, however, is not as simple as having a machine which automatically transfers one language to another. The provision of interpreters only makes the doctor-patient communication possible. Scholars have described the ample problems interpreted consultations have brought to the clinician's practice. A few of them have started investigating the issue and are exploring ways to understand interpreted consultations better and improve communication in medical consultations.

2.5 STUDIES OF FACE-TO-FACE INTERPRETED CONSULTATIONS AND THEIR IMPLICATIONS FOR EDUCATION

Studies of interpreted consultations have covered a wide range of topics and investigated different aspects of the issue. They are moving towards building up a

comprehensive understanding of this particular social event, which becomes a heuristic for the education of medical professionals and interpreters.

2.5.1 Cultural impacts

Culture is a big umbrella that includes shared values, beliefs and learned patterns of behaviour of people from a society. It has a significant impact on the dynamics of the triadic relationship between the doctor, patient and interpreter. Cultural competence allows doctors to learn to appreciate cultural diversity in the multiethnic society, reduce misunderstandings, avoid conflict, establish mutual trust and empathy with patients, improve interpersonal relationship and, ultimately, improve the quality of health care (Jacobs et al., 2006, Moss and Roberts, 2005, Roberts et al., 2005, Skelton et al., 2001). However, the attempt to transfer the knowledge of culture or cultures, from cultural studies to the teaching of communication is facing substantive challenges. One of the biggest is the fact that no single study can complete the study of the diverse forms of cultures the doctor could possibly be confronted with (Skelton et al., 2001). International migrants come from different parts of the world with distinctive cultural backgrounds. Even those who are from the same big cultural community may belong to many different subcultures, which have substantial differences in communication styles. It is not unreasonable to say that the efforts put into integrating the knowledge of all cultures into one communication model are nothing more than an extremely bold illusion (Carrillo et al., 1999). As Skelton and colleagues (2001) have questioned, 'to what extent can our understanding of general principles in other cultures be summarised and presented for teaching in a way which does not descend into caricature?...Can features of other cultures be presented in ways which do not descend into particularity?' (257)

2.5.2 Interpreter categorisation

Current studies basically agree on classifying face-to-face interpreters into two big categories, namely, professional interpreters versus ad hoc interpreters (Karliner et al.,

2006, Hsieh, 2007, Flores, 2005). In some studies whether an interpreter is professional or ad hoc is decided by whether they have received vocational training and hold certain qualifications for doing medical interpreting (e.g.: Flores, 2005, Tebble, 2003, Hsieh, 2007). For others the distinction is drawn according to whether one is interpreting for salary or voluntarily. In the latter case being professional does not necessarily mean that they have had professional training for doing medical interpreting or hold any qualifications (Karliner et al., 2006). In contrast, ad hoc interpreters are any other individuals who can speak more than one language and are temporarily interpreting in medical consultations. They can be family members, friends, receptionists, other medical staff, link workers or strangers. Some ad hoc interpreters, such as medical staff, receptionists or link workers, can be trained in short courses which were aimed to help them improve their extra work as interpreters, as I have mentioned in the previous section.

Knowing the characteristics of the behaviour of each kind of interpreters allows doctors to anticipate the potential difficulties they may be confronted with so that they can prepare themselves with strategies for working with different interpreters. However, the problem of this preoccupation for classifying interpreters according to their types and potential problems each type may present is that it may lead to the danger of overgeneralisation and may result in doctors' premature assumptions of what they should do and say when working with a certain kind of interpreter. It disregards the fact that interpreters, be it ad hoc or professional, are not pre-programmed machines that only operate according to the set rules (Roy, 2000, Pochhacker and Shlesinger, 2007). People's behaviour changes from person to person and from one social activity to another. Even within one social activity our behaviour changes as the conversation proceeds (Drew and Heritage, 1992b).

2.5.3 Roles of interpreter

People's attitude towards the role of medical interpreters is changing. Early authors follow what Reddy has called the 'conduit' role (1979). According to this model,

interpreters are considered as a language machine that transfers one language to another, word for word. They are not supposed to be meaningfully engaged in the conversation (Davidson, 2002). However, the conceptualisation of the role of interpreters has taken a 180 degree turn. Researchers, particular those coming from the background of interpreting, point out that an interpreter is not a passive puppet between the main interlocutors but a co-constructor or an active participant in the conversation (Angelelli, 2004). Authors supporting this idea rename 'interpreted consultation' as 'interpreter mediated consultation' to emphasise the interpreter's active role in the consultation. Yet, this 'active' turn is not an ultimate solution. It sees its pitfalls, as Hsieh points out, when it overlaps with the doctors' responsibilities and services (Hsieh, 2007) and sometimes makes doctors feel that they have lost control over the consultation (Hsieh, 2009).

Although more and more scholars begin to acknowledge that interpreters are playing an active role in a consultation, Hsieh's worry is not unreasonable. In my view, there is no fixed answer to whether an interpreter should assume the role of a cultural broker, co-diagnostician, advocate or merely an interpreter translating verbatim from one language to another. I would argue that there are no predetermined rules prescribing which role interpreters should take and when to take it; but rather this is a choice whose decision is locally made in the ongoing verbal interaction among the doctor, interpreter and patient (see Chapter 7). An interpreter does not only play one role in a consultation. Instead they are shifting from one role to another depending on the way the interaction is being undertaken by the participants (see Chapter 7). Sometimes they interpret verbatim, sometimes they advice on culture and sometimes they advocate on certain affairs (see Kai, 2006 for an introduction to the different roles interpreters can play, 2005). Given this dynamic role play on the part of interpreters, I use the term '**interpreted consultation**', rather than '**interpreter mediated consultation**' in my study so as to keep a neutral stance towards the interpreter roles.

A useful communication model for work with interpreters should not stereotype interpreter roles or only alert doctors to different roles interpreters may assume but it should enable doctors to distinguish which role is being taken at a particular moment in the turn-by-turn ongoing consultation and how to negotiate for the right role for the interpreter to undertake (see more discussion in Chapter 7).

2.5.4 Interpreting errors

Errors in interpretation can cause serious consequences in medical care. Studies show that both professional and ad hoc interpreters make mistakes that may lead to potential clinical consequences (Flores et al., 2003, Flores, 2005, Farooq, 2003). Investigations of interpreting errors identify the source of the medical mistakes, their impact on medical consultations and advice on solutions to reduce mistakes. These investigations have a very strong impact on the practice and training of medical professionals and interpreters.

However, the definitions of errors are very problematic. Box 3 is one of the kinds of list of interpreting errors.

Box 3 Interpreting errors (Flores et al., 2003)

Omission: a word/phrase uttered by the doctor or patient is omitted in the interpretation.

Addition: a word/phrase not uttered by the speaker is added in interpretation.

Substitution: a word/phrase is substituted for another different from that in the original utterance.

Editorialisation: the interpreter's own opinions are given in place of that of the speaker.

False Fluency: an incorrect or non-existent word/phrase is used.

As mentioned earlier, interpretation is not like a mechanical search for exact equivalents in the target language for the source language, but rather it is a very sophisticated cognitive procedure, during which the interpreter is actively participating and indeed driving the interaction (Wadensjo, 1998, Roy, 2000, Pochhacker and

Shlesinger, 2007). As Danica Seleskovitch (1975) has put, interpreting does not proceed directly from source to target text, but through a language-independent ('deverbalised'), mental representation of the meaning of the source text. Because of this process of deverbalisation the production of a target text can be significantly different from its source text (Seleskovitch, 1975 cited in Dam, 1993). Studies of professional interpreting suggest that the abovementioned 'errors' are actually considered as indispensible 'interpreting techniques' constantly adopted by interpreters (Dam, 1993, Lin, 2004). Dam's (1993) analysis of the interpreting behaviour of five professional conference consecutive interpreters interpreting a same 7 minutes Spanish speech into their A-language (first language) Danish has demonstrated how these techniques were put into practice by interpreters. The author segmented the target texts and put them into different categories for the investigation of how they are constructed on the basis of the source texts. These segments fall into six categories (274-275):

1. **Parallel segments**: ie. Target text segments that are practically identical—semantically as well as formally—to those source text segments...
2. **Selective segments**, ie. Target text segments that contain or consist of selected elements from one or several source text segments...whereas the rest of the elements of the source text segment(s) in question are deleted.
3. **Substituting segments**, ie. Target text segments...are constructed by replacing some or all the elements of one or several source text segments by different elements.
4. **Additional segments**, ie. Target text segments that contain or consist of elements that have no counterpart in the source text.
5. **Other segments** are those that do not fit into any of these 4 categories.
6. **0-representation** (fully deletion [of the source text])

The author's numeric analysis of the results (Box 4) reinforces that word-for-word paralleling interpreting is not the normative way of interpreting but only one of the possibilities that the target text is to be constructed.

BOX 4 (DAM, 1993: 276)

ST segments	Representation in the TTs
14%	Parallel segments
53%	Selective segments
18%	Formally substituting segments
3%	Generalizing segments
1%	Integrating segments
3%	Other segments
17%	0-representation (full deletion)

In producing different target text segments, interpreters are constantly adding, substituting, editing and deleting the source language. These actions are necessary due to the sophistication and highly demanding cognitive workload of interpreting, as well as the unparallel nature of the two working languages.

The colliding notions of errors and techniques problematise the way the terminologies have been used and defined in the studies of interpreter errors. It is true that problems or mistakes may occur but it does not mean that it is a result of using these interpreting strategies. Therefore, when training doctors' communication skills, it is important to inform the trainees of the nature of interpreting and, at the same time, the skills to distinguish whether it is interpreting skills that are used or errors that require doctors to rectify.

2.5.5 LINGUISTIC STUDIES

In the 1950s scholars in the field of translation and interpreting studies began to seek theoretical account for translation and interpreting. A lot of them ended up with adopting various linguistic approaches.

Nida pointed out that translation should be studied as a communicative event and the significance of it being an act of communication which should not be overlooked or underestimated (Nida, 1964). He proposed sociolinguistics (Ervin-Tripp, 1982, Gumperz and Hymes, 1972) as an approach in this pursuit in that to understand translation processes needed to account for various factors—interpersonal relations, extra linguistic features, and linguistic, cultural and social variants—which influence the way people communicate information. This call was also echoed by Shuy (1987, 1990) who stressed that translation and interpreting should be studied as a communicative event and sociolinguistics and its subfield discourse analysis were appropriate tools for researching interpreting and interactive events.

In 1990 sociolinguistics was brought to the forefront of the study of interpreting by two books: *Discourse and the Translator* by Hatim and Mason (1990) and *The Bilingual Court* by Berk-Seligson (1990). They pointed out that study of interpreting should look at the interaction among all participants and researchers need to record and transcribe talk. Hatim and Mason started with the sociolinguistic approach but then turned to advocate that more research should be done to look at how *conversation analysis* can help investigate interpreting given the recognition that turn-taking, adjacency pairs, preferred responses and so on are relevant to the process of liaison interpreting. Later many scholars have carried out research trying to describe the interactive patterns in interpreted events, using the framework of turn-taking, adjacency pair, overlapping speech, repair etc. (Wadensjo, 1998, Bolden, 2000, Davidson, 2002, Mason, 2006, Merlini and Favaron, 2007, Gavioli and Baraldi, 2011)[5].

Wadensjo (1998) argues that the interpreted discourse is a co-constructed outcome of the interactions among all participants, highlighting the fact that an interpreter is not merely a 'voice box', who is mechanically transferring one language into another but

[5] These quoted studies have drawn on conversation analysis and have particularly addressed issues in turn-taking and turn-design. Those that are not included in this thesis may be important in this field interpreting studies but not relevant to the research topic I am concerned about.

rather an active contributor to the content or meanings of the interpreted conversation. She points out that the interpreter has the function to facilitate and mediate the conversation. Bolden (2000) investigated the interpreter's involvement in history-taking in medical consultations and reiterates the fact that interpreters are active participants in the conversation. He further points out that the interpreter is selecting the quantity and quality of information as related to the 'world of medicine' rather than that of the 'lifeworld', which results in them either translating or rejecting the primary interlocutor's words. Davidson further explored how interlocutors establish a 'common ground' (Clark 1992, 1996, cited in Davidson, 2000 p1273) for conversation and how they negotiate meaning in interpreted discourse, by investigating the generic possible turn-types, which I will further discuss later. Mason has also drawn on the insights of conversation analysis to further the discussion of context as being 'evolving and intra-interactional' (Mason, 2006: 359). In line with Wadensjo's stance that meaning is co-constructed in the interaction, Mason links the construction of meaning with the process of joint negotiation of contextual assumptions. He points out that although the accessibility of such assumptions is the precondition for conversation, sometimes 'divergent contexts may emerge among participants' (ibid). He talks about both the 'local context' created in the ongoing conversation and the broader 'frame' which provides the setting in which the conversation takes place. Merlini and Favaron's investigation of turn-taking in the setting of speech pathology points out that the concept of adjacency pair should become '*adjacency trio'* (2007: 108). They also briefly investigated pauses and overlaps. The authors mainly found that pauses are likely to indicate speech difficulties on the part of the patient failing to produce the last component of the adjacency trio and the turn would be taken either by the speech therapist or the interpreter to do a repair. Only a few cases of overlaps were found in their data and they categorised them on the basis of their distance from *transition relevance places*. Gavioli and Baraldi have integrated most of the above mentioned studies and further investigated the interpreters' function in intercultural mediation (2011). Unlike other studies that only focus on interpreters, they investigated the interpreters' behaviour in relation to that

of other interlocutors in the interaction in both healthcare and legal settings. In so doing they found that in court an interpreter is less likely to talk back to the primary interlocutors; however, this is more likely to be found in the healthcare setting, in which interpreters are found to talk back with *continuers* or *acknowledgement tokens*, etc. They also found that the interpreter is also playing a significant role in allocating floors, during which they tended to exclude the weaker party and consequently their active involvement could reinforce the asymmetry relationship in the institutional settings in discussion.

Many of these authors have envisaged that their research may have implications for training for interpreters and other professionals working with interpreters but only a few have really established this link. Tebble (1996) is one of the first. Her empirical study using sociolinguistics provided evidenced-based approach for her to establish the model for teaching community interpreting. She also developed a programme using video and linguistic theories to teach medical professionals how to effectively work with professional interpreters (see later section for details).

These authors have provided detailed empirical studies of interpreting as an interactive event and communication mode. They are very significant in our understanding of medical interpreting from the perspective of people's language use. However, as these authors are mostly experts in the field of translation and interpreting studies, their linguistic studies only look at professional interpreters. There has not been a proper linguistic study that has investigated ad hoc interpreters in the interpreted discourse.

2.6 New communication skills in medical education

These studies have contributed significantly to the understanding of interpreted consultations and also shed light on the development of communication models and teaching of communication skills. In the wake of the recent development in many significant regulating documents (such as *Tomorrow's Doctors* (Ong et al., 1995,

General Medical Council, 2007), *Good Medical Practice* (General Medical Council, 2006, 2009) and *The Vital Connection: An Equalities Framework for the NHS* (Department of Health, 2000)) which share the same spirit of improving the communication and quality of care across language and cultural barriers, many medical schools have begun to teach communication in keeping with the growing ethnic diverse society and scholars have proposed various communication models.

2.6.1 Current situation of communication education

Up to now there has not been a study on the situation of how communication skills in linguistic discordant medical consultations are taught across medical schools in the UK. As far as I am aware of, programmes of communication skills for work with interpreters are not yet available in all the medical schools. Compared with the traditional programmes in monolingual settings, the pedagogical approaches to teaching communication across cultural and language barriers are less coherent across medical schools. This is due to a lack of sufficient research that can provide a systematic and evidence-based understanding of the situation that can enlighten education (Jacobs et al., 2006). The following authors I am going to review have taken different approaches to investigate interpreted consultations; yet they have revealed some common characteristics of what an interpreted consultation is composed of and what strategies should be applied to accommodate the conversation and improve medical care.

2.6.2 Standard qualitative approach

Most of the abovementioned studies have taken a standard qualitative approach by using questionnaires, interviews and focus groups to elicit the participants' opinions and ideas towards their medical encounters. In this section I will review some of the authors who have taken this approach to develop communication models that have been accepted by many medical schools.

2.6.2.1 THREE TEXTBOOKS

Bischoff and Loutan (1998, 2008) have collected people's narratives about what they think about communication in interpreted medical consultations and what can be done by medical professionals to improve the communication. Participants were professional interpreters, physicians, nurses, social workers, psychiatrists and teachers. As diverse as its source contributors, the target readers of this handbook range from medical professionals in hospital or primary care, interpreters as well as patients. Its aim is to help people, be it professionals or service users, to understand interpreted consultations and improve their communication. Unlike other researchers, who only focus on professional interpreters (e.g. Tebble 1998, see below), Bischoff and Loutan conceive interpreters as any individuals who understand the two languages, the cultural and political context embedded in both languages and are able to convey contextual information from one language to another.

Although Joe Kai's Valuing Diversity (2006) and PROCEED (2005) are based in the UK context, they are written not only for developing communication skills but also more to provide a comprehensive overview of the current problems and issues imposed upon health care by growing ethnic diversity. Kai has taken an ethnographic approach to investigate a wide range of relevant topics. Like Bischoff and Loutan, Kai has devoted a big portion to introducing the background and establishing awareness. He specially discusses issues of communication difficulties and develops medical professionals' skills to improve communication with LEP patients.

Although these models come from different studies conducted in different countries, one in Switzerland and the other in the UK, the authors have proposed the same basic structure which includes information about the logistic organisation, housekeeping background introduction and recommended strategies for professionals to apply to improve their communication skills. Box 5 synthesizes the communication strategies these studies propose.

BOX 5 COMMUNICATION STRATEGIES FOR DOCTORS

Before the consultation

1. Preparation: explain to the interpreter what you expect of him and how you intend to conduct the consultation with the patient.
2. Content: explain to the interpreter the objective of the consultation.
3. Working relationship: explain how you see your working relationship with [the interpreter].
4. Confidentiality: inform the interpreter that he is obliged to maintain professional confidentiality.
5. Time: allow enough time
6. Administration: make sure things like payment, hourly rates etc. are made clear.

Beginning the consultation

7. Introductions. Introduce yourself and the interpreter, explain confidentiality and establish mutual trust.
8. Patient agreement: ask the patient if they agree for this interpreter to interpret and ask interpreter if they are willing to participate.
9. Look at the patient, not the interpreter.
10. Speak directly to the patient: use 'you' rather than 'he'.

During the consultation

11. Patience
12. Speak slowly and clearly
13. Keep it simple; use layman's terms where possible
14. Check: check regularly to make sure that the patient has fully understood.
15. Clarify confusing responses
16. Ask for verbatim translation if the response is still unclear
17. Guide the conversation: keep control of the consultation.
18. Encourage: encourage the patient to speak freely and to ask questions.
19. Observe: observe while the interpreter is talking with the patient.

After the consultation

20. Exchange: talk with the interpreter
21. Ask interpreter for cultural information
22. Summing up: Go back over the consultation briefly with the interpreter and ask for his impressions.
23. Support: support interpreter's feelings if sensitive issues came up in the consultation.
24. Keeping a record: record that this patient needs interpreter and record the interpreter's name, address and telephone number in case you need them next time.

2.6.2.1 Problems

These teaching models improve our understanding of interpreted consultations and the education of communication skills. They were developed by synthesising participants' recollection of their experience of the interpreted medical consultations and opinions about what can be done to improve the communication. There has not been much theory behind the models. This list of skills or recommendations is a valuable resource for doctors, students, educators and professional interpreters. However, they are not the utmost solutions to the problems in interpreted medical consultations because the following limits hold back their instructive capacity.

Not practical

Most models have mentioned meeting the interpreter or at least contacting them for preparation before the consultation and also talking with them afterwards. This is desirable but often not practical, particularly not in primary care. Given the limited time doctors have for each patient and the pressure of the large number of patients a doctor has to see each day, it is not likely that they will have time to talk to each interpreter before and after the consultation. This is least likely to happen with ad hoc interpreters who may turn up with patients spontaneously.

'How' is not addressed

Some key strategies, such as point 12-15 and 17-18 in Box 5, are very useful and important in improving communication. Most of them are actually not only applicable in interpreted consultations but also in language concordant consultations. However, they are not as easy to apply as they would appear at first sight. Telling doctors to keep things simple, use layman's terms or guide the conversation does not really ensure they know how to do it. Taking layman's terms for example, these models have not said how to distinguish a layman's term from a professional term. An English speaking doctor's layman's term may not be 'layman' enough for an interpreter speaking English as a second language.

OVERSIMPLIFIED

Interpreted consultations are dynamic and complex. Different interpreters and patients have different levels of English, different sociocultural backgrounds and personal relationships with each other. When these factors change, people's behaviour will differ. The techniques a medical professional uses with one pair of interpreters and patients may not be appropriate for another. Telling doctors a standard mode of interaction—rather than the skills to gauge the situation and react accordingly—is running the risk of being oversimplified and may lead to underestimating the complexity of the situation.

NOT COMPREHENSIVE

As reviewed studies have shown, problems always occur more often to ad hoc interpreters; while the burden on the part of the medical professionals' communication skills is relatively lighter when professional interpreters are present. However, these communication models have said little about the work with ad hoc interpreters.

2.6.3 A LINGUISTIC APPROACH TO COMMUNICATION

As mentioned above there have been quite a few studies that have investigated interpreted consultations from the linguistic point of view and mentioned that their studies may have implications for communication education. However, only a very few authors actually used the linguistic research findings in developing the education of communication skills.

2.6.3.1 HELEN TEBBLE

Helen Tebble's book for training doctors in Australia—Medical Interpreting Improving Communication with Your Patients (1998, 2003)—is one of the first guidebooks for teaching communication skills to doctors for work with professional interpreters. Largely informed by applied linguistics (Tebble, 1999), the author gives a comprehensive introduction to interpreted consultation as a matter of management as well as linguistic techniques (see Box 6). The communication strategies Tebble

proposed are in many ways similar to those demonstrated in Box5. However, in this model the author has added information about linguistic strategies, such as 7-9 in Box6.

BOX 6 (SEE TEBBLE, 1998: 45-47)

1. Brief the interpreter
2. Position the seats properly
3. Greet the patient and introduce yourself and the interpreter
4. Remember the patient's name, address them properly; use appropriate pronouns
5. Look at the patient and speak to the patient
6. Be ethical so don't expect the interpreter to be the advocate as well
7. Understand how turn-taking works and that interpreters can interpret segments rather than the whole turn if it is very long
8. Plan ahead, try to speak grammatically and not to 'think aloud'
9. Use proper questions
10. Exposition: give diagnosis/prognosis, suggest treatment etc.
11. Debrief the interpreter if necessary

The linguistic study has provided substantial information on the details about language use. The author not only introduces some linguistic concepts into the communication model, such as turn-taking, segments, turns, etc; but also explains the functions some specific linguistic elements, such as English pronouns. Doctors are encouraged to use the 2nd person pronoun, *you*, to address the patients (also see Bischoff and Loutan, 1998, 2008) in order to avoid talking about them in their presence, which may be considered so if using 3rd person pronouns, *he, she* or *they*. She also cautions that patients do not always appreciate this effort. Sometimes interpreters have to use *he* or *she* to refer to the doctor in order not to confuse the patient whether it is the doctor or the interpreter who is speaking.

However, Tebble stopped at only providing general linguistic knowledge rather than knowledge that is specific to the interpreted consultation (which, as I will discuss in the finding chapters in this thesis, has its unique features distinguishable from monolingual consultations). She also did not say how people can change their linguistic behaviour so as to improve the communication by possessing the linguistic knowledge.

Tebble's textbook is also limited by its sole focus on professional interpreters in Australia, where the interpreters' accreditation system and provision of accredited interpreters are well established and not always achievable or perhaps even desirable in other countries. Although a good interpreter cannot compensate the poor communication skills of a doctor (Hale, 2007), when clinicians work with them, the pressure on the part of the medical professionals' communication skills is much lower. However, in most other countries where ad hoc interpreters are still being used on a large scale in medical care, Tebble's model may not provide all the solutions the clinicians from these countries are facing (Hale, 2007).

2.6.3.2. ROBERTS AND COLLEAGUES

Another influential school of research in this field in the UK is Roberts and colleagues (Roberts et al., 2005, Moss and Roberts, 2005, Roberts and Moss, 2004, Roberts and Sarangi, 2005). Applying discourse analysis, or to be more specific, theme-oriented discourse analysis, they attempted to address a broad range of social issues in medical consultations in an ethnic diverse society. *Doing the Lambeth Talk* (Roberts and Moss, 2004) is the outcome of their empirical research work and a good example of combining linguistic study with teaching communication. In the advised teaching mode, students are shown videos of real consultations with LEP patients and required to use linguistic methods, namely interactional sociolinguistics (Gumperz and Hymes, 1986), to analyse the conversation with the assistance of the transcripts. The purpose of this is to let the students be aware of the importance of language and learn to analyse language in use so as to improve their own language skills and eventually improve their communication with patients.

However, this article says little about the work with interpreters. When this is mentioned, it is taken as problematic in that it is costly and difficult to manage in the routine management. They found that interpreters cause further miscommunication and some patients prefer to communicate directly with their doctor.

Although this article is not applicable to interpreted consultations, it shows us how linguistic studies can provide evidence-based teaching of communication skills in language discordant medical consultations.

2.7 Teaching communication across language and cultural barriers—a vignette at Leeds

As one of the few pioneers teaching communication skills across language and cultural barriers in the UK, Leeds University Medical School has drawn from a wide range of the abovementioned studies in constructing their pedagogy. In this section I elaborate on how the teaching in Leeds is arranged and how it has inspired the current PhD research.

2.7.1 Aims

The above studies and communication models have been adopted by many medical schools. Leeds University Medical School is one of them to have combined theoretical instruction with role-play using bilingual simulated patients (BSPs) in their communication programmes. The aim of the programme is to help students develop an awareness of the impact of language barriers, understand the importance of attitude of both patients and healthcare professionals, discuss different communication models and develop communication skills (Escott et al., 2009). By using BSPs to re-enact medical consultation scenarios dramatised by experienced practitioners based on real medical encounters, students are given the hands-on opportunity to conduct consultations with LEP patients and explore difficulties and solutions. The simulated role-play session covers a wide range of practices, including

using simplified English to consult, working with professional or ad hoc interpreters or using telephone interpreters.

2.7.2 In a regular day

In a regular day of the bilingual session, all the students will get together to have a theoretical instruction, in which they are informed of the basic knowledge about medical communication in the ethnic diverse society in the UK. This session provides an overview of the current demographic situation, the difficulties confronting medical care and logistical management commonly used to cope with problems and difficulties in the consultation.

After the big group introduction, students will be separated into small groups and assigned to a facilitator to work with BSPs. Students are given the opportunity to develop their own strategies in this process.

This programme has received overwhelmingly positive feedback from participating students (Escott et al., 2009). However, programme organisers have already realised its shortcomings.

2.7.3 Problems

The general introduction is not so problematic given the evidence the teaching has been drawing upon from the previous studies. However, this section is only to provide an overview of the specific situation where language and culture barriers occur. The introduction to skills is given in a rather brief manner and can hardly go beyond the somewhat overgeneralisation sourced from the abovementioned communication models. More problems arise when students come to work with BSPs. Firstly most of the facilitators are not trained to work with LEP patients and interpreters. Although some of the facilitators are aware of the communication skills mentioned in Boxes 5 and 6, because those skills only say *what* should be done but not *how* to do it, the understanding of the actual means to achieve those communication requirements

varies from facilitator to facilitator, depending on their personal experience. Secondly, as I criticised, these communication models are static and therefore not providing suggestions for resolving problems that are spontaneously emerging from the ongoing consultation. Consequently the actual communication skills students learn from each facilitator vary significantly. Students in different groups with different facilitators and peer students may receive different advice on the same problems in the same simulated scenarios. Also what the students learn from each scenario can be very specific to that particular scenario and cannot be easily synthesised and transferred to a different consultation by the students. Once the language, the relationship between patients and interpreters, the topics of conversation or any other communicative elements change, students may still find many new problems they do not know how to cope with. This also makes the observing students find it difficult to know what they should observe and what criteria they should apply to evaluate their peer's performance in the simulated consultations.

In order to develop the understanding of the interpreted medical consultation and enlighten a new communication skills model that can solve the problems the current models have left unsolved, this PhD project was initiated.

2.8 Research goals

What is known from the literature review is that communication is a core clinical skill for medical professionals and should be and can be taught by formal education. Medical communication education has been broadly carried out in medical schools in different countries, using the traditional communication models developed in the monolingual context. However, the increasing number of immigrants moving into wealthy countries including the UK, has imposed new challenges on medical communication and its education. Language and cultural barriers brought up by the new patients who do not speak the language of the mainstream society require the medical professionals to adopt new solutions to communication difficulties and more sophisticated communication skills to handle medical consultations across language

and cultural barriers. However, the traditional communication models have provided little advice on that. There are various kinds of solutions to the barriers reported in the literature and using interpreters is considered to be an effective solution. This leads to this research choosing to focus on the need for new communication skills for medical professionals' work with different kinds of interpreters. There have been attempts to develop supplementary communication skills models to cater to the new situation. However, the applicability of these models is limited by a lack of sufficient research evidence about people's behaviour (I will explain why behaviour is important in developing a useful communication model in the next chapter), the sole focus on professional interpreters, oversimplification and a lack of spontaneity.

Based on the literature review and the inspirations I obtained from the practice at Leeds University, this PhD aims to achieve the following **two goals**:

1. **To provide a generic understanding of the interactional behaviour of the doctor, patient and interpreter, without distinguishing the language and type of interpreters (both professional and ad hoc interpreters);**
2. **To develop communication skills (or strategies as I prefer) based on the understanding of people's behaviour.**

The new communication model should include skills for work with both professional and ad hoc interpreters, enable doctors to distinguish and anticipate errors committed by interpreters and also inform them of cultural variations, interpreter types and roles.

It seems very demanding for a single model to enlighten doctors on all the aspects of communication—culture, relationship, identify, age, social class, education or any other sociocultural factors. Yet, this is not an impossible mission in that these factors are embedded and conveyed in one important vehicle, language. When we use language to participate in a social activity, we constantly draw on some or all of these factors to make sense to others and make sense out of others' words. In an interpreted conversation, the presence of an interpreter allows people speaking

different languages to understand each other; therefore, through the interpreter the speakers can also understand each other's sociocultural backgrounds they are coming from. Ideally the sociocultural information relevant to a particular conversation should be embedded in the translated language and passed through the interpreter to the listeners. It is not necessarily conveyed through what is exactly said but often through the way people say it. Medical communication with language in its core can never be properly, at least not completely studied, without studying the use of language or the linguistic behaviour of participants. A linguistic study can focus on the generic features of language use or the generic interactive patterns of participants' use of language. Its result can be a heuristic for us to establish this new model that can provide evidence to enhance the existing communication models and solve the unsolved problems they have presented. Paul Drew and colleagues point out the potential to use conversation analysis (CA) as a key tool to solving communication problems in medicine (Drew et al., 2001). Heritage and Maynard's collected work in monolingual medical communication is a landmark of CA used in this field (Heritage and Maynard, 2006a) and has significant educational implications. Nonetheless, CA's use in studying interpreted conversations is still underdeveloped but its attention to talk-in-interaction fits perfectly with the context of interpreted medical consultation, in which doctors may not have the background knowledge of other participants but can obtain it through their use of language as the conversation goes on. CA gives the analyst the same perspective as the doctors to investigate participants' conversational behaviour, which is equally accessible for the doctors. Therefore, the research results can be transferred into communication skills that can be taught to medical professionals. In the next chapter I will further explain why conversation analysis is chosen for this research.

CHAPTER 3 METHODOLOGY

3.1 WORLDVIEWS AND STRATEGIES OF INQUIRY

The next two chapters discuss the design of the research. According to Creswell (2009), the research design spans the decisions from the worldview assumptions to detailed methods of data collection and analysis. A philosophical worldview is the starting point, from which the researcher is able to select the research strategies and actual methods for data collection and analysis. Creswell discussed four types of world views, namely, the postpositivism, social constructivism, advocacy/participatory and pragmatism. Post positivist researchers hold the assumption that knowledge is conjectural—there is no absolute truth (Phillips and Burbules, 2000). The purpose of research is to test or verify and refine the already existing theory. Researchers holding this worldview normally use quantitative methods for inquiry. Social constructivists endeavour to understand the world by understanding the meanings of the participants, of whom the researchers are also a part. The questions they ask are 'broad and general so that the participants can construct the meaning of a situation, typically forged in discussions or interactions with other persons' (Creswell, 2009: 8). Qualitative methods are usually used by them. Another group of researchers holding the worldview of the advocacy and participatory find the social constructivists' inquiry 'not far enough in advocating for an action agenda to help marginalised peoples' (ibid: 9). They intertwine research with politics and political agenda, aiming to address and change social inequality of marginalised social groups and individuals (Kemmis and Wilkinson, 1998). Qualitative research methods are normally chosen as their tool for inquiry. Pragmatic worldview holders are not restricted by any particular methods of inquiry. They utilise whatever is necessary for achieving the research goals, which are normally targeted at resolving certain social problems. They normally choose to use mixed methods, integrating both qualitative and quantitative approaches (Cherryhomes, 1992, Morgan, 2007, Creswell, 2009).

In order to achieve the two major research goals, which are to improve the understanding of interpreted medical consultations and develop communication skills, I have taken the worldview of pragmatism aiming at addressing the problem of the lack of knowledge of a certain social activity—interpreted medical consultation—and the lack of guidance for practice. In order to do so I firstly chose a linguistic approach, conversation analysis (CA), as a main tool of inquiry of the meanings of participants' behaviours. The traditional followers of CA normally take a social constructivist point of view, using solely the naturally recorded video or audio data (ten Have, 2007). However, this approach cannot serve the research purpose of this study completely. I therefore also chose to use interview data as a supplementary approach to enhance the trustworthiness of my understanding of data and the reliability of the communication skills developed from the study of CA. The pragmatic worldview allows for a problem-oriented approach to the research problem so the researcher was not restricted by the traditional methods in CA and was able to integrate different qualitative methods into the study. This chapter will focus on establishing the rationale for conversation analysis to be chosen as the main research tool in this study. It tends to be a theoretical discussion about the link between language and communication, the different philosophical opinions towards the study of language and the philosophical stances and theories in conversation analysis as a qualitative approach to inquiring society. More detailed design of data collection and analysis will be elaborated in the next chapter.

3.2 Focus of this chapter

This chapter basically elaborates on the exploratory path that I have undertaken to understand what is communication—the core of this research—the relationship between communication and language and how conversation analysis comes to be chosen to address the issues, about which this research is concerned. Different people have different understandings of what communication is and explain it from different perspectives. I have taken Cobley's (2001) viewpoint to perceive communication as semiosis, which establishes the intrinsic link between communication and language.

Language does not exist in a vacuum to form communication but rather it is influenced by many social factors, such as culture, gender, social status and so on. Language used in verbal communication is constructed in interlocutors' interaction and meanings are negotiated between the interlocutors in the ongoing course of communication. Studies of language have deconstructed language into smaller constructive units. The smaller ones build up bigger ones and eventually all the units come to form the language we use in reality. Linguistic inquiries can be situated at any unit level of language but their investigations alone do not allow us to understand how language is used in communication. This is where the concept of discourse comes into play. I reviewed two major methodological approaches to discourse, discourse analysis and conversation analysis and explain that conversation analysis' focus on the mechanisms or patterns in the talk-in-interaction better fits the goal of this research which is to develop communication skills. I begin with a very broad review of studies in language and end the chapter with a concentrated discussion about the specifics of conversation analysis and its application in studying interpreted discourse.

I will begin with a discussion about the relationship between communication and language.

3.3 Communication and Language

3.3.1 What is communication

Communication is not only a basic feature of being human but also an unavoidable activity we undergo in our social life every day. As Rosengren (2000) states, people 'cannot *not* communicate' (38). Communication can happen either intentionally or unintentionally. Even the very small things like the change of tones in speech or a slight increase of our speech volume can communicate things like emotional alteration such as surprise or anger, even if we do not intend to. Communication is so common in our life that people tend to take it for granted and overlook the importance of understanding how it is constituted (Fiske, 1990). Basically communication is a complex phenomenon, during which we not only exchange the 'basic message' that is

embedded in the words we speak but we also simultaneously communicate the 'metamessage' which is the intention of a certain kind of relationship that is conveyed beyond the words (Bateson, 2000). Communication is so common yet so difficult to satisfactorily define. A working definition for the discussion of medical communication is one proposed by Fiske, which states that communication is 'social interaction through messages' (1990: 2). This definition proposes a very important notion that communication is social. It highlights the fact that our communicative behaviour is not carried out in isolation but rather situated in a certain social context, either personal or institutional. Another important notion stemming from this definition is that communication is interactive. That is to say, it always involves more than one person and they are actively interacting with each other to make the communication possible. It is also important to note that communication is realised through messages which can be embedded in different forms such as sign language, the Braille system, semaphore (flag language), Morse code, and most importantly, language, which the majority human beings use in daily life. This definition also points out an important concept: meaning. Communication, in oversimplified terms, is the process in which the speaker is to mean something and the listener is to interpret what s/he means (Thompson, 2003). This coincides with what conversational analysts believe that meaning is constructed through interaction. More details will be given later.

The fundamental relationship between communication and language provides the rationale for this research to undertake a linguistic approach. So how can language actually enable communication?

3.3.2 Language as an embodiment

One model of communication is to take it as a form of semiosis (Cobley, 2001). This notion connects communication with language, a collection of signs in a system. However, language is not only a collection of signs indexing the physical world but it is also the embodiment of many other social factors—such as culture, ideology, identity, power, etc.—which interplay with one another to constitute communication. These

factors are all related to semiotic symbols and embedded in the form of language we use in the daily life. Culture is one of the most significant factors which can be seen as a set of sign systems. Kendall and Wickham regard culture as 'the way of life of a group (including, possibly, a society), including the meanings, and the circuits of power by which the meanings are valorised or derogated' (2001: 14). This definition reveals the fact that not all the meanings in society have the equal value or validity. They can be valorised or derogated, which is the result of the realisation of social power through discourses (Fairclough, 2001).

Closely related to culture is ideology. It has an important social meaning within the concept of culture and power. Berger and Luckmann (1967) define it as 'ideas serving as weapons of social interest' (18). These ideas belong to those who are in power and have access to the public discourse through which they make their ideas valorised and other adversary ideas derogated. Identity is another cultural entity determined through the interaction in communication within a certain society. It is also related to language, or discourse, to be more specific. A person's identity is 'the notion that one individual is different from another, [which] is established by drawing boundaries of, for instance, geographical areas, political or religious viewpoints, occupational categories or linguistic and cultural traditions' (Sarup and Raja, 1996: 11). It is not only what one believes s/he is but rather a determination of his/her sociocultural background and the result of the interaction between this individual and others or institutions. A good example in medical communication would be the study conducted by Moss and Roberts, which pointed out that patients need to explain the reasons for their visit to the doctor in a way that reflects how they want the doctor to perceive them as a patient and as a person. This process is complicated when patients' first language and cultural background interferes with the way they talk English (Moss and Roberts, 2005).

3.3.3 Study of communication begins with language

As discussed in the last section, communication is constituted in the course of interactions within the social context. It is closely related to culture, identity, ideology, power and so forth (Thompson, 2003). These fundamental factors are manifested and come to effect through the channel of discourse. In other words these factors are embedded in the language people use in the communication. Studies of communication tend to explore culture, identity, ideology etc. in their own right, as in the studies of the communication in interpreted medical consultations reviewed in the previous chapter. Here I would like to reiterate my argument that it is important to study culture, identify and other elements within the context in which the communication occurs, but it is the study of people's use of language that best informs us how these sociocultural factors come to affect communication and to constitute people's life in society. Therefore, the study of communication cannot go without investigating the use of language. Linguists are a school of scholars striving to describe the language through which to understand human society. Some of them are more focused on the surface structure of language while others concentrate on the social function of language in constructing human society.

3.4 STUDIES OF LANGUAGE

When we talk about language, most people would first think of the language we use to talk or write to one another in everyday life. Giving it a second thought we can think of more forms of languages used in human society, such as computer language, sign language, flag language or semaphore and Braille. They are all language in a broad semiotic sense. In other words, language can be any kind of sign system that communicates information. Different languages are used in different parts of human life and for different purposes. However, the most popular and fundamental is the spoken and written language based on which we are able to develop other forms of languages and, more importantly, the majority of human beings can use to manage their day to day lives. And it is this form of language that interest linguists the most and is relevant to my current study of medical communication.

Linguistic studies of human language focus on the sound and sign system of a language and how the sounds and signs come to make sense in our social integrations. In order to study language, scholars have deconstructed it into smaller constructing units which fall into different levels of the linguistic hierarchy as shown in Table 1. Linguistic studies can be situated at any level from the smallest unit of language formation (e.g.: phonetics, phonology and morphology) to the overarching structure of the text—the discourse level.

TABLE 1 THE LEVELS OF LANGUAGE (JEFFRIES, 2006)

1. Phonetics: the physical properties of speech
2. Phonology: the study of linguistic sounds
3. Morphology the study of word structure
4. Syntax: the study of utterance/sentence structure
5. Text/discourse structure: the study of higher-level structures
6. Context and use the influence of situation, participants and functions

Generally speaking, the smallest unit of a language is phoneme—the sound system--(e.g. /p t k h/ as the phonetic representations of letters *p, t, c* and *h* in *pot, tot, cot,* and *hot*). Phonemes come to form morphemes—the smallest unit of meaning (e.g.: a word such as*, ice*). Following the line up, morphemes constitute words and words can construct utterances, which then form the text through which we make sense and communicate to each other. This hierarchical relationship can be demonstrated in Figure 1.

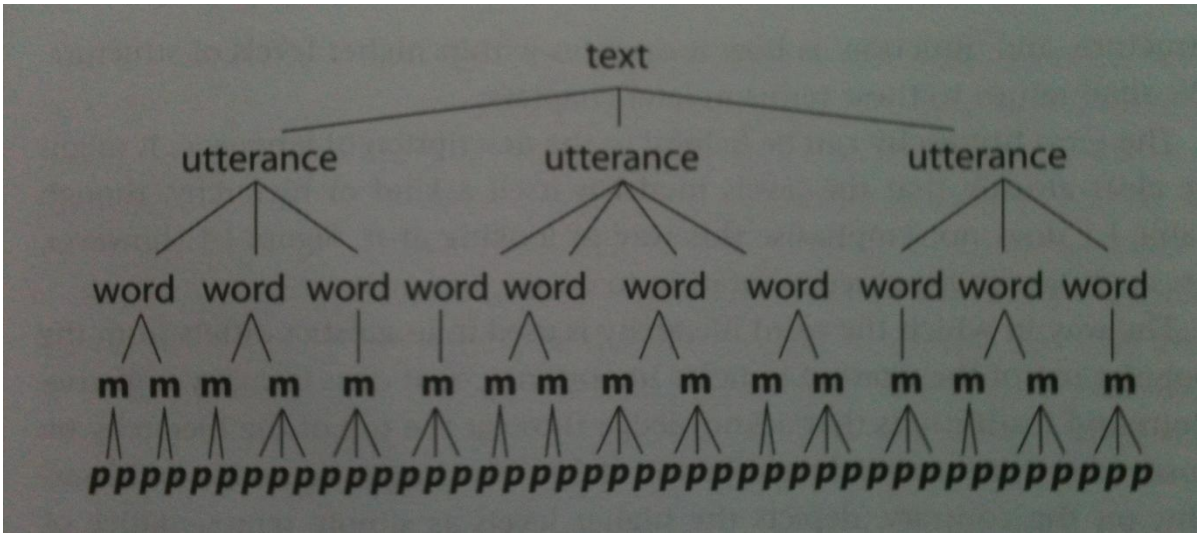


FIGURE 1 THE HIERARCHY OF LINGUISTIC LEVELS

Note: m=morpheme, p=phoneme

(Jeffries, 2006: 5)

3.4.1 PHONETICS

Phonetics is the term used in linguistics to indicate the study of the sounds that human beings use to communicate through language (ibid). Phoneticians are interested in the physical properties of speech sounds; that is, how the sounds in a language are produced as a result of the functions of certain body organs, such as our lungs, mouth, tongue, teeth etc. Each different language has its particular set of sounds, not all of which exist in other languages. These unique features of a language usually become the obstacles for non-native speakers in their second language learning. For instance, the uvular sound /r/ in French, German and some other languages does not exist in the English language. It makes it very difficult for English speakers to pronounce this phoneme properly when learning to speak these languages. The absence of certain sounds in a second language learner's mother tongue is the source of the difficulties for them adopting the native accent and thus resulting in a foreign accent. These confusions can be the cause of misunderstandings between native English speakers and non-native speakers.

3.4.2 PHONOLOGY

Another concept related to speech sound is **phonology**. While phonetics focuses on the physiological production of human speech sound in general, phonology refers to the set of rules which govern how sounds can be combined in particular patters in a language (Thompson, 2003). That is, instead of taking language as a general term, phonologists study the rules and patterns of the sound in **a** particular language. There is more than one variation in a language. Such variations can be dialects, personal style of pronouncing or accent. Different languages have different phonological rules and features. Taking English as an example, connected speech is a common phenomenon in the spoken language, which involves assimilation, elision and insertion (Jeffries, 2006). Assimilation is when a phoneme is pronounced more like the subsequent or the preceding sound. For example, 'give me' is usually pronounced by natives as *gimme*, in which the /v/ sound is assimilated to its subsequent /m/ sound. Elision is when a phoneme is omitted in the utterance, such as the /d/ sound in *handsome*. Elision usually happens when two consonants are adjacent to each other. It can be within a word or between two words (e.g. *Take that* is pronounced as /tei'θæ/). In comparison, connected speech is not common in the Chinese language in that the pronunciation of each morpheme is always composed of an initial consonant and a final vowel, such as my three-character (morpheme) name, *Li Shuang Yu*. However, Chinese has a very fundamental phonological feature, the tones, which determine the meaning of words. In contrast, tones in English can alter meanings in communication but they do not change the morphemes they represent, as in Chinese.

Phonological discrepancies in different languages can easily cause communication difficulties in native-non native conversations. Sometimes the non-native speaker could misunderstand or even fail to understand due to the accent or personal style of the native speaker. I once asked an Irish girl for the price of a tin of coca. She told me it was *one pound*. However, she pronounced pound as '*point*'. Although I knew every word in her response, I just could not understand until she had repeated it several times as the '*point*' sounds very clear to me and I was actually imagining there would

be something else coming after the 'point', like 'one point seven'. In interpreted medical consultations doctors should be aware that even the simplest sentence like this can cause communication difficulties. Likewise, if an interpreter is a non-native English speaker, their pronunciation can also cause problem. In their study of primary care consultations in multilingual settings, Roberts et al identified the phonological factors that can cause miscommunication, such as: pronunciation, word stress, intonation and speech delivery (Roberts et al., 2005). In a later chapter I will give an example of the interpreter failing to understand the doctor because of the unfamiliarity of English pronunciation (see Chapter7, Excerpt 12).

3.4.3 MORPHOLOGY

'Morphology is the study of how parts of words are combined to make whole words' (Thompson, 2003: 42). This again varies from language to language. For instance in English there are two types of morphemes, namely, free and bound morphemes (Jeffries, 2006). Free morphemes are the fundamental elements with no addition and can stand alone as a word, such as *free, ice, tea*; whereas bound morphemes are affixes (including prefix and suffix) to be added to the free morphemes to construct the grammatical structure (e.g. read+ing=reading) or change the meaning of the word (e.g. re+design=redesign).

Morphological variations can also impose communicative difficulties on the conversation with non-native speakers. Native speakers have a wide range of vocabulary in their own language, which enables them to use a variety of ways to express the same meaning. However, in the lack of the wide range of vocabulary the variations of expressions are limited for non-native speakers and so is their ability to understand the variations produced by a native speaker.

3.4.4 SYNTAX

Syntax is the set of rules which govern the organisation of words which is accepted by native speakers and considered as grammatically correct (Thompson, 2003). For

instance, in English language a singular subject requires a singular verb (e.g. *I am a student* versus *We are students*.), subject and predicate should be reversed in questions (e.g. *What <u>are you</u> doing*? But not *What <u>you are</u> doing*?).

These rules are taken for granted by native speakers but can be very confusing for non-native speakers. Some of the communication models (see literature chapter) advise that when speaking to either LEP patients or interpreters, doctors can use simplified English, which sometimes can be non-grammatical sentences in order to minimise confusions brought by the syntactic variations.

3.4.5 Semantics and lexicon

Semantics is the study of relationships between signs (lexicon) and symbols and what they represent (Jeffries, 2006). This is based on the understanding that words have meanings, especially referential meanings. That is to say, a word is referring to something in the physical world, either tangible or intangible. When we see *apple*, we know this word refers to a kind of fruit we can eat. When we say sad, we know this indicates a disagreeable emotion. There are words that have more than one meaning (polysemy) and words that have the same morphemes but different meanings (homonymy) (ibid). A native speaker would be able to tell that 'saw' in 'The saw is broken' is a noun but not a past tense verb. However, these semantic features can also be a source of communication difficulties in cross-cultural communication.

3.4.6 Language in use

Phonetics, phonology, morphology, syntax, semantics and lexicon can be called grammar[6] (Thompson, 2003). Knowing the grammatical structures of a language is the premise for one to begin to use this language to make sense to others and understand others. 'The assumption here is that the interactants are engaged in the use of

[6] It is uncommon to include phonetics and phonology in grammar but here for the sake of emphasising the structuralist approach to language I follow Thompson's categorisation.

conventional linguistic forms grounded in a common language with semantic and syntactic conventions' (Psathas and Anderson, 1990: 80-81).This premise is usually taken for granted by the native speakers of a language in that these conventions are integrated as part of their language ability (Jeffries, 2006, Schiffrin, 1994a). However, grammar can be a key issue that hinders communication if one or more of the interlocutors are non-native speakers (see Chapter 7, Excerpt 13 for an example where the grammar has caused interpreting difficulties).

However, in the actual use of language to achieve the goal of the communication, knowing the basics of a language is far from enough. There are other things beyond sentences or even beyond the language that come to affect our sense-making. The following example of a conversation between two native speakers can give a straightforward demonstration of how the background knowledge about an activity in which the conversation occurs can influence the interlocutors' sense making

EXAMPLE 1 (TAKEN FROM GRICE, 1975: 51)

A: Smith doesn't seem to have a girlfriend these days.
B: He has been paying a lot of visits to New York.

This is an artificial conversation constructed by Grice to illustrate that although B's utterance is seemingly irrelevant to what A says, it does not prevent us from understanding B's utterance as a legitimate reply to A. The reason is that when we are interpreting the conversation we do not only read the words and analyse the structures but we also resort to what we know about conversation—the conventions we follow to participate in conversations as a member of this language community. Such knowledge of conventions is also what the interlocutors have in order to make sense to and understand each other. To make this conversation legitimate, there are several kinds of knowledge A and B should have. Firstly they should know about each other. A should know that B knows this Smith and should be close enough to know

about Smith's personal life. Otherwise the talk about Smith's girlfriend would not make sense to B. On the other hand B also needs to know that A is qualified to know about Smith as, for instance, his friend rather than a lousy person trying to pry into another's private life. Secondly they need to know the topic. A should know about Smith and also may have noticed, for instance, that these days he has no female visitors or doesn't talk about a girlfriend. On the other hand B should also know where Smith has been. Thirdly they need to have the knowledge of the linguistic conventions that underpin people's behaviour in conversations. A's utterance is seemingly an assertion. However, it was received by B as an expression of the lack of information about Smith or even a request for such information. To understand A's utterance as such and respond appropriately requires B to understand not only each word said by A but also the intentions beyond the words.

In order to understand how people use language in real life, it is not enough just to investigate the constructing elements of a language. Instead it should be taken as integrated discourse, which is a level above sentences. Before I discuss more about the approaches used in studying discourse, I need to briefly talk about the concept of discourse.

3.4.7 Understanding discourse

There are two basic approaches to discourse, namely the structuralist approach and functionalist approach. Different approaches have their own assumptions about what is discourse and how it should be studied. Structural approaches view discourse as 'a level of structure higher than the sentence, or higher than another unit of text' (Schiffrin, 1994b: 24). Analysts take sentence as the smaller unit that comprises discourse. The advantage of this kind of approach is that it acknowledges that the study of language can go one level higher than sentence. On the other hand it also accepts that discourse is comprised of smaller linguistic units, such as morphemes, syntax and semantics that have been the focus of traditional linguistic studies. However, taking sentence as the smaller unit that constitutes discourse is flawed by

the fact that 'spoken language is produced in units with intonational and semantic closure—not necessarily syntactic closure' (Schiffrin, 1994b: 25). That is to say people do not always produce sentences when they talk. A word or even a non-verbal utterance like a sigh can make sense and function in a conversation.

In contrast the functionalist view of discourse provides a broader explanation of what comprises discourse. It considers any aspect of language use to be the content of discourse and the content of analysis (Fasold, 1990). Brown and Yule propose that the analysis of discourse is 'the analysis of language in use' (1983: 1). Analysts holding this viewpoint tend to focus on the social function of language in constructing, for instance, power, ideology or identity (such as critical discourse analysis (Fairclough, 1989, 2001)). This notion of discourse leads analysts away from the analysis of the basic structures of language to focus on the way utterances are situated in context.

Another approach to spoken discourse is to consider discourse as utterances. Schiffrin suggests that taking discourse as the smaller unit comprising utterances is to view it 'not as a collection of decontextualised units of language structure, but as a collection of inherently contextualised units of language use' (1994b: 39). This definition combines the notion of the contextualisation of language use in particular situations with the notion that language is constituted by structural rules. It extends the boundary of the formal study of language beyond the grammatical rules to look at patterns, sequences and orders of utterances. At the same time it situates the analysis into the context.

From different definitions come different analytical approaches to discourse. Linguistic studies that focus on the level of discourse of language are usually termed discourse analysis in a broad sense. To use discourse analysis as an umbrella term covering all the other approaches is more like shorthand used by authors (such as Flick, 2009, Schiffrin, 1994a), who usually introduce discourse analysis as a qualitative method. However, more scholars tend to distinguish discourse analysis from another approach, conversation analysis (CA), due to their distinctive characteristics (Wooffitt, 2005,

Silverman, 2006). The most significant difference between conversation analysis and other discourse analyses is people's attitude towards context and the use of context in researching discourse. For scholars of many discourse analysis approaches, sociocultural context plays a significant role in the interpretation of data. It is considered to be the constructing element of language use and provides the overarching rules which govern people's use of language. Supposedly the native speakers of a certain language community would have the sociocultural knowledge, with which to construct their behaviour using language. The analyst needs to take into consideration the role of sociocultural knowledge in interaction and to do so they have to be versed in the knowledge, which analysts may obtain by utilising other qualitative data. This kind of approach, however, is criticised by conversation analysts who argue that the analysis depending on the researcher's knowledge of the sociocultural context gives too much credit to the researcher's expert knowledge in interpreting the language in use; it is even more so in interpreting the non-empirical data (Wooffitt, 2005, ten Have, 2007). Conversation analysts acknowledge the impact sociocultural context has in constructing the spoken discourse but they disagree that the analysis should start from sociocultural context. Contrarily, they believe that despite the universal existence of sociocultural context, not all of it is relevant to a particular social event in which the talk-in-interaction occurs and is studied. It is only the context that the participants in such an event orient to in their construction of meaning in the interaction, that becomes relevant for the analysts to take into consideration in their investigation.

As I argued at the end of the last chapter, a study on skills for communication across language and cultural barriers will benefit more from CA's devotion to accounting for mechanisms in the verbal interaction. However, this does not mean that I am a strict traditional follower of CA nor will I disregard the benefits of other qualitative research methods. As I will explain in later sections, this research is an applied enquiry using CA (ten Have, 2007). In order to enhance the trustworthiness of the data analysis reflective interviews were also used in this study (which will be elaborated on in

Chapter 4). The following section further elaborates on the rationale for choosing CA for this research. I will begin with how CA has developed into a discipline in its own right.

3.5 Focusing on CA

CA studies talk in interaction in its own right. It is believed that mundane conversations are not at all random but rather can be systematically analysed and formally described (Sacks and Jefferson, 1992). As mentioned in the previous section, the aim of CA is to identify the patterns, practices or devices that underlie meaning and action constructed in people's interaction (Drew and Heritage, 2006). By investigating people's talk in interaction, analysts endeavour to disclose the norms, practices and competences underlying the interaction, through detailed analysis of recorded naturally occurring talk-in-interaction (Hutchby and Wooffitt, 1998).

CA is aimed to understand the patterns in social interaction. It is also assumed that 'such patterns can be used to develop procedural rules governing talk-in-interaction' (Bhatia et al., 2008: 4). An earlier study of interactions between patients and healthcare professionals by Paul Drew et al (2001) points out the lack of an appropriate method for studying the impact of communicative choices on the quality of medical services, following which the authors propose CA as a solution. They also imply that CA's capacity to identify patterns of behaviour may have implications for communication training for the doctors.

In the light of these implications, I am going to follow ten Have's discussion of the advantages of using CA in social research (2007) to justify and consolidate the choice of CA for the current research:

1. CA operates *closer to the phenomena.* To understand the nature of the verbal interaction in interpreted consultation is a matter of understanding the intricate manipulation of the language used in interaction. CA's perseverance

to work on detailed renderings of interactional activities and detailed transcripts enables the analysts to reach this goal more effectively and directly.

2. CA favours *naturally occurring data* and studies *language-as-used*. Prioritising naturally occurring data over the use of additional sources of information (e.g. interview, observation, field notes etc.) gives researchers a special position, from which they analyse the interlocutors' activities in the same way as GPs are analysing the activities of others when interviewing the patient through the interpreter.

3. CA's emphasis on the use of naturally occurring data prevents abstract theoretical constructs and idealization getting into the data. This guarantees that our understanding of talk-in-interaction is evidence-based, not idealized. Consequently, any communication skills based on this feature are evidence-based as well.

4. Conversational analysts perceive that conversations are organised and procedurally produced, instead of being random productions that cannot be formally described. This perspective matches the researcher's goal to have a systematic understanding of the interaction in interpreted conversations.

CA's focus on meanings created in sequential interactions, rather than meanings predetermined by sociocultural constitutions, distinguishes CA from other studies of discourses and also makes it the best candidate for communication study. Understanding of the diverse and dynamic sociocultural constitutions is a necessary component of communication education but it should not and also cannot be achieved by teaching each culture and custom. However, it can be achieved through the endeavour to understand people's systematic organisation of talk-in-interaction. The understanding of the systematicity in interpreted medical consultations is approved in this research to be informative for the development of a behaviour-based set of medical communication skills, which were found useful by the GPs who attended the interview. Then what indeed does CA do and how can CA be actually implemented in

researching talk in institutional context, such as a GP consultation? The rest of this chapter will try to answer these questions

3.6 UNDERSTANDING CA

3.6.1 DEVELOPMENT

CA originated from Harvey Sacks' study of the telephone calls made to the Suicide Prevention Centre (SPC) in Los Angeles during 1963 and 1964. He investigated the systematicity of how the callers construct their troubles through telephone conversation with the SPC counsellors. This has paved the way for his exploration of generic 'machineries' of turn-taking and sequential organisation in social activities performed through conversation (Lerner, 2004). In collaboration with Gail Jefferson and Emanuel Schegloff, Sacks started to disclose the comprehensive picture of how people construct their conduct in such a highly organised and orderly manner when participating in social activities.

Nowadays CA has developed into a multidisciplinary study to involve linguistics, sociology, anthropology, psychology (Schegloff, 1991), pragmatics (Fitch and Sanders, 2005) and sociology (Knorr-Cetina and Cicourel, 1981, Giddens, 1984, and Thompson, 1984), aiming at identifying the patterns, practices or devices that underlie meaning and action (Drew and Heritage, 2006) constructed in people's interaction. Students of CA study not only the mundane conversations that comprise people's everyday life, but also conversations in particular institutional settings, such as, in courtrooms (e.g. Atkinson et al., 1979), news-interviews (e.g. Heritage and Greatbatch, 1991), classrooms (e.g. McHoul, 1978), medical consultations (e.g. Drew et al., 2001) and so forth.

3.6.2 GENERIC FEATURES OF CONVERSATION

CA scholars have their unique theoretical assumptions about conversation. For them conversations may vary in terms of the content, the length of conversation and

participants etc. However, Sacks, Schegloff and Jefferson (1974: 700-701) have observed the following generic features embedded in any kind of conversation.

1. *Speaker-change recurs, or at least occurs*. Conversation is interactional. In order to converse, all the participants have to speak, yet before speaking they have to listen to what is said by other participants. When one is speaking, another or others will be listening and they take turns to speak and listen in order to realise the function of the conversation. Turns-at-talk are passed from one speaker to another; thus the speaker changes when the turn is passed on. This activity occurs at least once in a conversation and more often than not recurs as the conversation continues. If the speaker-change happens only once, it is considered as the 'special case of speaker-change recurrence' (ibid: 706).
2. *Overwhelmingly, one party talks at a time, and overlaps are common but brief.* This means that for most of the time in the process of a conversation, there is only one speaker speaking at a time. Although it is possible that more than one of them speaks simultaneously, the overlap is brief and only one speaker can finish the utterance till the end of the turn-constructional unit, while others withdraw right after the onset of their premature utterance.
3. *No gap and overlap is common in turn transitions.* The turns are passing from one speaker to another continuously and predominantly with no gap and overlap.
4. *Turn order and turn size are not fixed but vary.* Once a speaker finishes the turn, any participant who starts speaking first gets the right to speak in the next turn. Anyone can be the first to start speaking for the next turn and the order of the turn-taking among participants is not predetermined but varies as the conversation proceeds. In each turn, the speaker can speak for a longer or shorter turn according to the need of the nature of the content. A turn can be as short as a single word, such as 'What?', or as long as a stretch of many sentences.

5. *The length and content of the conversation are not specified in advance.* As in the turn size, the length of a conversation also varies according to the need of the participants. What they talk about is not predetermined but can change as the conversation carries on. A single conversation can cover one or several topics and the content of each turn is locally designed according to the immediate context created by the sequential interaction.
6. *Relative distribution of turns is not specified in advance.* Once a speaker finishes a turn, the opportunity is open for all the parties to assume the next. The current speaker can select who to take the next turn; however, the one who is chosen does not have to speak, while some other participant may do. If no one takes the turn, the current speaker may continue until the turn-taking is executed.
7. *Number of parties can vary***.** Different conversations may have different numbers of parties. Even in one conversation, the number of participants may change when people join or leave the conversation.
8. *Talk can be continuous or discontinuous***.** A conversation can stretch for many turns without a stop or stop when no one takes the next turn, and continue when the turn is resumed by one participant.
9. *Turn-allocation techniques are obviously used.* In the turn-taking system, the 'current speaker selects next' technique is always observed by the participants. The current speaker can either select an exclusive next speaker or leave the chance open so that all participants can self-select for the next turn. If no one takes the next turn in either way, the current speaker can self-select until another speaker takes the next turn.
10. *Various 'turn-constructional units' are applied.* Turn unit-types in English are classified as 'sentential, clausal, phrasal, and lexical constructions' (ibid: p4). A turn is constructed by one unit or a combination of more than one unit.
11. *Repair mechanism applies as well.* Conversations do not always go well. Misunderstandings, difficulties, or errors may happen from time to time. These are considered as the 'trouble sources' or 'repairables' (Schegloff et

al., 2007). When there is a 'repairable', a repair can be applied. It can be initiated by self and repaired by self, or by other; or initiated by other and repaired by self or other.

There has been a debate between a series of anthropological studies that report on the cultural differences in the turn-taking system (e.g.: Agliati et al., 2005, Gudykunst and Nishida, 1994) and other linguistic approaches that favour the claims of the universality of turn-taking (e.g.: Enfield and Levinson, 2006, Sidnell, 2001). A widely quoted response to this debate is a comparative study of 10 languages by Stivers and colleagues. They report that 'all of the languages tested provide clear evidence for a general avoidance of overlapping talk and a minimization of silence between conversational turns. In addition, all of the languages show the same factors explaining within-language variation in speed of response' (Stivers et al., 2009: 10587). They argue that 'robust human universals in this domain, where local variations are quantitative only, points to a single shared infrastructure for language use with likely ethological foundations' (ibid). This piece of research sheds more light on the possibility of the existence of a universal turn-taking system across cultural and language variations in interpreted discourse in medical consultations, which the CA study in my research is to investigate.

3.6.3 Four basic analytical concepts

The core of the above listed findings or of the generic features of conversation is the turn-taking system. It is constituted by four basic concepts (Drew, 2005, Drew and Heritage, 2006) CA students are striving to investigate in each conversation: turns at talk and turn taking; turn design; social action and sequence organization.

3.6.3.1 Turns at talk and turn-taking

The concept of turn-taking is basic for the organization of talks-in-interaction. Participants in a conversation take turns to speak. They pass the turns from one to another as the conversation proceeds. Each turn is constructed by turn-constructional units—lexis, clauses, and sentence, which have very fundamental significance for

linguistic analysis (Drew, 2005). At every possible completion of a first such unit exists an initial **transition-relevance place (TRP)** (Sacks et al., 2007). That is where the transfer of speakership takes place. The TRP is a chance for the turn to be passed from one speaker to the next. Participants of conversation take turns to construct their utterance with these turn-constructional units. Turn-taking does not happen at random, but rather through a systematic procedure, which guarantees that there is only one person speaking at a time. This system also oversees that overlap and gap between two turns are minimum in order to guarantee the smooth flow of the conversation. The rules of the system can be summarised in the following points (Sacks et al., 2007):

1. At any initial TRP of an initial turn constructional unit in each turn:
    a) The current speaker selects a particular other speaker for the next turn;
    b) If the current speaker so far does not select the next speaker, the chance for the next turn is open to any participants to execute self-selection; and the first starter has the right to the next turn to speak;
    c) If no one is selected or self selected, the current speaker can, but need not, do self-selection.
2. If neither 1a nor 1b is realised and the current speaker continues the turn till the next TRP, rules 1a-1c will recur at every TRP until the turn transfer is affected.

In sum, there are two groups of turn-allocation rules. One is what is called 'the current speaker's selecting next speaker' (ibid: 6) and another is the self-selection.

3.6.3.2 TURN DESIGN

When taking turns to speak, a speaker always has to design the turn. To do this, the speaker is designing, on the one hand, the kind of action to perform in the turn and, on the other, the kind of verbal constructions that he or she should operate to accomplish the action (Drew, 2005). Speakers always converse with certain purposes, either to enhance the social relationship or to exchange information. By selecting the lexis and syntactical structures in their utterances, they design their actions to achieve these

purposes. By using the following example, I will explain how turns at talk are designed by the participants for a particular conversational purpose.

EXAMPLE 2

(Mishler, 1984: 165)

1. Dr: How long have you been drinking that
2. heavily?
3. Pt: Since I've been married
4. Dr: How long is that?
5. Pt: (giggle) Four years

The two participants, doctor and patient, constructed four turns (5 lines) in this conversation to accomplish the purpose of exchanging biomedical information in a medical consultation. In line 1-2 the doctor constructs a question to ask the patient 'how long' she's been drinking 'that'. By producing this, the doctor is doing an action of questioning or requesting information. His choice of the present perfect continuous tense to construct the question indicates that he knows that the patient has been drinking heavily for a while and she is still doing so. In the patient's turn (line 3), she constructs the turn to answer the question by using her life time (time of her marriage) instead of the calendar time, which reveals the complainable information of 'why' she has started drinking heavily (Drew and Heritage, 2006). However, by redoing the question, the doctor denies the appropriateness of her response in such an institutional setting.

3.6.3.3 SOCIAL ACTION

When people talk interactively, they are not simply producing words, but also doing actions to participate in the social activity. As in *Example 2*, both the doctor and the patient are participating in the medical interview by verbal constructions. Analysts not only want to know what kind of actions people are doing, but also how they construct and understand one another's conduct in the interaction. This pursuit directly connects 'turn design with the accomplishment of social action' (Drew, 2005 :87).

3.6.3.4 SEQUENCE ORGANIZATION

Turns at talk are allocated in an orderly sequence. When producing an utterance in the current turn, the speaker is creating a certain context that the next speaker is restricted by. That is to say, the next turn must be relevant and responsive to the current turn. A 'question' requires to be followed by an 'answer', an 'invitation' precedes an 'acceptance' or a 'refusal', a 'greeting' is responded to by another 'greeting', and so forth. These norms are known to and observed by the interlocutors of a homogeneous society; therefore, a speaker, when performing an action, can expect the next turn to be restricted to an action paired with and relevant to the current action. Simultaneously, the recipient can recognize and understand the action and its expectations and then will produce a relevant action in a next turn. The basic form of such paired sequential organization of turns at talk is known as **adjacency pair**, which is defined by Schegloff and Sacks (1973) in terms of five basic characteristics: an adjacency pair is (1) a sequence of two utterances, which are (2)adjacent, (3) produced by different speakers, (4) ordered as first part and second part, and (5) typed, so that a first part requires a particular second part (or range of second parts) (Schegloff and Sacks, 1973: 295-6). Once a recognisable first pair part is produced, the speaker should stop on its first possible completion and a next speaker should start and produce a second pair part which belongs to the same pair type as the first pair part.

3.7 CA AND INSTITUTIONAL TALK

3.7.1 CONTEXT

Context and meaning are the two major issues CA sets its focus on (Heritage, 2004). However, the concept of 'context' is not of any kind that is believed in other studies of discourse to be pre-existent and have predominant bearing on the participants' action in conversation. Instead, CA treats context as a dynamic element that is 'locally produced, incrementally developed and, by extension, transformable at any moment' (Drew and Heritage, 1992a: 21). Context does not exist out of the conversation but instead is a creation through the conversation and is constantly developing as the sequence of verbal interaction progresses. In a conversation, there are two elements

that are not only context shaped but also context renewing, namely the utterances and the social actions they embody (Heritage, 1984). Context here means both the immediate local construction of the preceding activity in which the utterance is produced, and also the 'larger' sociocultural environment in which this local construction is recognisable. Utterances and actions are context shaped because they can only be fully understood by the participants in reference to the context their conversation is relevant to. The current utterance is restricted by and relevant to the context produced by the preceding utterance as well as the social context to which it referred. The current action performed through the constructed utterance is thus shaped. In every current turn an immediate context will be produced in the actions the speaker performs and it will have impact on the utterances and actions in the next turn. This locally produced context develops as the interaction progresses; therefore, the successive actions in sequence are also accordingly renewed (Drew and Heritage, 1992a).

Context in the conversational study of institutional interaction particularly means the social worlds of the corporation, classroom, medicine, law, etc. They "are evoked and made actionable in and through talk" (Heritage, 2004). Heritage (2004) made a significant point about the reality of social institutions and their realization in talk. Although institutions are "talked into being", their reality is not confined to talk but exists "in and as documents, buildings, legal arrangements, and so on." (ibid: 223) The purpose of doing CA under institutional contexts is to explore "how the institutional realities are evoked, manipulated, and even transformed in interaction" (ibid).

In order to be able to orient to the institutional context in the interaction, participants need to have the knowledge of the institutional realities either through social experience or by education or training. Institutional representatives or professionals are more likely to gain such knowledge through systematic education or training, while lay-participants also have a certain degree of such knowledge but it is likely to be gained through experience, which can be limited and inadequate. It is because of this

asymmetric knowledge of the institution between the professionals and lay-persons that makes the interaction necessary (Heritage, 2004).

However, not all the institutional properties known to the participants are oriented to in the conversation, neither are they all relevant to the analysis of the interaction. One reason for this is that the situation is changing constantly and some properties may apply to one situation but not another. Another reason is that different people may have different degrees of knowledge of the properties, and even professionals may be at various levels of proficiency. Conversational analysis concentrates on only the properties relevant to the participants. It helps to identify how the participants orient their talk, what kind of properties they make relevant to the talk, and what kind of techniques they use to effectively manipulate such orientation. This capacity of CA entitles it to be an efficient tool for developing communication skills.

3.7.2 Institutional talk

Institutional talk occurs in a certain institutional context, which provides particular environmental settings, identities and purposes that the participants of the conversation could orient their utterances and actions to for the production and understanding of the interaction. However, according to Drew and Heritage (1992a: 3-4), the institutionality of an interaction is not determined by its setting (or the institutional context) but by whether participants' institutional or professional identities are somehow made relevant to the work activities in which they are engaged. Therefore, there is no hard demarcation between institutional and mundane conversation in that participants can always shift their reference between the institutional context and daily life context. That is to say, sometimes the participants can talk the way they do in daily life, disregarding the institutional conventions. Therefore, the institutional context is oriented to by the participants but not necessarily all the time. However, the existence of institutional context still makes interactions in institutions different from mundane talks. Their features can be summarised into the following three points (Drew and Heritage, 1992a: 22):

1. Institutional interaction involves an orientation by at least one of the participants to some core goal, task or identity (or set of them) conventionally associated with the institution in question. In short, institutional talk is normally informed by goal orientations of a relatively restricted conventional form.

2. Institutional interaction may often involve special and particular constraints on what one or both of the participants will treat as allowable contributions to the business at hand.

3. Institutional talk may be associated with inferential frameworks and procedures that are particular to special institutional contexts.

I would like to elaborate on these three points by using the previous example (2) of an institutional encounter between a doctor and patient in the medical consultation. Regarding point 1, both of the participants know who they are and what they are doing there (although they do not always have the same expectations of the outcome of the encounter); that is to say, they have some mutual understanding of the goal and tasks in this interaction. Both the doctor and patient aim at getting the patient's medical complaints resolved. To achieve this goal they will have to work together to finish certain tasks. That will include the doctor requesting biomedical information from the patient and the patient giving adequate information for the doctor to provide appropriate treatment. Both of the participants will orient to these contextual factors to produce meaning and understand the other's meaning. However, this example is also a good example to show that participants do not always orient to the same institutional settings at the same time. As explained earlier, in line 3 the patient's response is not accepted as appropriate by the doctor under that particular institutional circumstance (the doctor considers that particular sequence of interaction as one to obtain biomedical information not for lifeworld complaint). The reason for this is that the previous action of the doctor is not understood as a simple request for biomedical information by a medical professional but as a chance opened up by the doctor for revealing the general complainable aspects in the patient's social life. Although both participants are talking in the same institutional context and orienting to certain institutional role of the doctor, they are really orienting to different roles the doctor may play in a consultation.

Following this explanation, point 2 of the constraints of the institutional context on the interaction becomes obvious. In this example, the doctor is to ask questions only relevant to the practice of healthcare, and so will the patient answer questions. Institutional restrictions are more strictly followed in activities whose level of formality is relatively high, as in courtrooms or job-interviews. While for others, like a doctor-patient consultation or social service conversation whose formality is not that strongly expected, participants' orientation to institutional constraints can digress. There are two types of digression. Firstly, the participants can change their reference from institutional to ordinary daily talk. That is how the patient's understanding of the doctor's action in line 2 of Example 2 digresses from the institutional goal of medical consultation. Secondly, participants can also change the reference from one institutional context to another.

For a medical encounter as in example 1, participants roughly follow a procedure, from initiating the session, gathering information, to physical examination, explanation and planning and closing the session (Silverman et al., 2005). This procedure, as proposed to point 1, characterises this sort of interaction and distinguishes it from other institutional interactions.

The following example, taken from Philip Strong in Sarangi (2000: 10), is between a doctor and a parent taking her child to see the doctor. In this conversation, as Sarangi analyses, the question-answer sequence resembles cross-examination in the courtroom.

EXAMPLE 3

A: Are there any other problems?
B: well, he chews cigarette ends…((laughs))….it's very difficult to stop him.
A: why are you laughing? Do you think it's funny?
B: No, I don't think it's funny.
A: Well. Why did you laugh then; do you always laugh at this?
B: No, I don't.
A: Why did you say you did?
B: I didn't

Although this kind of digression is not typical of medical consultation, the possibility is there for the participants to choose to refer to different institutional restrictions according to their need.

Any institutional interaction has its own set of procedures that participants have to follow and that restrict their contributions to fulfil the function of the institutional talk. Although medical consultation allows participants more freedom to choose verbal constructions and actions, there is still procedure to follow in order to accomplish the tasks of the consultation. Doctors will go through the process of starting the session with the patient, gathering biomedical and relevant lifeworld information, explaining to and planning with the patient about the treatment and closing the session (Silverman et al., 2005). Although different doctors with different patients can do this differently, this model provides an overall structure of medical consultation, which is a very important element in analysing the institutional talk that I am going to turn to next.

3.7.3 Analysing institutional talk

Although the specificality of the institutional context differentiates institutional talks from the mundane conversation in people's daily lives, the generic features of human conversation still remain. Turn-taking, turn-design, sequence organisation and lexical choices are still the features to look at when analysing talk in institutional settings. In addition, conversation in institutions is more structured than daily talk, which, however, may also have a rough structure of beginning and closing. Due to the particular purposes of the institutional interaction, there are a set of tasks the participants have to do through the interaction. These tasks are not undertaken at random but rather in a pre-organised sequence which is recognisable for the participants or at least for the person who is bearing the institutional identity. This sequence is the **overall structure** of the institutional talk and the manipulation of this sequence is the **overall structural organisation (Heritage, 2005)**. However, Heritage

(2004: 230) also points out that this structure is not fixed and always occurs in any conversation but rather something 'that we are looking for and looking at only to the extent that the parties orient to it in organizing their talk'. He (2004: 225) then suggests the six basic places where to investigate the 'institutionality' of interaction: 1) turn-taking organization; 2) overall structural organization of the interaction; 3) sequence organization; 4) turn design; 5) lexical choice; 6) epistemological and other forms of asymmetry.

3.7.4 TALK IN PRIMARY CARE CONSULTATIONS

Primary care, one of the most common medical encounters in people's lives, constitutes a particular setting, in which people's particular interactional identities, roles and larger social and institutional identities are established, maintained, and manipulated (Heritage and Maynard, 2006b). The interactional encounter between doctors and patients demonstrates, just like many other "non-formal" institutional interactions (Heritage and Greatbatch, 1991), a combination of ordinary life conversation and task-driven institutional interaction. Patients bring to the treatment room not only their medical problems but also their lifeworld, which plays an important role in their institutional encounter. There are certain procedures for interactional parties to follow in order to accomplish the tasks or the purpose of the interaction. Both doctors and patients have to work together to orient and negotiate the boundaries of each of the main activity components (Heritage, 2004). As Heritage and Maynard point out, conversation analysis will enable us to have a systematic insight into how doctors and patients, "distanced in terms of official expertise yet bound in the communicational sphere', conduct themselves to accomplish the practice of primary care. And this can improve the "scientific understanding of medical practice" and "also to improve it" (Heritage and Maynard, 2006b :21). This perspective is also shared in the current investigation of interpreted consultation in primary care by doing conversation analysis.

3.8 CA IN THIS RESEARCH

To understand how CA can help to understand interpreted consultation, we are committed to answer two questions. The first is how CA can contribute to our understanding of verbal interactions in the medical consultations as a kind of institutional talk. This has already received extensive attention for quite a long time. As Drew et al. (2001) point out, CA can offer a new insight to the interaction and communication between the doctor and patient. It helps to identify the patterns of behaviour, the interactional strategies of participants and to explore the relation between the interactional styles and their outcomes.

The second question is: how can CA explain interpreted conversation? CA has been successfully used to investigate human conversation in many languages. However, its use in across-language conversation or interpreter-mediated conversation is still novel (see sections 2.5.5 & 9.2) and so far there has not been adequate literature contributed to it. The following chapters report on the procedure of the research, findings of the conversation analysis of the empirical data, and the communication skills developed from the CA study. They hope to provide more insight into CA as a tool for social enquiry, the mechanism of interpreted discourse and also medical communication.

CHAPTER 4 METHODS—HOW IT ALL HAPPENS

Following the theoretical discussion in the previous chapter, this chapter explains the specific methods used for data collection and data analysis, the rigour of research and methodological limitations.

4.1 SITE AND LANGUAGE SELECTION

Bradford is where this research was situated. This is not only because the research funding is from the local NHS but also because of Bradford's unique ethnic composition. In keeping with the diverse demographics, various language services and supports are available in primary care and secondary care in the area (Nazir, 2003), making Bradford one of the most resourceful areas in the country for research into healthcare for ethnic minorities. But at the same it also imposes challenges on choosing participating GP practices. As part of a PhD, this project was only able to involve a small group of people and GP practices that were willing to participate in the research and also would best represent the population in the area.

The selection of practices is related to the selection of languages. In order to see whether the language and culture will affect people's way of interaction in an interpreted consultation, two languages that are culturally and linguistically distant from each other are needed. A practice to be eligible for the research has to have sufficient number of patients speaking either or both of the two languages and visiting the practice with either professional or ad hoc interpreters. Therefore, the selection of the languages and practices were carried out. The first thing was to identify the languages, which meet the contrasting requirements and are also representative in Bradford. Secondly I needed to identify practices where patients speak the languages. I looked into the official demographic statistics (Home Office., 2002) and consulted the manager of the NHS Bradford and Airedale Primary Care Interpreting Service (PCIS), who held a record for 2009, with such basic information as, the languages required by health departments, the names of the departments, dates and times, names of

interpreters and doctors, etc. According to this record from the PCIS, two languages were identified—one Asian language, Urdu[7] and another East European language, Slovak. What became clear was also the GP practices which had required interpreters for these languages the most in 2009. These practices were chosen for individual visits by me and the project NHS coordinator. At the same time in order to enhance the success rate of recruiting practices and also to give the equal opportunity to all possible practices in the region, a recruitment advertisement was sent to the PCT newsletter—Bradford PCT Primary Care Update to be circulated across the GP practices. Eventually three practices were recruited, Hor, Ken and Kil as shown in the transcription. All of the practices use both professional and ad hoc interpreters and have patients speaking Urdu and Slovak. However, Kil was not able to recruit any patient and interpreter by the time the recruitment ended.

4.2 Data collection—video recordings

4.2.1 Participant recruitment and consent

There are three types of participants—the GP, patient and interpreter. The selection followed the following criteria:

Inclusion:

1. GPs who are using either professional or ad hoc interpreters in consultations.
2. Patients who do not have sufficient English and need an interpreter when seeing the doctor.
3. Professional interpreters affiliated to certain organisations providing interpreting services and receiving payment.
4. Family members, friends, strangers, medical and nonmedical staff who act as ad hoc interpreter for the non-English speaking patients (included in 2).

Exclusion:

[7] Mirpuri Punjabi was accidentally included in one consultation.

1. GPs who consult with patients with limited English proficiency without using interpreters.
2. Patients who use interpreters but speak a language not chosen for this research.
3. Patients or interpreters who cannot give written consent.
4. Patients or interpreters who the research assistant believes are not fully able to understand the information given about the research on the information sheet and in the RA's explanations.
5. Patients or interpreters who are under the age of 16.

The GPs were recruited in parallel with the recruitment of the practices in that the meeting at each practice was usually attended by the manager and GPs interested in participating. If they agreed to participate they would give their verbal consent during the meeting; however they would be asked to give written consent before each consultation was recorded. Initially 5 GPs were recruited but by the time the data collection was ended, only **two** GPs from Hor and Ken had eventually succeeded in recording some of their interpreted consultations. Other doctors had to withdraw either because of other commitments or because they were unable to recruit other participants.

The recruitment of patients and interpreters were complicated and difficult. Three documents were prepared in advance for use in recruitment—**a poster**, **information sheet** and **consent form**. They were originally written in English and then translated by professional translators into Urdu and Slovak. Three posters in all three languages were displayed in each practice to draw people's attention. If a pair of potential participants were identified, a member of staff (a GP) who was responsible for obtaining consent would approach them, using the poster to seek interest. The staff member would first approach the interpreter coming along with the patient and then asked the interpreter to interpret for the patient during the whole process of explaining and obtaining consent. If they were happy to be given further information they would get the information sheet and hear about the research in detail. If they

were happy to participate, they would be asked to sign on the consent form before the consultation was to be recorded. They would be asked to sign the consent form again after the consultation in case things they had not anticipated before the consultation happened and they had to change their mind.

The initial plan was to use receptionists at each practice to obtain consent. Training was given to equip them with sufficient understanding of the project and the appropriate way to obtain *informed consent* (Caulfield et al., 2005). Detailed information can be found in the training handbook in Appendix B. However the plan had to change soon after the recruitment had started. Problems stemmed from the sophisticated process of approaching the participants and getting consent. Firstly the whole process was time consuming because of the complexity of content to be passed to both participants and the need for translation. Receptionists were finding themselves busy with the administrative work when the patient came and unable to obtain consent as required. Secondly the communication imposed difficulties on the process. Although the three documents were written in plain language and contained only the most basic and crucial information about the research, the communication was still highly demanding. Without training in passing difficult messages, the receptionists found it difficult to do the job. And the use of an interpreter made the whole process even more difficult. Therefore, the recruitment had to be commissioned to the GPs. The two practices adopted two modes of recruitment. In Hor, to which the NHS coordinator is affiliated, the recruitment was done by her; while in Ken and Kil the participating GPs were willing to do it themselves. Having a GP to obtain consent proved to be effective. In Hor the participating GP would identify interested people and then asked the coordinator to talk to them about the research in detail. In Ken the participating GP would do it before each consultation. The advantages of this approach are that the GPs understood the research and the required procedure for obtaining informed consent better than receptionists. Moreover, patients and interpreters trusted them more.

Despite these advantages the whole process was still reported to be very difficult. Sometimes the GP had to spend 30 minutes to recruit a pair of participants and yet there is no guarantee that people would agree to participant despite the time the GP spent. The poster was found to be very useful for generating interest. The information sheet was more helpful for the GP when explaining the research in detail than for giving the patient and interpreter information. Although all the documents were translated, not all the patients were able to read and interpreter also found it difficult to verbally translate the information sheet. In some occasions the GP had to disqualify them due to a lack of evidence that they understood. Because of some patients' low literacy the explanation was very challenging. Sometimes the GP even had to explain what 'research' meant before they could begin to explain this particular research. It was also found that the communication was much easier through professional interpreters than through family members serving as ad hoc interpreters.

4.2.2 Video recordings

For getting naturally occurring data, as required by CA, a wide-angle video camera was situated in the GP consultation room. Once the consent was obtained from the Pt and Int the Dr would start recording. Physical examinations would be done out of scene if necessary. By the time data collection was finished, the data were composed of 7 consultations, including two GPs, three interpreters and 7 patients. The non-English languages involved were: Urdu, Mirpuri Punjabi, and Slovak.

4.2.3 Transcription and translation

Transcription is a significant supplement to the actual data—the audio recordings. Due to the language barrier in the research, to ensure a reliable transcription production bears even higher significance than in other CA studies, in which the researcher speaks the investigated language. In this research I developed a collaborative work mode to produce transcripts. Professional translators were recruited and trained to become bilingual transcribers, who worked closely with me to transcribe and translate the data.

Various measures were taken to combine my expertise in linguistics, translation/interpreting, second language education and the transcribers' expertise in the languages and cultures in order to ensure the reliability of the transcript and hence the data analysis.

4.2.3.1 BILINGUAL TRANSCRIBERS: RECRUITMENT AND TRAINING

Recorded consultations were all transcribed using Jeffersonian conventions or CA transcription (see Jefferson, 2004; also Appendix A) and translated into English. The work was done in collaboration between the researcher and trained bilingual transcribers. A bilingual transcriber was required to do three things: transcribe as normal, translate into English and transform the transcript using the Jeffersonian system. The multilayer tasks were so new that there were not any readily professionals who have practiced in and are readily available. In order to overcome this difficulty, I recruited and trained qualified bilingual professionals to do the job (see training document in Appendix C). A job advertisement aiming at postgraduate students majoring in language and education was sent out to relevant departments at the University of Leeds and other universities. A few students responded to the advertisement and those who had experience in language translation were shortlisted for training. The recruitment information was also known to some professionals outside university, who were also invited to the training.

The training lasted for two hours. Apart from giving an overview of the research, it was aimed to train people with CA, the transcription system, the requirement for translation, the use of software and confidentiality regulations (All of them signed a Confidentiality Declaration Letter (see p244 in Appendix C)). The trainees were also given extra readings about CA transcription. Unfortunately, most students declined the job right after the training. Some of them felt the job was demanding and time-consuming so they would not be able to afford the time. Some felt it was difficult to learn the transcription method. Some feared the pressure if they would not be able to carry out the work to a sufficient standard and thereby jeopardise the research. It took

a long time before I was able to recruit two transcribers, one for Urdu and another for Czech. Both of them were educated to a master's degree level.

During the data collection a consultation using Mirpuri was recorded accidentally. Although the patient and interpreter told the doctor they spoke Urdu, it turned out to be Mirpuri. This was not found out until the Urdu transcriber started the transcription. However, I did not exclude this consultation. Firstly, the data collection had been very difficult and the number of data collected by that time was small. Secondly, it could be a bonus for testifying the hypothesis about the universality of people's behaviour in an interpreted conversation disregarding the language difference (which turned out to be true). Rewarding as it was, it was time consuming to find a new bilingual transcriber. He was a qualified translator but also encountered difficulties in doing the CA transcription but after meeting with me a few times, we managed to solve the problems and I was convinced that the transcript met the required standard.

Another two translators speaking Urdu and Slovak were recruited later for double translation in order to enhance the reliability of the translation. Due to the time restriction the Mirpuri transcript was not double translated. I will explain double translation more in the later section but before that I will explain how the transcribers worked in collaboration with me to produce satisfactory translation and transcription for analysis.

4.2.3.2 Work in collaboration

There are five steps for transcription in this research:

Step 1 (S1): content transcription (CT)—the transcriber transcribed what was said in the recording.

Step 2 (S2): translation (T)—based on S1 the transcriber translated the foreign language into English. They could also add CA symbols at this stage if they wish to.

Step 3 (S3): CA transcription (CAT)—the transcriber added CA symbols into the transcript.

Step 4 (S4): double translation (DT)—the CA transcript was sent to an independent translator for double translation.

Step 5 (S5): cross check—the researcher compared the first and second translations and discussed discrepancies with the bilingual transcriber.

The process of working with the bilingual interpreters was explorative, which means the unexpected was rather expected. In order to ensure contingencies got addressed in time, the transcribers and I were working in collaboration during the 5 steps of translation and transcription. Once the transcribers finished the CT, they would send it to me so that I would begin the CAT for the English part while they were translating. When the translation was finished, I would send them my CAT for them to do their part for the non-English text and also add CAT into the translated text. Although the transcribers had training, it was still very challenging for them to use Jeffersonian symbols without previous experience in actually doing it. What actually happened was their skills in doing CAT were improving gradually with the increasing amount of work they did. The repeated listening to the recordings for doing CT improved their familiarity with the details in the conversation, which prepared them for doing CAT. My CAT of the English text also set an example for them while doing their own part.

Although having my CAT for reference made their work much easier, misunderstanding of particular symbols could happen from time to time so the transcript had to go back and forth several times before it was finalised. Transcribers' abilities also vary. Some of them could complete the work just by exchanging emails with me; while some had to meet me in person, listen to the recording and add the CA symbols together. Once the CAT was finished and returned to me for preliminary analysis I was able to identify further problematic transcription with the assistance of the context, which came clear through the translation. Queries would be passed back

to the transcriber for revision. Once the transcripts were finalised, it would be passed to an independent translator for double translation.

4.2.3.3 DOUBLE TRANSLATION

Double translation was used to enhance the trustworthiness of the translations (Temple and Young, 2004, Squires, 2009). All CTs without translation were sent to an independent professional translator for a second translation. The two versions of each transcript were carefully compared against each other. Compared results would be discussed with the transcriber. Due to the fact that the non-English languages included in this study are very different from English, it was expected that different translators may choose different words and sentence structures for the same source text and both of them can be eligible translations. In this case the first translation by the transcriber (T1) would be kept. As shown in Example 1 below, the two translations are different but the difference is not so big that their meanings would be understood differently. Therefore T1 was kept as the final version.

EXAMPLE 1 TRANSLATION COMPARISON (DIFFERENT BUT THE SAME)

Original text (OT): Int: to je jedna nevýhoda. Ak chcete tak, on počká tie dva týždne.

Translation 2 (T2): INT: that is one disadvantage. If you want, he will wait those two weeks.

Translation 1 (T1): Int: this is one disadvantage. If you want then he can wait those two weeks.

*Int=Interpreter

However in other cases the problem is obvious and needs to be discussed with the transcriber. In the following example, for instance, the questions in T2 and T1 are two different questions. 'How often' is used to ask for the frequency; while 'how long' is asking for the length of the duration. Obviously the Int in the recording could only ask either one of them. Although in the previous turn the Dr did ask 'how long' I could not assume that the Int said the same thing because she might have asked a different question due to, say, her language deficiency. Cases like this were brought back to discuss with the first transcriber, who would listen to the recording again to check the transcript first and then chose the proper translation (T2 in this case).

EXAMPLE 2 TRANSLATION COMPARISON (OBVIOUSLY PROBLEMATIC)

OT: Int: Ako dlho to máte takto?

T1: INT: How often do you have it like this?

T2: INT: How long have you had these problems?

Some translation pairs were more difficult to distinguish right from wrong. For instance in example 3 there are two problems. Firstly 'take blood' is different from 'do your blood test'. The latter reads better than the former in English but the former could be a close translation which is preferred in this research. After consulting with the transcriber I learned that the Int did say 'take blood' in Czech so T2 was closer to the OT than T1. However, the close translation in this case did not help in the analysis. Contrarily it was very misleading. 'Take blood' reads less proper in English; therefore, I thought the interpreter might also sound as such in Czech. However, if 'take blood' makes sense in Czech, T1 would be more appropriate in that it gives an English reader exactly the same information as is given in Czech. That is to say, the translation has the same effect as its origin.

Another problem in this example is the second half of the sentence: (T2) 'let's say, this clinic is open up until 8pm in the evening' and (T1) 'because anyway this clinic that it is till 8 o'clock in the evening'. Obviously T2 makes better sense than T1. However in this case, T1 was more appropriate in that the Int in effect was not making herself clear and the utterance in Czech was difficult to understand. In order to maintain an equal effect in the translation, T1 was again chosen as the preferred translation.

EXAMPLE 3 TRANSLATION COMPARISON (VAGUE MISTAKES)

OT: Int: je to, že môžu Vám odobrať krv, lebo aj takto klinika, že je až do ôsmej večera.

T2: INT: is that they can take blood, because, let's say, this clinic is open up until 8pm in the evening

T1: Int: it is that they can do your blood test, because anyway this clinic that it is till 8 o'clock in the evening.

During the discussion, the transcribers' understanding of conversation analysis and sensitivity to linguistic nuances between languages were improving. The work got done much quicker as it moved on. The double translation strategy not only improved the quality of the translation but also provided an opportunity for me to learn about

the linguistic and cultural aspects of the non-English languages. Such knowledge enabled me to better help the transcribers and translators with their work.

4.2.3.4 USING SOFTWARE—AUDACITY

The video recordings were transformed into MP3 files to be sent for transcription. One reason for this is to protect confidentiality. Participants' personal identities were almost unidentifiable in the audio files even for the transcribers. Another reason is that the transcribers were recommended to use the software, *Audacity*, which is free open source software for recording and editing sounds (http://audacity.sourceforge.net/) but can only run audio files. The major functions of the software that facilitate CA transcription are repeat play, slow-speed and timer.

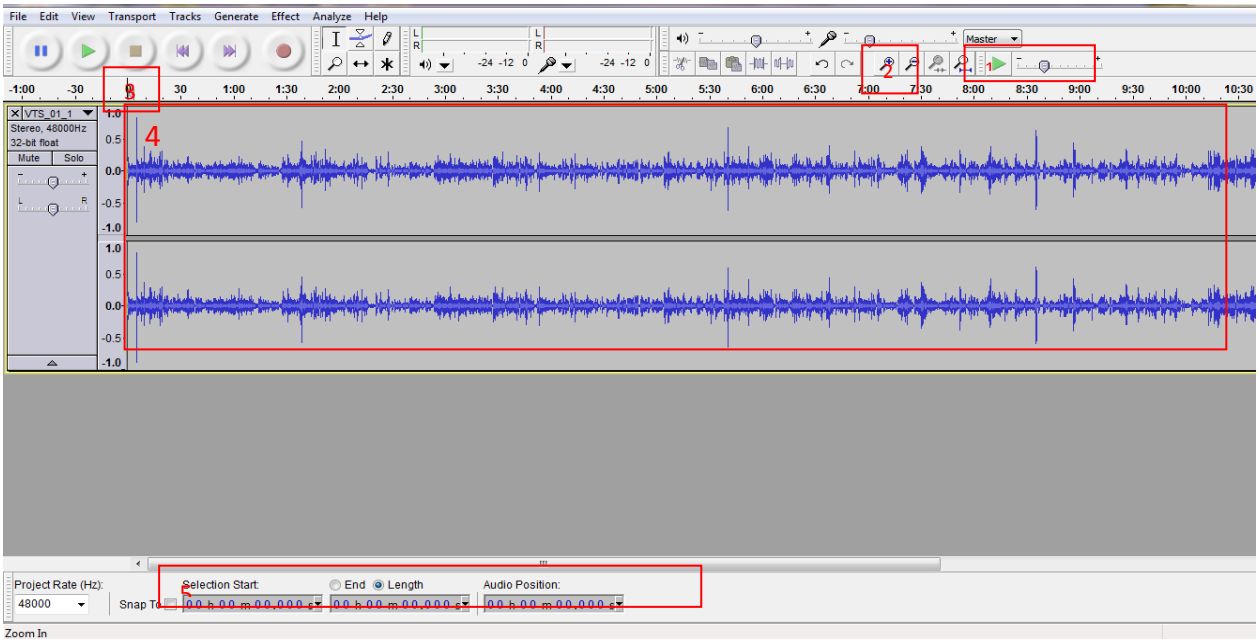


FIGURE 1 AUDACITY

In order to note down detailed phenomena, such as overlapping speech, laughter, false start, etc. the transcriber has to listen to a segment of utterance normally no longer than a few seconds several times. Audacity enables the user to choose any point (shown as No. 3 in Fig 1) of the sound track by clicking on the sound wave (No. 4) and clicking the 'space' key on the keyboard will return to play from the chosen point. This function can be facilitated by using a foot pedal. If a certain stretch of talk is

difficult to hear the transcriber could use the speed down function (No. 1) to slow down the speed. One of the major features of talk that affects the analysis is pauses. The software also provides a very accurate measure (No. 5) of a chosen length of sound wave, which could be used to measure the length of pauses. Pauses are normally shorter than two seconds; which is normally a visible flat line on the sound wave. If the line is too short, one can use the 'zoom in' function (No. 2) to enlarge the sound wave and accurately select where a pause occurs and measure the length of it.

The use of Audacity significantly reduced the burden of doing CA and increased the accuracy of transcription. It was also an important attribute to the reliability and validity of analysis.

4.3 Ethical issues

4.3.1 Recruitment

The research was designed according to the regulations of doing ethical research stated in two major documents—Leeds University *A Researchers' Guide to Research Governance* (Dorsett, 2009) and NHS *Research Guide* (National Patient Safety Agency--National Research Ethics Service, 2009).

Before the onset of data collection, NHS Ethical Approval (ref: 09/H1302/106) and NHS R&D Research Governance Approval (ref: 001_21_12_09_0000) were obtained from Bradford Research Ethics Committee and Bradford Institute for Health Research respectively. Informed consent was obtained during participant recruitment. All participants were given a copy of the information sheet and the consent form, which bear the researcher's contact information. They could contact the researcher to withdraw from the research at any time without obligation to give explanation and with no penalty.

Patient and interpreter participants were carefully selected by the recruiters. Children and people with mental disabilities were not included in the research. Those that the

recruiters believed not to be able to understand the research because of the language barrier and low education would also be eliminated. This has limited the research to exclude people who have the least access to language support and are the most deprived in healthcare due to the fact that the informed consent could not be fully obtained because of the language barrier. From this difficult recruitment process emerges a question about how to balance between the need for informed consent in research across language and cultural barriers and giving the equal chance to linguistically deprived participants to be involved in research which they would benefit from. This is not only a problem in this study but also other social studies and it could be an area that deserves scholarly attentions on its own.

4.3.2 Confidentiality

Confidentiality was observed throughout the research. All participants were kept anonymous. No personal data were obtained. Names mentioned in the consultation were changed to pseudonyms and private telephone numbers were replaced with 'x' signs in the transcription. Only the researcher could view all the videos in the analysis. Drs could view the videos of their own consultations in the member checking interviews.

Confidentiality is not only for the purpose of research but also for the protection of the participants. It was anticipated GPs may worry that their behaviours would be viewed by and compared with their peers and feel reluctant to participate. Assuring them that anonymity and confidentiality would be strictly observed in the research increased GPs' trust of the research and the chance for them to participate. It also helped the GPs to behave naturally when they were seeing the patient.

The self-esteem of the transcribers had not become an issue until the second translation was fed back to the first transcriber for discussion. I took it for granted that transcribers, as professionals themselves, would see double translation as a routine procedure for checking the quality of work. However, the discussion did not go far

before I started to notice that they felt uncomfortable for being challenged about their proficiency by another unknown colleague. In order to ease their worries, I made it clear that the second translator is a professional, all transcribers and translators were anonymous to each other, the translator did not see the transcriber's translation, and the questions I was asking were not from the translator but from myself and they were not only questions about the accuracy of the translation but also about variants that could alter the analysis. Once they regained their sense of security and understood the need for me to be 'picky' about the variants, the discussion moved on smoothly.

4.3.3 Encryption of data—Trucrypt

'The appropriate use and protection of patient data is paramount' (Department of Health, 2005: 8). Data encryption is essential in data protection. With the assistance of the University IT manager, the free open encryption software, Trucrypt, was used for this purpose. The programme was installed, on the university PC, where the data would be stored and analysed; on my own laptop, which sometimes were used to transfer data between sites instead of a USB and also on the PCs at the GPs' practices. The participating Drs were given a thorough written instruction on how to use the software so that they could encrypt the recordings immediately after they were taken. The software enabled the easy transport of data from the GP practices to the University computer. Audio files were also encrypted in the same way and burned onto a DVD for posting to the transcribers. They were also required to encrypt their transcripts before they emailed them back to me.

4.3.4 Report of malpractice

The translated transcripts reveal some significant translation errors made by the interpreters, which have drawn my attention. In the analysis I particularly looked into the interactions around those places where mistranslations occurred. In addition, excerpts containing mistranslations were selected to form most of the examples for GP

interviews and workshop (see Section 4.5) so that the Drs were alerted with the Int's malpractices, especially those of the professional interpreters.

4.4 DATA ANALYSIS

4.4.1 METHOD—CONVERSATION ANALYSIS

The methods of doing CA have been discussed in detail in the previous chapter. This section is to report on the procedures the CA was undertaken. The analysis of the recorded consultations was done in several steps. The first step was to analyse the actual interactions in detail, which involved intensive work on the recordings and transcripts. I first watched each video several times with the assistance of the translated transcript to gain an overview of each consultation. Then I began to listen to the recording by detail, while adding CA symbols and checking the accuracy of the transcription of the English speech. As discussed in the Methodology Chapter, although CA transcription aims to catch what is said and how it is said as accurately as possible, transcription itself also embodies how the transcriber understands the meaning of the interaction. Therefore, as I transcribed I was analysing at the same time and marking out what I saw happening by using CA symbols. This process also enabled me to see which part needed further investigation and what the bilingual transcriber should be attentive to while doing CA transcription.

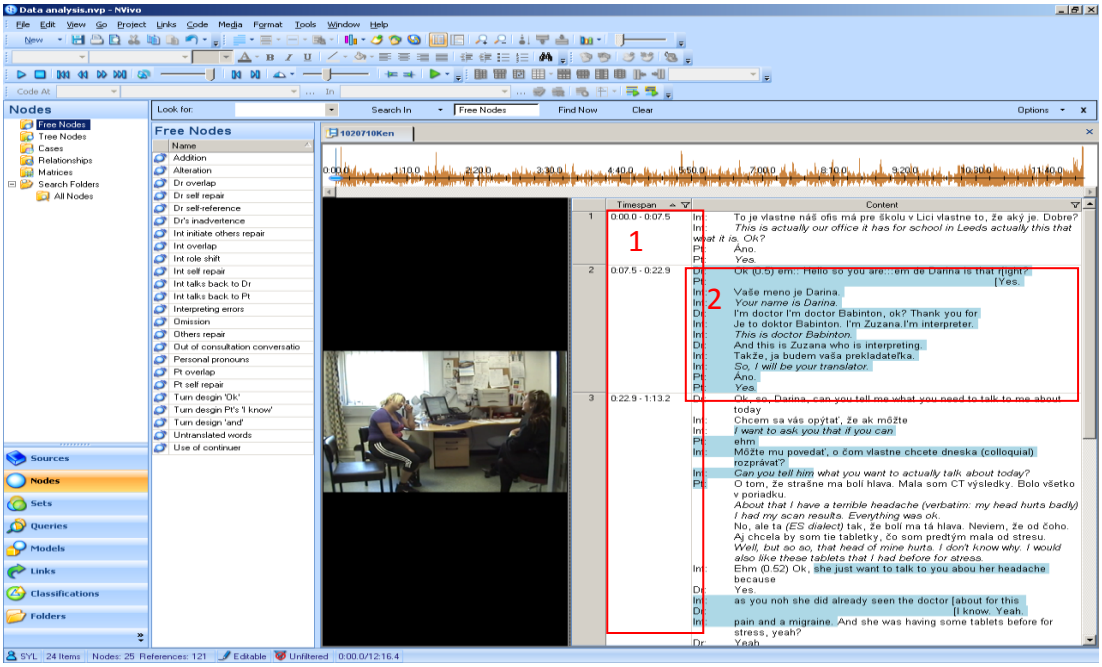
Once the transcription was consolidated I would move on to code the data in the next step. Two software programmes were used to assist this process—Nvivo 8 and MindGenius.

4.4.2 TOOLS--NVIVO8 & MINDGENIUS

Nvivo8 was used for managing all the documents in the research, including transcripts, notes, analysis, theoretical framework, etc. This programme provides a convenient tool for analysing videos which, after decryption, could be imported into this programme for analysis. Transcripts saved as Word documents were imported into the

programme so that the researcher could watch the video while amending and analysing the transcript. Once the folder with video files were encrypted, the links between Nvivo and the videos were lost so even if an unauthorised person were to open up Nvivo, he or she still would not be able to view the video. The transcripts were saved as part of the Nvivo project but the information was revised to ensure no personal identities would be revealed. Each transcript was segmented into several sections. These segments were numbered and their time span given at the front of the boxes (1 as shown in Figure 2), which enables easy location of each stretch of talk. When analysing data, I built up free nodes to group stretches of talk that fell into the same behavioural category. If a particular word, sentence or several turns needed detailed analysis, such information would be added by using the annotation function, (2 in Figure 2) which allows me to recall my analysis and reasons to group them together at a later time.

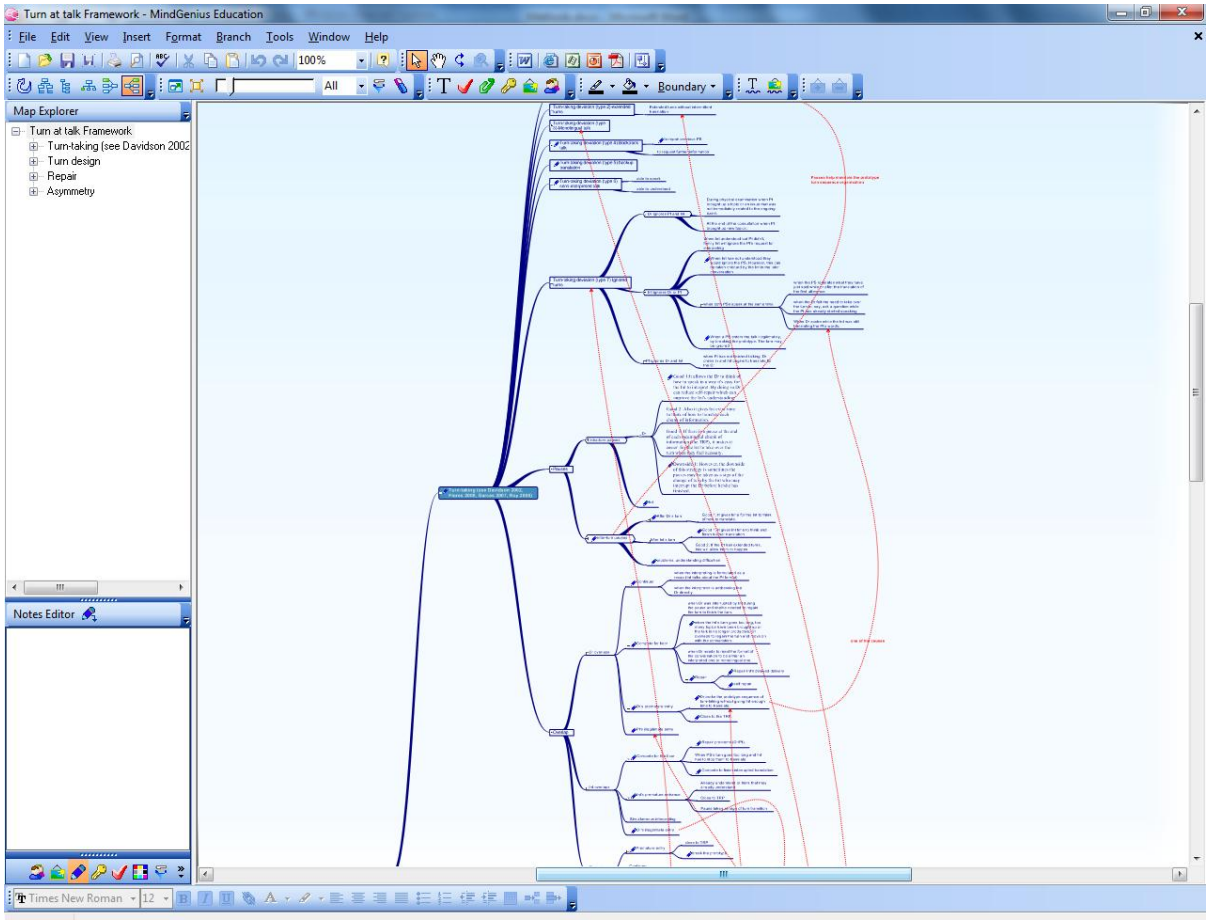
FIGURE 2 NVIVO 8



When free nodes began to show relationships between one another, I would use MindGenius to organise the free nodes into a mind map (as in Figure 3). Then the mind map would be replicated in Nvivo as tree nodes. Although the map was constantly

changing as more data were analysed, the changes were all minor. After the fourth consultation was analysed, the diagram began to consolidate. Further analysis found no more new phenomena but only added examples into existing tree notes in Nvivo.

FIGURE 3 MINDGENIUS



4.4.3 THE RESEARCHER AS THE MEMBER OF THE INVESTIGATED SOCIETY OR NOT—LANGUAGE AND CULTURAL BARRIERS

Some conversation analysts (Hutchby and Wooffitt, 2008, Moerman, 1988) point out that in order to understand the conversational material it is essential for the analyst to have 'membership knowledge' of the particular language and culture in discussion or even the specific activity being investigated. These scholars use CA not only to explore the mechanism or the orderliness of the talk-in-interaction but also the orderliness of

society. Membership knowledge is equally important in this research but the concept of membership knowledge is not restricted to a specific culture or language. As is established already, the aim of CA is to understand the universal interactive mechanism or the 'technology' (ten Have, 2007: 75) of talk-in-interaction in interpreted GP consultations. I, as a member of human society who uses language to participate in social activities, have the membership knowledge of language use in a generic term, which fits into the goal of the research on universality of interpreted discourse. As a trained interpreter and translator I have the knowledge about the nature of an interpreted consultation, issues related to translation and the logistics and management related to the work. As a second language learner and participant of cross-cultural communication, I have the knowledge about the linguistic and psychological difficulties my research participants may have. As a trainer of medical consultations, I have the knowledge about the structure and content of a GP consultation. In summary, I have both the membership knowledge about the social context in a generic sense as well as the specific knowledge about the particular social activity (a medical consultation) I am investigating. My membership knowledge in these areas provides me with a comprehensive insight into the data, which may not be available to someone who lacks such knowledge even though he or she may be a native speaker of any of the investigated languages.

4.5 Member checking—individual interviews, a focus group interview & a workshop

Member checking is a strategy used in qualitative research to enhance the validity of data analysis (Creswell and Miller, 2000, Creswell, 2009, Carlson, 2010). In this research it is related to achieving the second research goal—developing communication skills—and to the rigour of research. **Two sets of interviews** and a **workshop** were conducted with different groups of GPs for them to review the findings and the accuracy of the data interpretation.

The interviews were conducted at different stages in parallel with the completion of the two research questions—to understand the interactions in an interpreted medical consultation and to develop the education of communication skills. The **first interview** was conducted when the conversation analysis of the recorded consultation data was almost finished and the turn-taking and turn-design frameworks (see Chapters 5 to 7) established. The two GPs participated in the recording were invited to two separate interviews, which were **aimed** to check whether the frameworks identified from the data were also observable to them and whether what I saw happening is what they saw as well. The feedback from both GPs confirmed that the frameworks were comprehensive and accurate in describing the interactional phenomena and providing the knowledge of people's interactions. Video recordings, transcripts, written documents and questions were used as stimulus materials to conduct the two sets of interviews. For the first interview, a stimulus document (an anonymised version of this document can be found in Appendix D) was provided, which contains the information about the background of this project, useful explanations of key concepts, excerpted transcripts and the theoretical frameworks to be discussed in the interview. The interview was led by this document and the GP would hear the introduction, watch their own consultations with the assistance of translated transcripts and discuss the analysis with me. The GPs were only shown the transcripts and recordings from their own consultations due to the consideration of confidentiality and also to prevent the GPs from feeling that they were compared and evaluated.

Based on the completion of the first research question, a series of communication strategies (See chapter 8) were developed and brought back to a **focus group interview** for three GP trainers to **comment and advise on** the strategies. Two of the GPs were the same ones who participated in the recording and the first round of individual interviews. Another GP is the project coordinator who knew about the background of the research but was not as familiar with the research findings as the other two. The idea of including her is that she would provide comments from a novice's point of view, which could help me anticipate how people would react to the

strategies if they are used in teaching. The focus group was also led by a stimulus document (see a copy in Appendix E), which provides an introduction to the basic linguistic concepts, terminologies, an instruction for the interview and the communication strategies. This document was sent to the GPs prior to the interview. They were required to score the usefulness of the communication strategies, give their reasons to discuss in the interview and advise on improvement. Their views not only served as a confirmation of the usefulness of the strategies but also contributed to improving the clarity of the language used in the strategies and my own understanding of these strategies. They also inspired me to think of the teaching of these strategies. These will be further discussed in Chapter 8.

The member checking of the research outcome was carried one step further by the final check with a different group of GPs in a **workshop**. This workshop was conducted in Ken practice with their 5 GPs who had no pre-knowledge about this project participated. The purposes of this workshop were firstly to **check the accessibility** of the strategies and secondly to **disseminate** the research results in a small scale. Participants were given two documents, a handbook and a list of the communication strategies. The handbook contains an introduction to the basic concepts, and six interactive tasks, for which the participants would work as a group to analyse the sample transcripts and answer questions. They were expected to come up with their own communication strategies by analysing the sample conversations, which resembles the conversation analysis I did. Then they would compare their own strategies with those on the list. This inductive way of teaching the strategies worked very well in the workshop. Almost all the GPs were able to grasp the essential elements of the strategies involved in each task. Details regarding this workshop will be given in Chapter 8.

4.6 Rigour of research

The purpose of this and the previous chapter is to partially establish that this research is rigorous. The concept of rigour of research traditionally requires the assessment of

'the worth of a study—the soundness of its method, the accuracy of its findings, and the integrity of assumptions made or conclusions research' (Long and Johnson, 2000: 30). In traditional quantitative research the rigour of research lays in a research study being able to meet the requirements of *reliability* and *validity*. Although the appropriateness of these two terms to be used to assess qualitative research has been debated by many researchers and alternative terms proposed (such as *trustworthiness* and *soundness*) in place of these two (Wood and Kroger, 2000, Guba and Lincoln, 1989), there are still scholars advocating that these two terms or criteria are equally eligible for maintaining and assessing the rigour of qualitative research, while acknowledging that the means of addressing them are different as opposed to those in the traditional approaches (Long and Johnson, 2000, Creswell, 2009). While taking the same stance as Long and Johnson (2000) to agree that no alternative terms are needed, I would argue that whatever the terms or criteria are, the key concepts of rigour of research remain on the focus of the *process* and the *product* of research. The research process should be accountable, stable and systematic and the research claims or conclusions should be 'solid, credible and convincing (because they are logical, based on evidence)' (Wood and Lroger, 2000: 167).

As demonstrated in this chapter, I have taken a series of measures to ensure the reliability of the data collection process. In the selection of site and languages the local PCT was consulted and reliable statistics obtained. During the data collection process, GPs were trained to get consent and record the consultations in order to minimise the coercion of the participants and the contamination in generating naturally occurring data due to the researcher's involvement. GP participants were involved in both the conversation analysis and development of communication skills. In generating transcripts for data analysis, strict criteria were applied in selecting transcribers. All selected transcribers were trained with CA transcription technology, the requirements for doing the translation and the use of the assisting software. Double translation was applied to check and enhance the quality of translation. In the process of data analysis,

two software programs were used for assisting the analysis and organisation of data. Finally limitations were acknowledged and reported in this thesis.

These measures ensure that the process of data collection and analysis is reliable and allows for a sound prerequisite to produce meaningful research findings. However, the validity of the findings (the product) will have to be evaluated by evaluating the report of research findings presented in the following chapters. I said at the beginning of this section that the chapters hitherto have only partially established the rigour of research, not only because the following finding chapters also form part of the rigour of research, but also because, as Wood and Kroger point out, the '*warrantability*' (or rigour, as I prefer) of discourse analysis is a co-construction of the researcher and the reader or reviewer (Wood and Kroger, 2000: 168). It is also up to the readers of this document to judge whether the whole research is warrantable or rigorous. Therefore, the endeavour to demonstrate the rigour of research will continue in the next few chapters of this thesis.

4.7 METHODOLOGICAL LIMITATIONS

Despite the efforts undertaken to ensure the rigour of research from the research design to writing up the thesis, there are limitations that need to be acknowledged. The first limitation would be my lack of the languages involved in the research, which, as discussed in the chapter, was an issue needing to be solved at different stages of the research. It has prolonged the whole process of the research for extra time taken to get documents translated, find qualified translators and transcribers, check the quality of work, etc. At the same time, all of this made the research very costly.

During the data collection the participant recruiters could only rely on the Int's ability to interpret and the Pt's ability to read written documents in their own language to explain the research and get consent. Those who are most deprived potential participants might have to be excluded for research because they could not understand the information fully given the language barrier.

The language barrier imposed difficulties on the transcript and translation production as well. Double translation was the only instrument I could use to check the quality of the translation. Checking the accuracy of transcripts was restricted as well. I could only judge the quality of their work based on the quality of their English transcripts. I assumed that if the transcribers, as non-native speakers of English, could transcribe the English speeches satisfactorily then the transcription of their mother tongue should be satisfactory as well. One transcriber had to be replaced and his work redone by another transcriber due to the low accuracy in his English transcript. It turned out that his transcript of the non-English language was poor as well.

Another limitation exists in the use of video recordings. This method is expected to produce naturally occurring data which CA prioritises among other forms of qualitative data (ten Have, 2007). However, naturally occurring is not 100% achievable in that the process of recording would affect the interaction (Drew and Heritage, 1992b). Participants being recorded might behave differently from how they would normally do without the presence of a camera. In the analysis I did not catch any obvious scene, where the participants were seen to be influenced by the camera apart from two cases, at the beginning of which the participants talked about the recording (1150910Hor & 3020710Ken). Goffman (1990) points out the possibility for participants to alter their behaviour so as to present themselves in a positive light. This might be a bonus for this research which has a bias for positive interactive behaviours due to its goal to develop communication skills.

Another limitation is the small amount of data due to the difficulties in participant recruitment as discussed earlier. However, the seven recorded consultations already presented rich generic phenomena, good enough for the purpose of this qualitative research. They include three interpreters, a family member, a professional interpreter with higher skills and a professional interpreter with lower skills, representing the three interpreter types as discussed in the literature chapter: the family member interpreter, professional interpreter and other ad hoc interpreter. In general terms

different types of interpreters were not found to be different from each other although they differ quantitatively. This could be further investigated with more data for each interpreter type. This research also did not have any consultations in which a medical colleague acts as an interpreter, the involvement of whom may enhance the usefulness of the findings for a bigger audience.

CHAPTER 5 FINDINGS—TURN-TAKING SYSTEM IN INTERPRETED MEDICAL CONSULTATIONS

5.1 AN OVERVIEW OF FINDINGS

Chapters 5 to 7 are going to present the findings in the research aiming at fulfilling the first research goal to **provide a generic understanding of the interactional behaviour of the doctor, patient and interpreter, without distinguishing the language and type of interpreters.** People do two things when participating in a conversation. Firstly they take turn to speak; secondly they design each turn when they speak. The design of a turn does not stand alone but is rather interdependent with other turns adjacent to it. The preceding turn influences how we design our current turn and the current turn determines how the next turn is going to be designed. Conversation analysis mainly investigates turn-design and turn-taking in talk-in-interaction. Part of the current research is to understand the verbal interactive patterns that interlocutors of an interpreted GP consultation demonstrate. By using CA, I investigated the **turn-taking** and **turn-design** in the interpreted GP consultations and found that these two conversational features have their specific patterns that can be formally investigated and accounted for just as in monolingual conversations. This chapter elaborates on the seven types of turn-taking organisations identified across the data (7 video recordings of naturally occurring GP consultations), which include three languages and three types of interpreters (one family member, one professional Int, one semi-professional Int[8]). Pauses and overlapping speeches are two common features in talk and found as two fundamental components of the turn-taking system. They will be discussed in Chapter 6. The seven types of turn-taking, pauses and overlaps are seen across the data, despite the differences in the types of interpreters and languages. The involvement of different types of interpreters does affect the interactional patterns in the conversation but such variations are only quantitative. Some turn-taking organisations are more typical for one type of interpreter than the other but the

[8] The semi-professional is working for the PCT, but has demonstrated significantly low interpreting skills.

interactional features exist in all the seven consultations. Despite the universality in all consultations the quantitative variations resonate with findings in other research that the professional Int is more likely to be associated with behaviours that can improve communication outcomes.

Not only does the turn-taking show systematic patterns but the turn-design is also systematic. Interlocutors' turn-design is achieved through the interaction of the interlocutors while they are taking turn to speak. It is found that the quality of translation, demonstrated in the interpreter's turn-design, is key to the quality of the overall communication. In order to provide useful information for developing communication skills I focused on investigating the interrelationship between the PS' turn-design and that of the interpreter. As in an ordinary monolingual conversation, the interpreter's turn-design is influenced, if not determined, by that of other participants—the doctor and patient; therefore the improvement of the overall communication outcome can be partially realised by improving the turn-design of the doctor and patient. Although improving patients' behaviour is not inconceivable, it is more likely to teach doctors strategies for working with interpreters. This again sheds lights on the development of communication skills. However, the interpreter's turn-design is not only determined by the interactional factors as just mentioned but also by autonomous factors which are less likely to be influenced by other interlocutors but it is still useful knowledge for doctors to bear in mind. Detailed discussion will be given in Chapter 7.

The findings of turn-taking and turn-design in interpreted GP consultations highlight the fundamental difference between monolingual and interpreted talk-in-interaction. They provide an insight into the mechanisms of people's interactional behaviours, from which sound evidence can be sought from the Dr's beneficial behaviours that can improve the communication with patient through the work of an interpreter. Based on the evidence, I took a more innovative approach combining the CA findings, interviews with GPs and my own expertise to propose a series of communication strategies. The

strategies will be presented in Chapter 8. For this Chapter I will focus on the turn-taking organisation to begin with.

5.2 TURN-TAKING

The analysis of the sequence organisation, focusing on the inter-turn interaction, identified seven types of turn-taking: the prototype, extended turns, monolingual talk, backtrack talk, backup translation, semi-interpreted talk and ignored turns. Before I explain each type of the turn-taking, I will briefly explain some general characteristics in the interpreted discourse—the speakers and the languages involved.

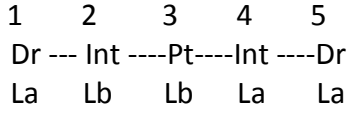
In an interpreted triadic medical consultation, it is observable that three interlocutors are involved, two languages used and two types of speaker-role presented. The doctor and patient can be defined by using Davidson's terms (2002), as the primary speakers (PSs) (or primary interlocutors as in Wadensjo (1998)). Accordingly I refer to the interpreter as the secondary speaker (SS) or secondary interlocutor. Two PSs are constructing the structure and content of the conversation while the SS is facilitating this process. The caveat, nevertheless, needs to be made sooner than later that the terms PS and SS do not indicate that one is more important than the other. The doctor and patient constitute the nature of a medical consultation; while the interpreter adds the features of an interpreted consultation. In an interpreted consultation there is interpreted talk in which the two PSs are speaker and listener; while the interpreter is the linguistic transformer or rather the linguistic mediator. In this case a turn at talk will be done twice and in two languages, one by a PS and one by the SS. As part of the ongoing interaction, there is also non-interpreted talk in which all participants are PSs and each turn is done only once in one language. That is to say, the distinction between primary speaker and secondary speaker is drawn according to the institutional structure of a medical consultation. If we consider their roles only in the context of an interpreted discourse, all the participants are primary speakers. Nonetheless, in my point of view it is more appropriate to distinguish the participant roles according to a medical consultation to emphasise the function of a medical

consultation, the responsibility of the doctor in an event that involves people's life and health, the importance that the patient should not be disempowered as a result of the lack of the language and the fact that interpreters are needed only because of the language barrier which is only a special case of medical encounters. Again it can never be overemphasised that the interpreter is as important as the doctor and patient to make an interpreted consultation possible. The participant roles will be discussed in a later chapter; while in the meantime, I will turn to explain the seven types of turn-taking organisation.

5.3 Type 1 Turn-taking Prototype:

A prototype turn-taking organisation is an ideal form of talk among the participants. PS role and SS role always apply throughout the conversation. PS's words are always translated by Int into another language for the benefit of another PS, who then speaks according to the preceding PS's turn and is translated back to that PS. To be more specific, a round of prototypical turn-taking can be described in this way: one of the PSs starts the 1st turn (usually the doctor) in language A (La) (in this case English) and the interpreter will take the 2nd turn to interpret in language B (Lb) (Slovak, Urdu or Mirpuri). Then the patient will take the 3rd turn using the same language as that of the interpreter. The interpreter then translates from Lb into La in the 4th turn, which will trigger the production of the 5th turn by the doctor in a continued conversation, from which the same procedures will be repeated. The recurrence of the turn-taking continues until it suffices the need of the conversation. It can be demonstrated by using the following diagram:

Diagram 1 Prototype turn-taking



The number on the top indicates the turn sequence, the second line is the interlocutors in the conversation and the last line indicates the languages they speak.

EXCERPT 1 (1020710KEN 3:52.2 CZECH, SEMI)[9]

1. Pt: [ale ja teraz neviem presne, že kedy prídem. Lebo
2. ja pracujem a neska som sa len vypýtala, takže
3. Pt: *but now I don't know exactly that when I'll come because I'm working*
4. *and today I have asked to have a day off, so*
5. Int: And she does want to telling you something because she working and
6. it is really hard for her attend for .hh[appointments
7. Dr: [for blood tests. What's the best time for her?
8. Int: Ktorý by bol najlepší čas pre Vás?
9. Int: *Which would be the best time for you?*
10. Pt: Tak myslím, že minulý tu tak
11. Pt: *So, I think that last (week)(.)here so*

Excerpt 1 shows how the three interlocutors take turn to speak following the prototype turn-taking organisation. The Pt started the first turn in Slovak and then the Int took the immediate second turn to render the translation in English. Then the Dr continued in response to the translation in the third turn (Line 7)[10] in English. Then the fourth turn was taken by the Int to translate what the Dr has said in Slovak. Then in the fifth turn the Pt responded to the translation in Slovak.

An important observation concerning this type of turn-taking is that to maintain the prototypical organisation of turn-taking the interpreter has to use a language different from the preceding turn but the same as in the next turn, while the doctor and the patient always use a language the same as the preceding turn but different from the next. This structure can minimise the chance for the Int to talk back to the PSs instead of translating for them (although talking back is not always harmful (see Section 5.5.1)). It is also an indicator, although not always an accurate one, that the Int stays in

[9] The label indicates: the serial number of the consultation; starting time of the excerpt; foreign language in use; type of interpreter (semi, prof or family).

[10] Hereinafter line numbers will be indicated in the form of L# (e.g. L7 or L5-6) and excerpt numbers Ex# (e.g. Ex 1).

the role as an interpreter not, say, as a family member. As in this example the prototype turn-taking is preserved so the Pt and Dr were able to talk to each other through the Int. Although the Dr and Pt cannot monitor the accuracy of the Int's translation, turn-taking and language change are two signs observable to them so ensuring the turn is passed on according to this prototype and language changed accordingly allows the Dr and the Pt to maximise their chance to be translated for each.

Such prototype turn-taking is more likely to be kept with professional Ints, but even so in many occasions interlocutors may deviate from the prototype to other forms of turn-taking. However, not observing the prototype does not necessarily mean it is problematic nor does it mean that the interaction is no longer an interpreted one.

5.4 Type 2 Extended turns

Medical consultations, as other institutional encounters, involve specific tasks the participants are attempting to achieve through the conversation (see Methodology Chapter). These tasks are allocated in different parts of the overall structure of the encounter and require each participant to take corresponding actions to achieve them. The tasks of a medical consultation from the beginning to the end can be roughly summarised as eliciting the reason of Pt's attendance, examination, diagnosis, explanation and planning. In order to achieve these tasks sometimes the participant needs to have an extended turn to do the talk. For instance, at the beginning the Pt may need an extended turn to explain the reason for their visit to the Dr; while at the end of the consultation the Dr may take an extended turn to explain to the Pt what the problem is and how the treatment is going to be implemented. This kind of extended turn taken by Dr and Pt does not seem problematic in monolingual talk; however, in an interpreted conversation, as found in this research, they can cause trouble.

In interpreted discourse the longer a turn is produced by the speaker, the more burdensome it is for the interpreter to remember and render an accurate translation

close to the original utterance. To reduce the burden of the interpreter sometimes PSs may chunk an extended turn into several small turns so that the amount of information given at each turn can be effectively processed by the interpreter. Consequently, the talk will be accomplished in several turns with interventional turns of the interpreter translating each turn of the PS. This is the second type of turn-taking organisation which I refer to as chunked **extended turns*.*** When interpreting these extended turns, the interpreter's language is always different from the preceding and the following turns, which agrees with the language shifts mentioned in the prototype turn-taking shown above; therefore, this organisation does not change the nature of the conversation as an interpreted one. The following (Ex2) is an example of how chunked extended turns were used between the Dr and the Professional Int to convey complicated information.

EXCERPT 2 (01170910HOR 2:30.0 URDU, PROF)

1. Dr: it is complicated this
2. (0.97)
3. Int: °Yea kehti hai k ye samjna (0.94) kafi mushkil bat hai°
4. *Int.: she is saying it is very tough to understand*
5. Dr: and it's complicated for you to understand so I'm not surprised that it is °em
6. (0.4) confusing°.
7. (0.3)
8. Int: Yea aap ke leie bhi samajna bara mushkil hai isi leie aap ko samaj nahi aa
9. rahi.
10. *Int.: it is tough to understand even for you that's why you are not understanding.*
11. (0.3)
12. Dr: I am finding it difficult to understand as well.
13. Int: Eis ko khud samjne main mushkalat aa rahi hain
14. *Int.: She finds it hard to understand herself.*
15. (1.08)
16. Dr: and I may well get a specialist opinion because of that
17. (0.6)
18. Int: Or shahid yea kisi or ke mashora, specialist ka mashora uh le is bat per
19. *Int.: and she might get a specialist opinion on this matter*
20. (0.7)
21. Dr: .hhhh (0.6) the thyroid (0.59) which is the gland in your neck (0.27) that
22. causes tiredness and feeling weak and changes in your hair and weight gain (0.9) that is
23. improving but slowly.
24. (0.5)
25. Int.: Yea jo thyroid hain na jo glands main hoti hain jis ki waja se aap ke baal
26. ghirte hain or wazan bar jata hai yea jo hoti hain nishanian, yea na behtr ho rahi hain

Int.: You know the thyroid, which is in the glands, because of which your hair
falls out and you gain weight, these symptoms, they're getting better.
(2.47)
Dr: but (0.36) I think the reason you have the pain::s and the feelin::g e:m the
feelings in the bo::nes and things like that and in your muscles .hh is a different
problem.
(0.4)
Int.: lekin jo aap ko derd ho ra he na muscles ka or yahan yea koi yea kehti hai ke
koi or waja hai
Int.: but the pain you are feeling in your muscles and here she is saying that there
is another reason for this.

L1-19 is a good example to show the benefit of using a series of extended turns rather than a single extended turn. The Dr kept each turn short but meaningful, which enabled the Int to render a translation close to the original utterance. In contrast to this are two very long turns, L21-23 and L30-32, which led to subsequent troubled translations. In L21-23 the Dr explained that the thyroid is the gland in the neck but this was translated as 'the thyroid, which is in the glands' (L27). The Dr mentioned the cause of 'tiredness', which was omitted in the translation. This turn is not only long but also contains complex grammatical structures, both of which add up to the burden on the Int's memory and linguistic ability and therefore the translation was problematic. I will talk about the grammatical structure of this turn in Chapter 8 Ex7 when I discuss the communication strategies. Similar problem also occurs in L34-37 when the Int was translating another long turn in L30-32. Here the Dr mentioned two types of symptoms, the pain and feelings in the bones and muscles; however, the translation becomes about the 'pain' 'in your muscles and here'. Although this distortion may not have clinical significance in this consultation, this demonstrates how the translation can be easily distorted when the utterance gets long and complex.

Not only were the Drs found to be using a series of extended turns but also the Pts. However, the Pt's use of extended turns is less strategic compared with the Dr. Ex3 is a stretch of conversation in which the Pt was explaining the reasons for his visit to the Dr, using a mixture of chunked extended turns and **a** long extended turn, while his son was interpreting.

EXCERPT 3 (01150910HOR 4:26.0, MIRPURI, FAMILY)

(A few lines prior to this are omitted)

Int: so basically um my dad is [saying=
Pt: [fer akhne
Pt: [then say
Int: =errr on MOnday that he had to take:: there were three like sachets (0.74) obviously I have saw medicine (0.3) before the camera test (0.5) he had to take one at 2 o'clock one at three and I think 1 at 4 (0.3) because of them because he hasn't taken taken them before (0.3) he wasn't supposed to eat anything (0.5) because of them (.) the diarrhoea started you see?
Dr: Right=
Int: =[ji
Pt: [j mungl[are (0.3) before 8 tu pehle pehle 1 or puri [khadi
Pt: then on Tuesday before 8 I had another sashay
Int: [on tuesday [Before 8 o'clock in the morning he had to take another:: (.) sashay of medicine
Dr: uh hum
Int: mixed in the water I think and drink it (0.5) before going into hospital so [he=
Dr: [right

(7 lines omitted)

Int: and they put a camera in the thing and they think everything is ok (0.5) and they gave him some medicine to take=
Pt: =for 7 [aa satan dina waste
Pt: hum for seven days
int.: [for seven days this is a different medicine
(1.2)
Pt: 7 din khan[e suba 2 (0.4) tou:: shami oun
Pt: have to take seven days 2 in the morning and 2 in the evening
Int: [oh yeah
Int: so:: what he is saying is yesterday he took 2 in the morning 2 in the evening (0.4)
Pt: 3 sorry 3, 3 ni 3 ni 3
Int: Yeah yeah three of these I don't know he knows

It is observable not only in this excerpt but also in other consultations in the data that Pts tended to use one extended *turn* rather than chunk their words into several extended *turns*. They had low awareness of the difficulties this may cause to the Int and the high potential for information loss and distortion in the translation. Even if the Pt did use several extended turns, as shown in this excerpt, he did not seem to use them as a strategy to facilitate the communication but rather as a remedy for troubled talk. Before this excerpt the Pt had just taken a long extended *turn* to explain his early visit to the hospital to the Int. The Int started in L1 to interpret only when the Pt had

finished talking in the preceding turn. Obviously from L2-3 one can tell the Pt still had more to say but was cut off by the Int. Therefore, he tried to regain the floor in L2-3, in which he did not succeed. He then attempted to compete for the floor several times by overlapping with the Int, while the Int was doing the same to keep the floor in order to translate, as in L11-12, 19-20, 23-24. The consequence of the competition was that both the Int and the Pt were speaking simultaneously, which resembles simultaneous interpreting (e.g. at a conference). Compared with the Dr, the Pt was not using complete utterances but rather short utterance fragments (L2-3, 26-27, 30-31, 34), which seem to have worked better than full utterances in that the fragments were sufficient for adding new information and able to capture the Int's attention while he was speaking so that he could feed the new information into his translation as it went along.

In comparison the Dr and the Int in Ex2 seemed to have reached an agreement on turn taking sequence. They allowed each other enough time to talk by leaving pauses in between the turns so that both of them could hold the floor properly and one would not take over until the floor was given away by the current speaker. The Dr's use of extended turns seemed very strategic and did produce a good rhythm of turn-taking which made the conversation flow smoothly and minimised communication difficulties. However, the situation in Ex3 is less optimistic. The Pt tended to use long turns without intentionally giving away the floor. The occasional use of chunked extended turns seemed to be a consequence of the competition for floors between the Pt and the Int. Sometimes it ended up as simultaneous interpreting, with both the Pt and the Int speaking at the same time (or in other words, it is overlapping speech, which will be discussed in the next Chapter). Nevertheless, the use of extended turns helped reduce the burden of the Int (which seems to be the result of his own effort in competing for floors) and allowed the Pt to complete his talk.

Chunked extended turns happen for a particular need of the PS, yet they do not change the nature of an interpreted consultation. Other forms of turn-taking to be

discussed next seem more problematic and sometimes they may change the dynamic of the interaction.

5.5 Type 3 Monolingual talks

5.5.1 involving the Int

As mentioned before, while the Dr and Pt remain in a relatively stable role as PSs, the Int can be shifting between a SS and PS for various reasons. This shift changes the triadic conversation into a dyadic one and the conversation is no longer interpreted but becomes **monolingual talk**. Monolingual talk, as the name indicates, is talk between any of the two participants using the same language. Although the conversation is no longer interpreted, it is still part of the interpreted discourse. Any participant can talk back to the previous speaker to initiate monolingual talk which breaks down the continuation of the prototype turn-taking sequence and thus excludes the third person's involvement. The participants were found consistently to be talking back and shifting from an interpreted conversation to monolingual talk for various reasons. Different participants have different reasons to talk back. Some reasons are legitimate and necessary for the smooth flow of the conversation; while others may not be necessary and can even hinder the progress of the consultation.

5.5.1.1 Continuers

The first kind of monolingual talk is the use of **continuers** or **back-channel responses** (schegloff, 1982). Continuers are conversational makers, such as 'uh hum', 'yeah', 'yes' etc. which are used by the listener who responds to the ongoing speech of the current speaker (they can occur either in overlap or during the speaker's intra-turn pauses (see next chapter for more about intra-turn pauses)). They function as a way for the listener to show their continuous attentiveness and understanding of what the speaker is saying and to encourage the current speaker to carry on speaking. Continuers were found to be used by the participants of interpreted medical consultations for the same purposes.

EXCERPT 4 (0120710KEN 4:41.4, CZECH, SEMI)

1. Int: ok, e::::hm (0.3) (°if°) is it's really hard [o::n me.
2. Dr: [uh hum
3. Int: .hhhhhh Ok, .hhhh she just saying about for work now. (1.4) She will be working
4. definitely for next two weeks twelve hours every each day,
5. Dr: [>yap<
6. Int: [yeah ?
7. (.)
8. Dr: yap
9. (0.8)
10. Int: ok, that is to 6 from eh till to 6 and after two weeks if you will be book appointment
11. for blood test
12. Dr: fine.
13. Int: that time (.) she will be ((cough)) she will be eh asking out from work. She will be like
14. take a day off.
15. Dr: °ok°
16. Int: but then two weeks she need working twelve hours every each day.

This excerpt shows the Dr's active interaction with the Int by using different kinds of continuers, while the Int was producing a very long translation. The Dr was using things like 'uh hum' (L2) 'yap' (L5) and others as in L8, 12, 15 to indicate his attentiveness to the Int and at the same time signal to the Int 'to carry on'. These continuers were inserted in between an extended turn the Int was taking to translate; therefore, they sometimes occurred in overlap with the Int's speeches. The Dr's use of continuers in this excerpt seemed to contribute to the success of the communication. As one can read in L1 the Int suggested that the translation would be '*hard*' for her. By using continuers the Dr was able to demonstrate his understanding and support without interfering much with the Int's translation process.

Continuers were found to be used when less skilled Ints were involved and when the speaker was speaking for long, which quite often led to translation difficulties on the part of the Int. All participants were found to use continuers in the consultations with the family member Int and the less skilled professional Int. However, in the consultation with the better skilled professional Int, continuers were not found and it

is common to see participants using several extended turns to chunk their talk into several parts while giving the floor to the Int in between the turns for translation (as shown in Ex2).

5.5.1.2 Repair

Another reason for the participants to talk back to initiate a monolingual talk is to **repair** or **initiate a repair**. Conversation analysts consider repair as a natural part of conversation, a mechanism people use to deal with conversational problems. Liddicoat explains repair as 'a set of practices designed for dealing with the types of difficulties which emerge in talk' (2011: 208). The concept of repair is broader than correcting errors although correction is a part of the repair system. What is called the *repairable* or *trouble source* (Schegloff et al., 1977: 363) is any kind of trouble or problem that affects the flow of the conversation. It can be something which is obviously wrong, such as a false statement, or an incorrect pronunciation of a word. It can also be something that is not wrong but still causes problem to the conversation, such as a false start at the beginning of an utterance, for which the speaker needs to restart it; a search for word or just a slip of tongue. A repair can be initiated by the speaker (*self-initiated repair*) or by the recipient (*other-initiated repair*). The initiator can repair the repairable, which is called *self-repair* or the recipient can repair, which is called *other-repair*.

Participants in an interpreted consultation were found doing the same thing as in a monolingual conversation. However, what makes it different is that when the recipient initiate a repair or do an other-repair, they talk back to the previous speaker, which turns the conversation into the monolingual talk. The Ints demonstrated the most sophisticated actions they took to initiate or repair in that they were the only one who could speak to both the Dr and Pt. An Int can talk back to either of the PSs to ask for clarification when there is a problem with understanding. In Ex5 the Int did not understand what the Dr was referring to by 'anti-inflammatory'; therefore, he asked 'what's that?' to initiate a repair by the Dr to explain further. An Int can use this as an important technique to ensure that they understand exactly what the PS has said so

that they can translate properly. The Int can also initiate a repair when the information given by the PS is obviously inappropriate. As shown in Ex6 the Pt misunderstood the Dr's question about her available time for next appointment. She thought the Dr was asking about the time for her last appointment. Knowing that this was inappropriate, the Int initiated a repair, which triggered the Pt's self-repair in L19-21.

EXCERPT 5 (01150910HOR 22:41.2, MIRPURI, FAMILY)

1. Dr: Did you stop the anti-inflammatory?
2. (0.5)
3. Int.: what's that?
4. (0.89)
5. Dr.: you know the diclofenac (0.5) that he was on (.) pai::n

EXCERPT 6 (1020710KEN 4:08.01, CZECH, SEMI)

1. Int: Ktorý by bol najlepší čas pre Vás? (unusual syntax, very awkward)
2. Int: *What would be the best time for you?*
3. Pt: Tak myslím, že minulý tu tak
4. Pt: *So, I think that last (pause)here so*
5. (0.3)
6. Int: Najle[pší, kedy
7. Int: *The best time when*
8. Pt: [týždeň
9. Pt: *week*
10. Int: by ste sa mohli dostať
11. Int: *you could get here*
12. (.)
13. Pt: Piatok, minulý týždeň?
14. Pt: *Friday, last week?*
15. Int: Nie nie nie nie, myslí na najbližšie apointmeny *(English word)* na odbratie krvi.
16. Kedy eh ktorý čas by bol pre vás najlepší. Kedy pracujete, od ktorej do ktorej?
17. Int: *No no no no, he means the very next appointment for blood tests.*
18. *When eh would be the best time for you. When do you work, from what time to what time?*
19. Pt: Ja pracujem teraz väčšinou 6-6, ta tak dva týžni (says this in Eastern Slovakian
20. dialect, says it incorrectly, unclear what she means) do dvoch týždňov by som mohla prísť
21. Pt: *Now I'm working mainly 6-6, so so two weeks, in two weeks I could come*

Repair is also found to be used by Drs to obtain clarification from the Int when the translation was unclear due to, for instance, irregular grammatical structure or unusual pronunciation used by the Int, which may cause understanding difficulties. Repair is an important tool used by the Dr to request for a translation, when its rendition is delayed. This is found particularly useful with the family member interpreter, who was frequently reminded by both PSs to interpret for them. The conversation in Ex7 happened at the beginning of the consultation when the Dr was setting the ground rule about how she wanted to run this triadic consultation. As one could see in L3 the Dr paused twice (0.47) and (1.1), which were quite long pauses where the Int could have taken over the floor to start interpreting. However, this did not happen; therefore the Dr verbalised her request for a translation to be delivered for the Pt at the end of the turn.

EXCERPT 7 (01150919HOR 2:53.30, MIRPURI, FAMILY)

1. Dr: .hh so (0.38) the way I plan to do this is that I will speak in English but I will
2. as- I know you understand some but I'll ask your son to interpret directly .hh what I
3. say (.) .hhh em if that's possible (0.47) em (1.1) you perhaps want to say that to him
4. maybe?
5. Int.: ane k ae akhne k tusan ki akhni k tusan ki thori samj ae (.) liken fer main
6. tuse ne nikay ki akhsan k tusan ki samjawe
7. *int.: she is saying that she is saying to you, you understand a bit, but still I will tell*
8. *your son to explain to you*

Later in the same consultation I found the Pt requesting for a translation several times as in Ex8. Prior to this stretch of talk the Pt might have noticed that there were a few times after the Dr's turn the Int did not render a translation. Here as well, the Dr finished her turn in L3 and a translation was due to be delivered in the next turn, which, nonetheless, did not happen. Therefore, the Dr said 'ok' very quietly to indicate the end of her turn, which did not elicit a translation. The absence of a due translation breaks the prototypical turn-taking organisation and is observable to both PSs. In this case the Pt initiated a repair by requesting a translation in L7. In another occasion as

shown in Ex9, the Dr realised that the Int had not translated several of her turns so she initiated the repair.

EXCERPT 8 (01150919HOR 20:55.01, MIRPURI, FAMILY)

1. Dr : but I have to be honest and say my opinion as a doctor is that I kno::w how
2. long people get take to get better from the operations (0.6) and that your father
3. had thee:: problem with the stomach anyway so I am trying to be realistic,
4. Int.: yea yea
5. Dr: °Ok°.
6. (0.7)
7. → Pt: kai akhni ye?
8. *Pt: what did she say?*
9. (0.5)
10. Int.: akhni waise 13 hufte tan liksi chonke tora luma time ae na
11. *Int.: she said that she will write 13 weeks because it's short period of time*

EXCERPT 9 (01150919HOR 20:20.00, MIRPURI, FAMILY)

1. Dr: I know it seems like a long ti:::me, but that's why you got to get it sorted out really
2. isn't.
3. Int.: yea
4. (3.1)
5. Dr: .hhh (0.6) If (.) a patient gets certainly better and can run around and do their jo:::b
6. (0.39) I can do another note that says, he is fit to go back to work [so I can knock the
7. time off for the 13 weeks
8. Int.: [°yeah°
9. Int: Ok
10. → Dr: Do you understa::nd↓
11. Int: °Yeah°
12. Dr: ( ) explain that to him

Pts can also talk back to the Int to ask for clarification. However, this was only seen in one consultation in which the family member was interpreting. In the following excerpt (10) the Int did not make it clear whether the Dr was going to give the Pt a 'letter' as he wanted or a sick note which he had been insisting in the talk prior to this that he did not want. Therefore he asked the Int for the clarification. The Pts in other consultations with two professional Ints were not found requesting clarification. This is definitely not because the professional Ints were doing an excellent job that there was

no need for clarification. In fact there were occasions when the Int was obviously incomprehensible but the Pt was still appearing to be able to understand. In Ex11 as one could read from the English translation of the Int's words, the meaning was very ambiguous. I discussed this with my bilingual transcriber who told me that the Int made a few grammatical mistakes in Slovak (see the English notes inserted by the transcriber) and her meaning was very difficult to comprehend. Even so the Pt did not seem to have problem understanding. In L3-4 she verbalised her understanding and in the end she did not ask any questions. There were also other occasions in this consultation when the Int struggled to translate but the Pt was still found to be eager to show her understanding. It occurred to me that in this particular case this Pt was very eager to demonstrate her ability to understand the Int and felt responsible for any misunderstandings.

EXCERPT 10 (01150919HOR 19:49.01, MIRPURI, FAMILY)

1. Int.: akhni ae k knee ni problem vi vich baasi te stomach ni vi vich likh si
2. *Int.: she is saying that she will write about your knee problems and stomach as well*
3. Pt : theek ae likhi shorae, main e ye letter main una ki chai daisaan na
4. *Pt: ok write it, I will give that letter to them then*
5. Int.: °Ji aa°
6. *Int.: ok (yes)*
7. Pt : sick note koi ni, sick note tae ni bnaan lai na
8. *Pt: not the sick note, she is going to make a sick note, is she?*

EXCERPT 11 (1020710KEN 2:53.20, CZECH, SEMI)

1. Int: cetéčko hlavy, čo sa týka na (wrong preposition) seriózne (in Slovak the right
2. term would be 'vážne', referring to illnesses) v preklade, je to vlastne na hlavné
3. alebo najnebezpečnejšie alebo v tom význame, ako by som Vám to preložila
4. Int: *CT scan of the head regarding serious translated as, it is actually the main or*
5. *most dangerous or in this sense, how would I translate it for you*
6. Pt: ehm, viem
7. Pt: *ehm, I know*
8. Int: eh choroby, ste už testy mala, čo sa týka, krvné.
9. Int: *eh (hesitation) illnesses, you had the tests done, regarding, the blood ones.*

10. Pt: ehm
11. Pt: *ehm*
12. Int: Cétečko je v poriadku, všetky krvné tieto ako čo choroby by sa by sa mohli
13. ukázať
14. Int: *CT scan is ok, all the blood errr, illnesses might be might be shown*
    (several lines omitted)

In some rare occasions the participating Drs were found repairing the Ints' language problems. They either repair to confirm their understanding or to facilitate the Int's translation. In the following excerpt (12), it seems the Int was confused about the usage of ordinals in English. When she was trying to match the Pt's use of ordinals by using ordinals in the translation, she produced an unusual expression 'it's about two:::, second or third of months', which the Dr might have found difficult to understand; thus the (0.8) pause in L9 and the repair produced in a quiet voice in L10. The repair was accepted by the Int in L11 ('yep'), which confirmed that the Dr understood her correctly despite the confusion caused by the unusual expression. The same kind of repair happened between the same pair of Dr and Int in Ex13 but this time it is the pronunciation that caused understanding difficulty. The Int said something like 'ball' and 'troat' which did not make good sense to the Dr and thus a long pause (1.64) (L2) before the Dr tempted to repair by giving his best guess 'throat' in L3, which then was accepted by the Int in the next turn.

EXCERPT 12 (1020710KEN 2:04.4 , CZECH, SEMI)

1. Int: [Ako dlho máte tieto problémy?
2. Int: *How long have you had these problems?*
3. Pt: Tak teraz je to asi druhý mesiac.
4. Pt: *So, now it is about the second month.*
5. Int: Now
6. Pt: Tretí
7. Pt: *The third.*
8. Int: it's about two:::, second or third of months
9. (0.8)
10. Dr: °Ok two or three months°=
11. Int: =yep

EXCERPT 13 (5020710KEN 0:45.0, CZECH, SEMI)

1. Int: But she just thinking that doesn't help her about the (ba::lls) and the troat.
2. (1.64)
3. Dr: It didn't help he::r about [the throat.

This confirmation function of repairing the Int's language discrepancy prevents potential misunderstandings of the Int's meaning due to the unusual expressions in the utterance. However, if the repair comes prematurely it may misfire and cause further problem. In Ex14 the Int was seemingly having a troubled translation which was marked by a long hesitation 'a:::' and a change of prepositions from 'at' to 'in'. These linguistic markers sent a message to the Dr that there might be a trouble source; therefore, the Dr immediately proposed a repair in L3 ('seeing a specialist') trying to help the Int finish the turn. However, this was not what the Int intended to say and it consequently caused another repair by the Int. She first denied the Dr's proposal in L2 ('No:: ↑') and then restarted the translation from the beginning in L4-5.

EXCERPT 14 (3020710KEN 4:51.1, CZECH, SEMI)

1. Int: [She been at a::: in Slovakia
2. [she's been in Slovakia for eight months. No::↑
3. Dr: [seeing a specialist alright.
4. Int: She just saying I've been in Slovakia for eight months and I don't have nothing
5. problems [and now

The Int, as a non-native speaker of English, may need more time to think about how to construct a sentence; therefore, a few false starts and hesitations do not always mean that they need help with the language. Premature language repair may misfire and impede the flow of the conversation; however, if the Int is given enough time and there is enough evidence that they may be seeking help from the Dr, such repair can be beneficial for the conversation. A troubled translation rendition is well evidenced in Ex15. In L1-3 the Int had quite a few false starts (e.g.: 'on the:: obviously on the...'), hesitations and pauses and used many unnecessary adverbs ('BASICally', 'obviously', 'briefly') to help him search for the right words to put in the utterance. A very obvious sign of seeking help is 'you know...'. The Dr could have chimed in to finish the sentence

at several places but she did not do so until this point (L5). In so doing she gained enough information from the Int and was more likely to succeed in her repair.

EXCERPT 15 (01150910HOR 9:30.7, MIRPURI, FAMILY)

1. Int.: [yeah so BASICally on the:: obviously on the letter
2. obviously he needs ehh doctor you yourself (0.45) to write (0.44) briefly what's the::
3. sort of a:: (0.5) you know like a:::
4. [If-
5. Dr: [the problem=
6. Int.: =problem that is about his knees [that's-

5.5.1.3 PASSIVE TRANSITION

Apart from the fact that the Dr may directly address the Int, which turns an interpreted consultation into a monolingual talk, there are other occasions when the Dr may passively transform the conversation into a monolingual talk by not taking the relevant action. This is what I call **passive transition**. This transition might not be the Dr's primary intention when he or she was speaking but due to the absence of the Int's translation or the Int opting to be the addressee the Dr is not talking to the Pt anymore but rather to the Int. However, even though the Dr knows their message has not got across to the Pt, they choose not to take any action against it and therefore passively transform the conversation into a monolingual talk.

EXCERPT 16 (1020710KEN 6:16.0, CZECH, SEMI)

1. Int: Yeah? As well, she just stray (.) she just say straight away she wanna
2. eh some tablets
3. → Dr: yeah, yeah, there's no problem. I'm gonna give her some [tablets as well.
4. → Int: [OK.
5. → Dr: They are very good for headache too.
6. → Int: ehm
7. Dr: An(d) (0.5) there's couple of other things that I need to ask her.
8. Does she drink any alcohol?

In Ex16 the Dr's turns in L3 and 5 were not translated by the Int but instead she responded to them herself in L4 and 6. Seemingly the Int understood her task in the

interaction as only to get what the Pt wanted from the Dr and ignored the fact that her main responsibility was to facilitate the communication between the two PSs. Because of this misunderstanding of the Int role, the Pt was deprived of the right to know what the Dr's suggestions or decisions were. In L5 the Dr explained the function of the medicine, which was important information for the Pt, but was not considered worth translating and therefore omitted by the Int.

EXCERPT 17 (1020710KEN 9:57.9, CZECH, SEMI)

1. Dr: That's ok::. I'll just print that out for her.
2. (1.6)
3. Dr: [and
4. Int: [and before I was not hear you properly about for what you say about for
5. prescription. You meant with [that the prescription is she

In Ex17 the Dr was telling other interlocutors what he was doing '*I'll just print that out for her.*' This is a signpost which is an important message the Dr gave Pt to lead them through the process of the consultation. It tells the patient what the Dr is doing, where they are in the consultation and what they should or can do at the moment. Signposting is also helpful for building rapport with patients. However, this Int did not seem to share the same understanding of the significance of signposting and omitted the due translation. She might have taken it as a message sent to herself that 'at this moment there is no translation required'. The Dr is partially responsible for the Int's omission of his utterance in that in L1 the Dr used the third person pronoun 'her' rather than 'you', which leaves it open to the Int to interpret whether she should translate to perform her duty as an interpreter or whether she should see herself as an addressee so that she did not need to translate.

EXCERPT 18 (01150910HOR 12:14.10, MIRPURI, FAMILY)

1. Int.: akhni waise 13 hufte tan liksi chonke tora luma time ae na
2. *Int.: she said that she will write 13 weeks because it's short period of time*
3. Pt: aa tika tik akhni, isi bather pata na, chalo
4. *Pt: yea okay, she is right, she knows better, let's doctor*

5. Int.: [agar bilfarz ae na na letter aya te fer pate kay tusan 1 hor appointment kino
6. *Int.: suppose if you don't get this letter then you book another appointment*

The Pt was also found passively transforming the conversation. In Ex18 the Pt was echoing with the Dr's decision on how long he might need to be on a sick leave. This turn was obviously addressed to the Dr as he said 'let's doctor'. However, this message was not considered worth translating by the Int. Instead of translating it, the Int talked back to the Pt to give his own advice. Although L4 did not bear clinically significant message that may alter the Dr's clinical decision, this passive transition reduced the chance for both PSs to build a personal connection with each other. As shown in the above examples, passive transition normally happens when the PS's turn is vague in denoting the addressee. Therefore, the Int could understand the PS's words as relevant to themselves rather than to another PS. What's more, passive transition is usually observable to the PS in the previous turn as it has broken the prototypical turn-taking sequence but the PS chooses not to take any action to restore the interpreted discourse. The reason for this may be that most of these utterances bear only *soft information*, such as signposting (Ex16), small talk (Ex17), or explanation(Ex15 L5) etc. They are significant for the communication but may not be clinically significant so they may be treated as secondary by the participants. As a result, even if the PS realises they are not translated, they are not bothered to change it.

5.5.1.4 EXPLAINING CONVERSATIONAL SITUATIONS

Explaining conversational situations is another reason for the Int to talk back to the previous speaker and change to monolingual talk. The Int could talk back to the previous (or the current) speaker to explain such meta-pragmatic things as their feelings or conversational difficulties, which are not part of the medical consultation. This phenomenon is more common with ad hoc Ints. There is no such case found in the consultation with the professional Int, less with the semi professional Int, but more with the family member Int. I will use the following examples to explain further.

EXCERPT 19 (2020710KEN 0:21.1, CZECH, SEMI)

1. (3 lines omitted)
2. Pt: .h strašne ma to bolí. A nepomáhajú mi ani tie antibiotiká, čo mi pán doktor akože: (0.4) dal.
3. *It hurts me badly and not even these antibiotics that the doctor's eh given me help.*
4. Pt: Vôbec. [Pas- ( )
5. *Not at all.*
6. Int: [Ehm Len mi musíte povedať trochu viacej, lebo ja neviem nič, [čoho sa to týka.
7. *Eh you just need to tell me a bit more because I don't know anything about it.*

This excerpt (19) is taken from the beginning of the consultation with the semi-professional Int. The Pt was answering the Dr's question, 'what I can do for you today?', by giving extensively detailed explanation to the Int, which made the Int feel overwhelmed so she decided to explain how the conversation could be better run in L6-7 by telling the Pt 'you just need to tell me a bit more because I don't know anything about it.'

EXCERPT 20 (01150910HOR 5:20.7, MIRPURI, FAMILY)

1. Pt: 7 din khan[e suba 2 (0.4) tou:: shami oun
2. Pt: *have to take seven days 2 in the morning and 2 in the evening*
3. Int: [oh yeah
4. Int: sorry what he is saying is yesterday he took 2 in the morning 2 in the evening (0.4)
5. Pt: 3 sorry 3, 3 ni 3 ni 3
6. Int: Yeah yeah three of these I don't know he knows

In this case (Ex20) the Pt was constantly repairing himself so that the Int had to repair his translation as well. Both of them felt somehow responsible for the trouble so the Pt apologised (L3) and the Int decided to explain to the Dr what's going on (L6). It occurs to me in several consultations that the family member Int and the semi-professional Int seemed to feel the need to establish themselves as a trustworthy person to the Dr in order to establish and maintain their own credibility as an interpreter, just as in this example.

EXCERPT 21 (01150910HOR 19:50.1, MIRPURI, FAMILY)

1. Dr: you see what I mean
2. Int.: yeah

3. Dr: I think he doesn't understand the system that's why I asked (0.5) are you employed
4. or are you self-employed (0.9) and it's a different system but you need a note °yes° to
5. cover it
6. (1.2)
7. Int.: so in here you are gonna write what's his problem and every[thing
8. Dr: [exactly and I'll I am
9. going to write the knee surgery and it is a waiting surgery but I am also going to write
10. (0.6) the stomach problem

Explaining situation is not only found with Ints but also with the Dr. This is an example (Ex21) of the Dr explaining the situation for the family Int. The Dr was trying to explain to the Pt the complex procedure for getting sick benefits. However, she was not convinced that the Pt understood the situation through the Int so she decided to explain to the Int how she felt about the current situation and what she was doing (L3-5). What the Dr was doing here is to stop the interpreted conversation mode, change to monolingual talk yet also provide explanation of her action. In so doing, she opened up the opportunity to align the Int as a team to do the explanation for the Pt, which would avoid the awkwardness to pass the turns among three people in the interpreted conversation and could speed up the consultation. This was what happened afterwards—the Int explained directly to the Pt what the Dr had said and the Pt could ask him questions and get answers without having to be translated.

The professional Int was not found to either explain the situation to the Pt or to the Dr. She was able to effectively collaborate with the Dr to carry out the consultation without having to resort to extra communication (or meta-pragmatic) strategies as I just discussed. Also, none of the Pts were found to explain the conversational situation.

5.5.1.5 Speaking on behalf of the PS

Ints sometimes not only play the role as an interpreter but they also participate in the consultation as an active interlocutor. It seems that ad hoc Ints are more likely to go astray from their expected role as an Int, while professional Ints are more likely to stay in the same role throughout the consultation. In this study, the family member Int

frequently spoke on behalf of the Pt in respond to the Dr's words. In some occasions he also spoke on behalf of the Dr to give the Pt advice. The semi-professional Int was found speaking on behalf of the Dr very often but not much of the Pt. The two PSs' reactions to the Int's delegation were very different. While the Dr could either accept or reject the Int's delegation and request to return to the interpreted form of talk, the Pt did not seem to have such flexibility but to accept it as legitimate contribution to the conversation.

EXCERPT 22 (01150910HOR 9:43.7, MIRPURI, FAMILY)

1. Dr: ri::ght, ok. Is that why you rang up then.
2. Pt: [ah-
3. Int: [yeah yeah, that's why.
4. (0.4)
5. Dr: Do you just want to check that with him is that why he rang up because
6. he wa[s
7. Int.: [Taai'en, aakhni ae k tusaan fon [kita si
8. *Int.: that's why, she is asking that's what your called about?*

In Ex22 the family member Int (L3) responded to the Dr's question (L1) without translating. This was rejected by the Dr who did not continue the consultation but instead requested a translation (L 5).

EXCERPT 23 (01150910HOR 16:35.0, MIRPURI, FAMILY)

1. Dr: you haven't been to work for five weeks=
2. Int.: =He hasn't no=
3. Dr: =Ok, so what have you done about a sick note in that time.

This is taken from the same consultation but here the Int's answer to the Dr's question was accepted by the Dr, who then moved on to the next question (L3).

EXCERPT 24 (01150910HOR 16:35.0, MIRPURI, FAMILY)

1. Dr: Have you not had any sick note
2. Int: No no
3. Dr: Ok did you not ask before for one
4. (0.5)
5. Int.: no no he hasn't.

6. Dr: Right,
7. Pt: ( )
8. (0.5)
9. Dr: Do you want to check that with him I can't find any record that he's had one, but he
10. should've had one, you've not been able to wor::k (0.5) an::d because of his anaemia and
11. because of his knee, then you should've been claiming and fill them the sick note

Sometimes the Dr did not directly ask the Int to translate but 'nudge' them to do so. In Ex24 the Dr asked a second question when the first was not translated but answered by the Int. The two questions were worded differently but both aimed at the same answer. In addition, the Dr used the second person pronoun 'you' to address the Pt, trying to send the message that she needed to hear from the Pt. When this indirect approach did not work, the Dr had to request a translation and at the same time gave the Int an explanation about why she needed to hear the answer from the Pt. Explanation of the conversational situation seems to be a very effective strategy the Dr can use to redirect the Int to take the role the Dr wants without hurting the Int's feelings for being rejected.

EXCERPT 25 (01150910HOR 18:18.5, MIRPURI, FAMILY)

1. Dr: it's a sick note you want
2. (0.66)
3. Int.: sick note no no he doesn't want it, he just want another, sick note te nai na chaie
4. *Int.:* *do you require sick note?*

The family member was very likely to speak for the Pt especially when they are also the caregiver who knows the Pt very well. A few minutes later in the same consultation following the previous example, the Int spoke back to the Dr on behalf of the Pt again (Ex25). However, due to the previous experience he anticipated that the Dr might not take his response into account and request for a translation, he withdrew his initiative half way through his utterance and returned to interpreting for the Pt (L3-4).

EXCERPT 26 (2020710KEN 10:47.0, CZECH, SEMI)

1. Dr: Hh::m, .hhhh How long has it been going on for?
2. (Pt's response omitted)

3. Int: Eh:::m. (cough) eh:::m that happens for about one month. And she just saying from Slovakia from pharmacy she was having some vitamins.
4. Dr: Yeah
5. Int: And something from magnesi[u::m an::d something does to mean that .hhh=
6. Dr: [yeah, yeah
7. Int: =A pomohli Vám?
8. *And have they helped you?*
9. Pt: No niečo zabralo, ale ja [som nemala veľa
10. *Well, something has worked out well, but I haven't had many*
11. Int: [THA::::::::::::t helped her a little [bit but she now have two most of
12. that=
13. Dr: [a little bit

Ex26 shows the situation when the Int spoke on behalf of the Dr. The Dr only asked 'how long' in L1, which got the answer from the Pt in L2 and the translation in L3, 5. However, right after the translation, the Int did not pass the turn back to the Dr but rather turned back to the Pt to ask a question 'and have they helped you?'. This act was accepted by both PSs as legitimate. The Pt answered the question and the translation of the answer was accepted by the Dr as well. Although both the PSs could see that the Int had broken the prototype turn-taking, neither of them rejected this act probably because neither of them could be certain whether the Int was speaking back to repair (in case she did not get what the Pt had said) or to speak for herself (as in this case).

What is also found in the data is that the conversation does not always have to involve the Int as the messenger in that it is very rare that the Pt cannot speak any English at all. Therefore, there are occasions when the Pt was found to speak to the Dr without translation. That is the last mode of monolingual talk—**the PSs' talk**.

5.5.2 PSs' TALK

In the data I only found PSs talking with each other in English but not in other languages. It reflects the common situation in the real world that the Dr is less likely to be able to speak various languages but most PSs can speak a little bit of English. In the consultation, the Dr can invite the Pt to speak English if the Dr is confident about the Pt's language ability. Or on the contrary, the Pt can volunteer to speak directly to the Dr. PSs' talk was found at the beginning of the consultation or during the physical

examinations. It seems helpful for the Dr to establish a direct connection with the Pt and speed up and smooth the conversation. However, it can only be used when the conversation is relatively simple and the information is less significant. Otherwise it would become problematic. An interesting finding is when the PSs' talk became problematic, the professional Int would provide a backup translation to remedy it but this was not found with another two ad hoc Ints.

EXCERPT 27 (01170910HOR 6:30.0, URDU, PROF)

1. Dr: [CAptures and hurts °yea° endum (3.89) what about here do you get pains in your legs.
2. Pt: no only knee::
3. Dr: only knees right↓ before you were talking about your ankles=
4. Pt: =yea:::: ankle but ankle is feel (.) well now (0.6) sometime swelling on the ankle but I
5. °do:n't kno:::w what's happen like that°
6. Dr: °Right° (0.4) but not as bad

In Ex27 the Dr invited the Pt into a monolingual conversation with her during the physical exam. As the Dr was checking the Pt's neck she was constantly commenting on the situation and asking questions as in L1. In this part of the consultation, the Dr's words were related to the action she was conducting on the Pt. By inviting the Pt to speak English the Dr was able to pass the information to Pt which was related to the body parts she was examining. Had the Int been involved here, the information the Pt got from the Int would be delayed and would not make sense as the information given did not match with the action the Dr was doing right now.

EXCERPT 28 (01150910HOR 0:30.0, MIRPURI, FAMILY)

1. Dr: hehehe CERtainly why would I be putting it on telly. (0.9) Oh, GOodness. I will be put
2. at the GMC if I put this on the telly=I will be (.) struck off (0.5) .hhhh em (0.4) Ok .hhh
3. thank you for your agreeing to the video=that's great.
4. (0.7)
5. Dr: [em
6. Pt: [Even for us it's alright
7. Dr: [Absolutely we do any-
8. Pt: [you know that's why, that's why I say yes
9. Dr: Yes
10. Dr: [we trying to impro::ve [(.) the way we [work
11. Pr: [beca::use [becau- [I'm sorry=You explain us (0.3) I

12. understand but not much sometime (0.38) I stuck that's why I bring my son
13. Dr: Right
14. Pt: bring my daughters here u know
15. Dr: yeah
16. Pt: an::d explain easy for me
17. (0.36)
18. Dr: .hh so (0.38) the way I plan to do this is that I will speak in English but I will as- I
19. know you understand some but I'll ask your son to interpret directly .hh what I say (.)
20. .hhh em if that's possible (0.47) em (1.1) you perhaps want to say that to him maybe?

This talk (Ex28) happened at the beginning of the consultation in which the family member was interpreting. Although the Pt's English was not good he was eager to talk, which was accepted by the Dr. However, right after this the Dr decided to change to interpreted talk as the mode for the consultation (L18-20).

EXCERPT 29 (01170910HOR 5:31.0, URDU, PROF)

1. Dr: ((feeling the Pt's neck and shoulders)) when you first ca::me you had swelling on your neck, didn't
2. you.
3. Int.: Pehli bar aye ti tu [sojan ti
4. *Int.: first time when you came then was enlarge*
5. → Dr: [Try to speak English if you want you know?
6. [Hehehe
7. Pt: [hehehe
8. Dr: It's just sometimes we are not very clear about understanding between us (0.5) and it was
9. quite big then wasn't it. it's still there [a little bit
10. → Pt: [yea::::::::
11. (0.8)
12. Int: pehle kafi bara ta↑
13. *Int.: It was quite big before*
14. Pt: nahi pehle bi swelling kab:hi ho jati hai kab:hi nahi hoti
15. *Pt: No also before sometimes there would be a swelling, sometimes there wouldn't be a*
16. *swelling*
17. Int.: sometimes it swells and sometimes [it doesn't

Ex29 occurred prior to Ex27. In here the Dr interrupted the Int's translation using overlapping speech and initiated a change to monolingual talk in L5. Even so the Int still decided to translate what the Dr said for the Pt (L12). However, the translation was not rendered right after the Dr's turn but rather after the Pt had seemingly responded to it with minimum utterance in L10 (yea::::). Surprisingly this backup translation elicited more talk from the Pt in L14-15 but in Urdu not in English. The Pt

could have produced this piece of talk after L8-9 but it did not happen until the translation. This indicates that the Pt either had trouble understanding the Dr's turn in L8-9 or responding to it in English. As mentioned earlier, inviting the Pt to talk in English can be helpful but if it stretches the Pt's ability too much (as in Ex29), it may cause information loss. Had the Int not backed up, the Pt would have lost the chance to speak in this case.

Backup translation was commonly found with this professional Int in 01170910Hor. This again is the evidence that a professional Int has high skills in doing the job. They are more likely to keep themselves in role and are very attentive to any communication problems that might occur to the PSs and apply relevant strategies to remedy them. Here backup translation is another strategy that was used by the professional Int and in some rare cases by ad hoc Ints. It is also one of the six types of turn-taking that will be discussed in the next section.

5.6 TYPES 4, 5 & 6 BACKUP TRANSLATION, SEMI-INTERPRETED TALK & BACKTRACK TALK

5.6.1 BACKUP TRANSLATION

As I have touched upon in the previous section, backup translation (hereinafter BT) occurs when the Int suspects or actually sees that the communication between the PSs is not successful due to the monolingual talk initiated by the PSs either explicitly (Ex29) or implicitly (Ex30). The example in Ex29 shows that the PS initiated monolingual talk was suspected by the Int not to be fully successful and triggered a BT. This kind of proactive BT was only found with the professional Int. Ad hot Ints were found using it, too, but more as a remedy for communication problems (see Ex30). It is also noticed that most of the backup translations were rendered for the Pt but not for the Dr in that PSs' talk only occurred in English.

If a simplified turn-taking diagram of the prototype could be illustrated as Dr—Int—Pt, then the BT takes a sequence like this: Dr—Pt--….Int. Here the Int is no longer in

between the two PSs but rather at the end as a remedy of the communication after both PSs have spoken and problem may have occurred. This form of turn-taking suggests that although the PSs can shift the interpreted conversation to a monolingual one, the Int, as one of the participants, can always shift it back.

EXCERPT 30 (01150910HOR 16:26.0, MIRPURI, FAMILY)

1. Dr: so↓ the other issue is em when did you last wo:::rk and have you had sick notes
2. before.
3. Pt: eis ki akh
4. *Pt: tell her*
5. (0.78)
6. Int.: yeah yeah
7. Pt: ( )
8. (0.76)
9. Int: ila ani ye kila kam kita sae?
10. *Int.: when, she is asking, when did you work?*
11. Pt: akh qairban punj aik hfte hoi gai mai koi na kama tae gaia, mari gadi v khatum hone wali ye te badge v koi na,[main kama ten a jaie sukna
12. *Pt: tell her that nearly for almost 5 weeks I didn't go to work, my car is nearly finished (useless) as well and I don't have a badge so I can't go to work*

In Ex30 the Pt seems to have understood the Dr so he started speaking in the immediate turn (L3) after that of the Dr. The Int was ready to translate for him but the Pt failed to say anything after the first initiative, 'tell her' in L3-4. This and the two long pauses in L5 and 8 were understood as problematic by the Int so he produced a backup translation of the Dr's question in L10, after which the Pt was able to answer properly in L11-12.

5.6.2 SEMI-INTERPRETED TALK

Another type of turn-taking is called semi-interpreted talk (SIT). It is the kind of talk in which one of the PSs' turns does not need to be translated. This happens when the Pt can understand what the Dr is saying and responds in his or her own language without having the Dr's words translated; or the Pt could respond in English after the Dr's words were translated. The two occasions can be illustrated by the following diagrams:

DIAGRAM 1 SEMI-TRANSLATED TALK

① Able to speak:	② able to understand
Dr--Int--Pt	Dr--Pt--Int
La Lb La	La Lb La

① shows the turn-taking sequence when the Pt needs the Int to translate the Dr's utterance but can reply in English without a translation (see Ex31). ② is when the Pt understands the Dr but has to respond in their own language and let the Int translate for the Dr (see Ex32).

EXCERPT 31 (01150910HOR 2:53.3, MIRPURI, FAMILY)

1. Dr: .hh so (0.38) the way I plan to do this is that I will speak in English but I will as- I
2. know you understand some but I'll ask your son to interpret directly .hh what I say
3. (.) .hhh em if that's possible (0.47) em (1.1) you perhaps want to say that to him maybe?
4. Int.: ane k ae akhne k tusan ki akhni k tusan ki thori samj ae (.) liken fer main tuse ne
5. nikay ki akhsan k tusan ki samjawe
6. *int.: she is saying that she is saying to you, you understand a bit, but still I will tell your*
7. *son to explain to you*
8. Pt: *Aa :: tik a (0.6)* it's ok I'll I'll stay quiet (.) you just told me that I can talk with me
9. then us
10. *Pt: ok it's fine.*
11. Dr: Great stuff yeah

EXCERPT 32 (3020710KEN 5:04.0, CZECH, SEMI)

1. Dr: [She's got a bit of eczema
2. Pt: To sa mi toto robí stále
3. *It happens to me all the time*
4. Int: She has that all the [time

5.6.3 BACKTRACK TALK

Another type of turn-taking, backtrack talk, can be considered as a strategy the Int applies to repair a conversational problems. It can be considered as a kind of troubled talk. The trouble comes from a trouble source in the previous PS's turn and the Int failing to identify and repair (or initiate a repair) before the onset of the translation; however, the Int manages to initiate or do the repair within the same turn, in which he or she has started interpreting. Backtrack talk can be described as a segment of

monolingual talk inserted into the prototype sequence organisation and can be illustrated by the following diagram:

DIAGRAM 2 BACKTRACK TALK

① 1 1 2 .... n OR ② 1 1 2..... n
Int--- Int---Dr.... Int Int ---Int-----Pt..... Int
Lb La La... Lb La Lb Lb.....La

The most distinctive feature of this form of turn-taking is that the Int uses two different languages within a turn and the turn ends up with the same language as the Int used to start the turn. This distinguishes this form of turn-taking from the others mentioned before.

EXCERPT 33 (1020710KEN 11:10.0, MIRPURI, FAMILY)

1. Dr: exactly the same so [that's the one for headaches
2. Int: [Hovorí, že vám dáva presne tieto tabletky, je to (0,7)
3. *Int: He says that he's giving you exactly the same tablets, it is (0,7)*
4. use the () is a one tablet a day?
5. Dr: Yeah. It's one a day. [Sorry. That's actually my fault
6. Int: [OK.
7. Int: Je to jedna tabletka na deň.
8. *Int: It is one tablet a day.*

Ex33 took place when the Dr had just handed the prescription to the Pt but had not explained what was written on it. The Int did not wait but took the initiative to explain the prescription. However, she found an error in the dose of the medication the Dr had prescribed, which put the explanation on hold and the Int had to carry out a repair in L2-3, which was accepted by the Dr in L5. Then the interpreting was resumed from L6-7. In this case the Int was not only playing a role as an Int but also a health advocate. With prescription in hand, she believed she had sufficient knowledge to explain it to the Pt without involving the Dr. On the other hand she was also monitoring the whole process so that she felt responsible to point out obvious mistakes made by the Dr, which went beyond simply transferring the language from one to another.

EXCERPT 34 (3020710KEN 7:20.0, CZECH, SEMI)

1. Int: She just want to ask you because as well when she been in Slovakia, she no
2. have nothing of problems, yeah? An:::d like eh, Kedy ste sa vrátili alebo kedy ste prišli?
3. *When did you come back or when did you come?*
4. Pt: Eh, od marca.
5. *Eh, from March.*
6. Int: She came back to UK in March this year and per one month all tooth was came out

Backtrack talk is not always legitimately used by the Int as in Ex33. Sometimes the Int can talk back to speak on behalf of another PS. Such as in Ex34, the Dr did not ask a question about 'when' the patient came back to the UK; nor did the Pt intend to mention it but the Int felt necessary to ask and let the Dr know.

These two examples of backtrack talk resonate with the argument that the Int in an interpreted consultation is not simply a conduit or a 'voice box' (Wadensjo, 1998, Hale, 2007). They are also playing an advocate role. Sometimes their advocacy helps but in other occasions it may harm the consultation as Ints are after all not trained in medicine. However, how much they can actually advocate is still unclear.

5.7 TYPE 7 IGNORED TURNS

Apart from the prototype turn-taking organisation, the other types discussed previously are somehow a mixture of benefits and problems for the communication. The type to be discussed in this section is called ignored turns, which is nevertheless more problematic than any others. An ignored turn is one that is not taken on board by the addressee and therefore the information in it is eventually lost. Turn-taking as discussed at the very beginning of this chapter and in the methodology Chapter, is the fundamental way of conversing. Observing the turn-taking assures only one person gets the floor to speak at a time and the rest will be the listeners. In some occasions the sequence of speakership is predetermined so all participants know who will speak at what time. As noted in most part of this chapter, an interpreted conversation is best conducted when participants follow the prototype turn-taking organisation so that

when a PS is speaking, the Int is able to listen and translate for the next PS and so on. The participants are also using the prototype sequence to anticipate when they are going to speak. So the Dr might start speaking after the Int who interpreted for the Pt, the Int may take over to translate once either the Dr or Pt has finished talking, and so forth. However, in reality the participants do not always follow the prototype to speak, which may cause their turns to be ignored by other participants. There are three occasions where this could happen: 1) **illegitimate entry**, 2) **strategic ignoring**, and 3) **premature entry**. An illegitimate entry is a turn which comes in when it is expected to be taken by another speaker. Strategic ignoring means the participants strategically ignore a turn for certain communicative purposes. A premature entry is a turn which is a legitimate next turn but enters the talk before the previous turn is finished.

EXCERPT 35 (01150910HOR 18:20.0, MIRPURI, FAMILY)

1. Int.: [he just wants a letter from you
2. Pt: paie bimri [na likhae.
3. *Pt: only write about the disease*
4. Dr: [But I don't know who the letter's fo::r. We issue sick notes we do::n't do::
5. other letters unless that's a private arrangement but I can give you a sick note (0.4) who
6. would it be fo::r.
7. Int.: kis ne waste pochni
8. *Int.: she is asking for what?*

In Ex35 the Int has just finished translating a turn by the Pt (L1), after which the Dr was supposed to speak if they had followed the prototype turn-taking. However the Pt chimed in in L2-3 to add new information, which could turn the turn-taking into a series of extended turns. However, after the Int's turn the floor is open to be taken either by the Dr to continue with the prototype sequence or by the Pt to use extended turns. What happened here is both of them took up the floor to speak and overlapped with each other (L2-5). Obviously the interpreter did not consider the Pt's extended turns necessary in this circumstance but rather thought that the turn should be taken by the Dr. Therefore, the Pt's turn was ignored and his voice in L2-3 was never heard by its addressee.

EXCERPT 36 (1020710KEN 7:16.0, CZECH, SEMI)

1. Dr: alright↑. Interesting. That's good.
2. Pt: A ešte by som sa chcela povedať, [že ja nosím oku okuliare.
3. Pt: *And I would also like to say that I wear gla glasses.*
4. Dr: [could you (0.59) show me where she feels it?
5. Int: u:hm Môžte ukáza[ť
6. Int: *U:hm Can you show*
7. Pt: [Tu.
8. Pt: *Here*

Ex36 happened after the Int had translated for the Pt's answer to a Dr's question. Following this is normally the Dr's floor to ask the next question. Therefore, in L1 the Dr had already taken over the floor but he had not got the chance to ask another question before the Pt chimed in with a new topic about her wearing glasses (L2-3). As the Dr was not finished in L1 he decided to take over the floor by using overlap strategy (L4) (see next chapter for overlaps). The Int also did not see the Pt's entry as legitimate and therefore chose to translate the Dr's turn and ignore the Pt's.

I have already mentioned the advocacy role the Int may choose to undertake earlier. Strategically ignoring a turn is another manifestation of the Int's advocacy role, in which they select the content and the speaker to be translated in the conversation.

EXCERPT 37 (01150910HOR 24:01.0, MIRPURI, FAMILY)

1. Dr: [are you with me? And it says arthritis of both knees are waiting surgery left knee
2. (0.3) anaemia due to stew- stomach proble::ms
3. (1.2)
4. Dr: [okay?
5. Pt: kae baie?
6. *Pt: what did she say?*
7. Int.: okay
8. (1.0)
9. Int.: so you know the::: date that you wrote [13 weeks

As mentioned before, 01150910Hor consultation is with the family member Int and there is a complex stretch of talk where the Dr was trying to explain to both the Pt and Int what a sick note was for and how the Pt could use it to claim for sick allowance. Ex37 is taken from this consultation but from the part where they reached the point

when the Dr was explaining what she had put in the sick note. At this moment the consultation was about to end and he became a bit impatient (in an earlier turn he asked '°we nearly finished yeah°?'). In order to get out of the consultation as soon as possible but still get what the father wanted, he decided to cut the conversation short by not translating for the Pt. Even when the Pt requested for a translation in L5-6, he strategically ignored him. Another strategic use of ignoring a turn was found when the Int did not understand the previous speaker.

EXCERPT 38 (1020710KEN 8:17.9, CZECH, SEMI)

1. Dr: In fact, I'm going to put this bloo- prescription on repeat prescription for her (.) the
2. tablets, so she can get them (cough) when she needs them without having to see a doctor.
3. (1.3)
4. Pt: Tak pondelok by ma moch ako o dva týždne, ale v pondelok že by to bolo.
5. Pt: *So, on Monday he could, I mean in two weeks time, but preferrably on Monday.*
6. Int: if is it possible about for blood test, could you make eh:: next two::after two
7. Dr: two [weeks (before)
8. Int: [for Monday

In this situation in Ex38 the Int was later found not to have understood 'repeat prescription'. Instead of asking for clarification during the long (1.3) pause in L3, she ignored this turn for the time being. With little knowledge of English, the Pt had to assume the long pause indicates that the Int was not going to translate what the Dr had said for certain reasons. Therefore, she started a new topic in L4-5 and the conversation was able to continue.

This kind of strategy is not healthy for the medical consultation; however, it might be the strategy the Int uses to save face. As I mentioned earlier, this Int seems to be eager to establish her credibility as a trustworthy Int. Nevertheless, not only the Int but also the Dr could ignore turns strategically for some unhealthy purposes, as shown in the following example.

EXCERPT 39 (3020710KEN 12:57.0, CZECH, SEMI)

1. Pt: Dobre. (1.4) Ja som veľa popila cocodamol a potom som zvracala. Ja som to už cítila v ústach.

2. To mesiac som to pila. (2.0) Problém je so zubárama. Nemám. Stále som volala na pohotovosť.
3. OK. I have drunk lots of cocodamol and then I vomitted. I have felt it in my mouth. I drank it
4. for a month. There is a problem with dentists. I haven't got one. I call emergency all the time.
5. Dr: Try and find out what we can.
6. Int: aheheTakže na [ten blood test
7. So, for that blood test
8. Dr: [Thank you
9. Int: sa dostavíte. A potom sa uvidí, že čo bude ďalej. Dobre?
10. You'll come here. Then we'll see what will happen next. OK?
11. Pt: Ďakujeme. Dovidenia.
12. *Thank you. Good bye.*

Ex39 took place when the consultation was close to an end. The Pt was speaking after the Int had interpreted for the Dr. However, the Dr chose to take over the floor to wrap up the talk rather than giving it to the Int for translation, which made the Pt's turn ignored (L1-4). He forced in his closing utterance ('thank you' in L8) in overlap with the Int's ongoing translation of what he said earlier. Obviously the new topic the Pt's was just about to bring up regarding having problem with dentist was not taken on board.

EXCERPT 40 (5020710KEN 1:16.2, CZECH, SEMI)

1. Int: She just saying e:::::H there's her partner, just saying that she was (stru) every each morning when she is a wake up straight away she was having a real big discharge he::::re and she'd make the cough
2. Dr: Phlegm?
3. Int: that come last night
4. Dr: So, that was like a phlegm.

Ex40 shows how a turn was ignored when entered prematurely in case of a premature entry. This either causes overlap or ignored turns. Although in Ex40 the Dr was the legitimate speaker for the next turn, he came in to repair too early in L2, which therefore was ignored and he had to redo it in L4.

As demonstrated in the examples, ignored turns sometimes contain significant information that should not be ignored (e.g.: Ex39). In most cases turns are ignored because one participant is not following the prototype turn-taking organisation while another is following (Ex35, 36), or simply because they become impatient (Ex37, 39). Ignored turns were only found with the family member Int and the semi-professional

Int but not with the professional Int. In her case, the participants were found taking turn to speak in an orderly manner and between the turns they gave time for the previous speaker to finish; therefore, other strategies, such as extended turns, could be applied without having turns being ignored (e.g.: Ex2). In the next chapter I will talk about pauses and also its counterpart, overlaps.

CHAPTER 6 FINDINGS—OVERLAPS AND PAUSES

6.1 INTRODUCTION

One of the fundamental features Sacks and colleagues observed in human conversation is that '***No gap and overlap is common in turn transitions'*** (Sacks et al., 1974)**.** Although most of the time people take turn to speak, there are occasions when more than one interlocutor speaks at the same time or when no one speaks for a short period of time. These phenomena are known as **overlaps** and **pauses** respectively. Overlaps in the interpreted conversation have similar functions as in the monolingual talk in interaction. However, there is one function that is peculiar to interpreted discourse, that is, when the Int overlaps to do simultaneous interpreting. In my data overlaps are seen to be used strategically by all participants to achieve their communicative goals; however, undesirable overlaps also occur and can cause trouble as discussed in the previous chapter. Pauses, on the other hand, are found to have a more positive impact on interpreted conversations. They may be considered unnatural or causing embarrassment if there are too many pauses in monolingual settings[11] but they seem quite beneficial in the interpreted discourse in my data. There are two types of pauses, intra-turn pauses and inter-turn pauses. An **intra-turn pause** happens within a turn, when the speaker stops and continues several times before the turn is finished. An **inter-turn** pause happens between two separate turns taken by the current and the next speakers. Both types of pauses play a significant role in maintaining the smooth flow of the conversation.

Due to their significance in the conversation and thus in developing communication skills, I singled them out from the previous chapter and gave detailed discussion of the features each of them have in the following sections.

6.2 OVERLAPS

[11] This is true at least in English culture if not all cultures.

All participants, the Dr, Pt and Int, can use overlaps strategically or in a beneficial way. **Continuers** often happen in overlaps which do not interfere with either the speaker to speak or the listener to understand. Contrarily, they can be used to show that the current listener is attentive, understanding what the speaker is saying and willing to hear more. Another strategic use of overlaps is to compete for floor[12]. Drs and Ints are found using this strategy to repair misunderstandings, regain the floor taken by premature or illegitimate entries or change the speakership if the previous speaker has taken an extended long turn. The family interpreter was also found using overlap to do simultaneous interpreting while the current speaker was still speaking. It is very rare for Pts to overlap strategically. In fact Pts' are found to have used overlaps a lot less than Drs and Ints. Contrarily, their overlaps occur in more problematic situations, such as premature and illegitimate entries, which also happen to Drs and Ints. This may suggest a hierarchy in the power relationships in the interaction, with Dr on the top and down to the Int and then Pt at the bottom. Next I will explain in detail how different participants use overlaps differently with more examples.

6.2.1 Strategic overlaps

Overlaps are mostly seen **when continuers are used** as in the example in the previous chapter (as L2 &5 in Excerpt 4 in chapter 5). Short verbal cues such as, 'yes', 'uh hum', 'yap' are very useful. However, anything longer than that may seem to show the listener's active involvement but in effect may not be as helpful as short and concise continuers. The following is an example to elaborate on this point.

Excerpt 1 (3020710Ken 2:50.3, Czech, semi)

Before this the Pt just answered the question from the Dr: 'Does she even get what we call <u>cramp</u> in English, with muscle there is tight?' The following starts from the Int's translation.

1. Int: [that happened only one time, a night time when she been sleep

[12] The right to speak.

2. Dr: So, one [time she woke up at night
3. Int: [and <u>now</u> her wake up yeah, there was only one time, she was come after
4. that move proper with light, [yeah↓
5. Dr: [yeah that's what I was [hoping.
6. Int: [<u>But</u> normal [(she not possible it's
7. just that pain)
8. Dr: [normally, it's not that,
9. ok, °it's just aching in the back° She got any back pain↓

In Ex1 the Dr was eager to show his understanding and attentiveness by constantly trying to either finish the Int's turns or respond to them, which caused overlaps in L2, 5 and 8. The Dr seemed very cooperative and active in the interaction but his interference not only affected his understanding of the Int but also caused difficulty for the Int to translate. Observably the Dr did not always get what the Int was trying to say (L1 vs L2; L6-7 vs L8) and the interference stopped the Int's translation before it was finished; therefore the Int had to overlap with him in L6 to regain the floor and finish the translation.

From a professional interpreter's point of view, I understand that interpreting is a complex process that needs high concentration to do the work. It occurs to me in this case that the Dr's constant interference may have distracted the Int's attention and caused translation difficulties. As can be seen, the Int's first utterance in L1, although not very grammatical, is still understandable; however, her utterances in L3 & 6 are much more troubled and difficult to understand, even though what she was trying to say did not seem to have to be grammatically sophisticated. The reason could be the distraction caused by the Dr's overlapping speeches.

Another strategic use of overlaps by all participants is to **compete for floor**. Drs and Ints were found competing to **repair,** to **regain floor to finish a turn** or **change the speakership**. I will discuss each of them with examples. Ex15 (01150910Hor 9:30.7) in Chapter 5 is an example when the Dr chimed in to repair a troubled ongoing turn by the Int and succeeded so it helped the flow of the conversation. However, the attempt to repair the Int without knowing what the Pt had said runs a high risk to fail and hinder the conversation, especially when the Dr repairs without sufficient linguistic

cues that suggest a potential repairable. As in Ex2 below, the Int hesitated a bit ('*she been at a::: in Slovakia*') but she resumed the utterance very quickly. However, the Dr perceived the first hesitation (*a:::*) as an immediate repairable and produced a repair in L2, which overlaps with the Int's continued self-repair in L1 ('she's been in Slovakia for eight months.'). Without hearing sufficient information, the repair in L2 turned out to be incorrect and therefore was rejected by the Int straightaway ('No::: ↑' in L1).

EXCERPT 2 (3020710KEN 2:30.3, CZECH, SEMI)

1. Int: [She been at a::: in Slovakia [she's been in Slovakia for eight months. No::↑
2. Dr: [seeing a specialist alright.
3. Int: She just saying I've been in Slovakia for eight months and I don't have nothing
4. problems [and now

The following examples show how the Int used the same overlap strategy to repair misunderstandings.

EXCERPT 3 (1020710KEN 5:35.0, CZECH, SEMI)

1. Dr: there there is an opportunity for her to have blood tests late in the evening on
2. Thursday night, we have a late evening surgery up till 8 o'clock
3. Int: ehm
4. Dr: but the only trouble with that she'll have to take blood sample herself to the
5. hospital because there's there's no bus which is just near here
6. Int: yap
7. Dr: because the van that collects the sample (0.6) is comes at 5 o'clock [in the
8. Int: [and you can't
9. waiting fo::r after two weeks that will be me [that ()
10. Dr: [yeah, we could fit that in next [Thursday
11. Int: [because she is
12. just [saying
13. Dr: [But no, I'm happy to wait after two weeks, yeah? That's great?

EXCERPT 4 (1020710KEN 5:47.0, CZECH, SEMI)

This happened a few seconds after Excerpt 3. The Int was telling the Pt that she could make an appointment for two weeks later.

1. Int: to je jedna nevýhoda. Ak chcete tak, on počká tie dva týždne.

2. Int: *this is one disadvantage. If you want then he can wait those two weeks*
3. Pt: no?
4. *Pt: yes?*
5. Int: a až po dvoch týždňoch
6. Int: *and only after two weeks*
7. (0.8)
8. Pt: Ja by som chcela aj tie tabletky, to som, čo som predtým [brala
9. Pt: *I would also like these tablets, that I that I was taking [before*
10. Int: [Takže počkajte, čo sa týka
11. krvi, chcete, že by počkal dva týždne a po dvoch týždňoch potom na hocikedy?
12. Int: *[So, hold on, regarding the*
13. *blood, you want him to wait for two weeks and then after two weeks at anytime?*
14. (0.86)
15. Pt: tak áno.
16. Pt: *well, yes*

Prior to Ex3 the Int was trying to tell the Dr that the Pt had to work every day from 6 to 6 in the next two weeks so she wanted to have an appointment after that period of time. However, her translation was unclear and misled the Dr to think that the Pt had to work every day from 6 to 6 in the following two weeks and she could only come for blood tests after 6pm. That's why in this excerpt the Dr was trying to explain the late surgery, which obviously was not relevant to what the Pt wanted in the first place; therefore the Int chimed in L8 to initiate a repair before the Dr was able to finish the irrelevant explanation. Because this inserted repair initiation happened in overlap, the Dr did not understand her in the first instance and continued his explanation (L10). This then triggered the Int's further initiation of repair, which happened in overlap again (L11-12). Only then had the Dr realised the problem. Observably this kind of repair is very necessary but it takes a lot of efforts and runs the risk to fail in that it occurs in overlap with the current speaker. Such repair can be considered as an illegitimate entry, which may be ignored or misinterpreted by the speaker (as in Ex3).

Ex4 continued the talk in Ex3. The Int was confirming with the Pt to see whether she would come for blood tests on a Thursday night after 6pm or after two weeks. However, up until L6 the Pt did not give her a firm answer. Contrarily in L8-9 the Pt changed to a different topic about the tablets so the Int had to interrupt the Pt in

overlap in L12-13 in order to get a desired response from her before the consultation could move on.

Overlaps are also used to **regain floors to finish an interrupted turn**. However, such attempt is not always successful.

EXCERPT 5 (1150910HOR 9:37.0, MIRPURI, FAMILY)

1. Dr: [the couple of issues [that's-
2. Int: [yeah yeah
3. Dr: the diarrhoea he is still bothered ab[ou:::t
4. Int.: [yeah yeah
5. (0.76)
6. Dr: but that is improving [am I alright?
7. Int: [yeah yeah yeah yeah
8. Dr: An:::d [there's-
9. Int.: [the main thing is the [letter yeah
10. Dr: [the other thing is the:: em resu::lts:: of the test
11. from yesterda::y and the tablets to understand that .hhh and then there's something
12. about a letter, is it alright? [ok
13. Int.: [°yes yeah°

EXCERPT 6 (1020710KEN 9:57.9, CZECH, SEMI)

1. Int: [and before I was not hear you properly about for what you say about for
2. prescription. You meant with [that the prescription is she
3. Dr: [Yeah. The the prescription is now what we call on a repeat
4. [prescription. So it means she
5. Int: [Oh::: All right. Is that, is that if her tablets finished, she just bring prescription back here=
6. Dr: =ask for [more
7. Int: [and after [one day or something like that- Alright
8. Dr: [She doesn't need to see a doctor.

In Ex5 the Dr was summarising the issues the Pt had presented through the Int but before she finished, the Int chimed in (L8 & 9) prematurely; therefore the Dr had to overlap in L10 to regain the floor to finish her summary. In contrast the Dr in Ex6 was not that successful. Here the Int talked back to the Dr to initiate a repair regarding the 'repeat prescription', which she did not understand in the first instance. However, when the Int heard 'repeat prescription' again she realised what the Dr was saying so

she started to speak in overlap with the Dr to confirm her understanding. However, the Dr did not feel that his explanation was complete yet so he overlapped a few times attempting to finish his words. As one can see in L6 Dr added '=ask for [more' right after the Int's last word 'here=' but this did not regain him the floor. Instead the floor was retaken by the Int to produce another overlapping utterance in L7. Then the Dr attempted to regain the turn again in L8, which ends up with both of them talking simultaneously. However, an interesting thing to observe is that the Int seemed to be distracted by the Dr's utterance and resulted in a troubled utterance in L7. This resonates with the observation I made earlier about Ex1, that the non-native English speaking Int can be distracted by overlapping speech and perform below their normal language ability, which may result in odd utterances. The situation in Ex6 could be improved if the Dr stopped and let the Int continue. He could repair, had there been any misunderstandings in the Int's explanation.

The Int can also use overlaps to regain a lost floor and finish an interrupted turn. Ex1 in this chapter is an example of the Dr cutting off the flow of the Int's turn, which caused the Int to overlap in order to regain the floor. The Int's attempt could have failed had the Dr been too persistent or the Int given up, such as in Ex7 below. In the following example, the Dr took over the floor (L3) before the Int had finished the translation. Although the Int attempted to regain the floor in L5, the Dr repeated himself ('I can also give her I can…') and raised his voice on 'I can', attempting to keep the floor. Eventually the Int had to give up and let the Dr continue so the Dr never got the chance to hear what the Int had 'explained to' the Pt.

EXCERPT 7 (2020710KEN 4:15.0, CZECH, SEMI)

1. Int: Because before she was lose too much weight an::d she just saying if this time
2. you will give me trama[dol.
3. Dr: [Tramadol OK↑ I can al[so give her I can give her the long-lasting
4. tramadol if she prefers
5. Int: [I just explained to her ( )
6. Int: Tiež, keď chcete, môže Vám dať tiež ako ten silný tento tramadol.
7. Int: *Also, if you want, he can also give you eh this strong this tramadol.*

Compared with other two interlocutors, Pts were not found to be using overlaps to regain floors very often, although it did happen in some rare cases. Ex8 is one of the few where the Pt overlapped with the Dr to finish his words (L6). However, the Pt had this chance to behave as such maybe because the talk took place before the onset of the substantive talk about the medical consultation topics. Again this may reflect on the hierarchical relationships in the consultation, in which the Pt is at the bottom.

EXCERPT 8 (01150910HOR 2:34.0, MIRPURI, FAMILY)

1. Dr: [em
2. → Pt: [Even for us it's alright=
3. Dr: =Abs[olutely we do any-
4. → Pt: [°you know° that's why, <u>that</u>'s why I say yes
5. Dr: Yes [we trying to impro::ve [(.) the way we [work
6. → Pr: [beca::use [becau- [I'm sorry. You explain us (0.3) I
7. understand but not much sometime (0.38) I stuck that's why I bring my son
8. Dr: Right
9. Pt: bring my daughters here u know
10. Dr: yeah
11. Pt: an::d explain <u>ea</u>sy for me

The next type of strategic overlap is used by participants to **change the speakership** when the previous turn has gone significantly long. Although other two types of overlaps discussed above also lead to the change of speakership, this type is related to a long extended turn produced prior to the overlap. This usage seems a crucial strategy the Int uses to gain the floor to translate when they are unable to take in any more information from the previous speaker. As discussed in Chapter 5, the Dr can use several chunked extended turns to deliver complicated information so as not to burden the Int's memory and cause translation problems. However, Drs do not always use chunked extended turns, in which case the Int sometimes has to use overlap as a strategy to change the speakership. In Ex9 the Dr's turn stretches from L1 to L10 and still shows the tendency to go further; therefore the Int chimed in to begin the translation in L11. Ints were found to do the same to Pts if their turn went too long.

EXCERPT 9 (2020710KEN 6:40.3, CZECH, SEMI)

1. Dr: I think that's a very difficult question (.) I mean, obviously, there're different kinds
2. of work (0.3) And clearly, she could not do a job that require her to be stood up all day.
3. (1.3) BUt if her painkiller- pain control is (.) is good and she is not in pain, lots of people
4. with quite severe injuries, do useful things because (.) they're going to be sat at home
5. getting bored anyway. They might as well have their mind occupied, and they (.) so that
6. means they can do some kind of jobs, they can do sat-down jobs.
7. Int: Ehm
8. Dr: So, wha(.) they make this distinction between somebody who can't do any work and
9. somebody who can do some work but can't do other work. (0.7) This is the dif- this
10. [is the issue.
11. Int: [>Hovorí, akože, že je to veľmi ťažká akože otázka, čo sa týka, či môžte ísť do
12. práce alebo nie, hovorí, že niektorí ľudia majú taký problém ako vy.< .H a keď poberajú
13. tie tabletky ako od bolesti a im pomôžu tie tabletky od bolesti, .h tak jednoducho
14. niektorí ľudia zase nemôžte robiť stojacu prácu, ale môžte napríklad robiť sadavú prácu,
15. kde sa sedí.
16. Int: *He says eh that it is a very difficult eh question, regarding, whether you can go to*
17. *work or not. He says that some people have the same problem like you and when they*
18. *take these tablets like for the pain and these painkillers help them, then again some*
19. *people simply you can't do stand up work but you can for example do sit-down work*
20. *where you are seated.*

The Dr can also use this strategy to change the speakership when the previous turn has gone too long. This is seen more with less skilled Ints, especially with the family member Int, who constantly added his own words into the translation. The following example (Ex10) is taken from the consultation with a family member interpreter. Through the conversation, the Dr might have noticed that the Int was manipulating the translation and his language was not efficient, (which is even clearer to me, with the help of the translated transcript) so sometimes he tended to say the same thing several times but in different words. In this excerpt the Dr had already understood the Int's words so she overlapped with him to take over the floor (L6 and 8) and move on to the next stage of the consultation (L8 & 9).

EXCERPT 10 (01150910HOR 10:40.0, MIRPURI, FAMILY)

1. Int.: yeah, so yesterday when the::: nurses I think or doctors gave the:: my dad the
2. medicine, they suggested (0.4) when you go home if you do take and if you still (0.37) are
3. not improving if you seel, if you feel that you still doing a bit sick diarrhoea (0.6) that to
4. consult with your local GP and just show them the tablets
5. if these are [okay of [( )

6. Dr : [.hhhhh [I:::: see:: right
7. Int.: [so that's why basically I [wanna show you
8. Dr: [Ok [so shall we start with that↓
9. Int: yeah [yeah
10. Dr: [yeah I will have a look at them.

Comparing Ex9 and 10 I cannot avoid noticing that although both the Dr and Int used overlaps to stop a long preceding turn, the Dr's overlap seems more problematic than that of the Int. Generally speaking the Int's listening is to memorise what the speaker says and transfer it from one language to another as accurately as possible; while the Dr's listening is to process information and take actions accordingly. A long preceding turn for the Int can be a burden on the memory, which may cause memory failure and thus information loss in translation. However, a long preceding turn may just provide the Dr with more information for diagnosis, treatment and management. Dr's attempt to change speakership in overlap with the Int may also result in losing clinically significant information the Pt provided but the Int had not translated yet.

Using overlap to compete for floor after all is a risky practice. It always ends up with someone losing the right to speak and thus the loss of information. The harm caused by overlapping speech would be much higher in interpreted conversations than in monolingual conversations. In the latter case when overlap happens the interlocutors speaking the same language can still understand each other (such as in Ex6) because even if people are speaking simultaneously they can still hear and understand each other. However, this is not the case in an interpreted conversation, in which there are at least two interlocutors who do not speak the same language; therefore the risk to lose information is undoubtedly higher.

Apart from these features discussed above, overlap is seen to be used by one Dr to **change the mode of interaction** from an interpreted conversation to monolingual talk. In Ex29 in Chapter 5, the Dr initiated to talk directly with the Pt without involving the Int. The Dr's initiation was done in overlap with the Int's already started translation. This can be considered as a special way of repair, with the repairable being the

inconvenient mode of talk. As changing the conversation mode is not a common phenomenon in the data such usage of overlap is also rare.

Ints can also use overlap in a very unique way. One of the Ints was found to use overlaps to do **simultaneous interpreting**. Simultaneous interpreting normally refers to the translation service used in international conferences, where highly skilled simultaneous interpreters translate while the speaker is speaking simultaneously. These interpreters are also known as conference interpreters. Obviously the simultaneous interpreting observed in the data is not comparable with the work of a conference interpreter; however, they both share one similar feature—the speaker and the Int speak at the same time.

EXCERPT 11 (01150910HOR 5:25.0, MIRPURI, FAMILY)

1. Pt: =[j mungl[are (0.3) before 8 aath tu pehlain pehlain ik hor puri [khadi ae
2. *Pt: you see then again on Tuesday before 8 I had another sashay*
3. Int: [ji [on tuesday [Before 8 o'clock in the morning he had to take another:: (.) sashay of medicine
   (several lines omitted)
4. Pt: for 7 [aa sattan dina te, saat din khaniyaan paisan
5. *Pt: hum for seven days, I'll have to take for seven days*
6. int.: [for seven days this is a different medicine
7. (1.2)
8. Pt: 7 din khan[e suba 2 (0.4) tou:: shami wailae
9. Pt: *have to take seven days 2 in the morning and 2 in the evening*
10. Int: [oh yeah
11. Int: sorry what he is saying is yesterday he took 2 in the morning 2 in the evening (0.4)
12. Pt: three [sorry three, trai ni trai
13. Int: [Yeah yeah three of these I don't know he knows

In Ex11 the Int's simultaneous interpreting is more like a result of a series of short repairs of the Pt who constantly fed new information into the ongoing interpreting; rather than a result of the Int's skilful use of simultaneous interpreting (for instance, to allow the Pt to speak without having to stop). The translation is also not loyal to the original utterance but consists of the Int's own words based on what he heard from the Pt and probably also his knowledge about the Pt's daily life, of which he is part of as a family member. Although the skilful use of simultaneous interpreting is not found

in my data, it does happen in the real word. A participating GP told me about her experience with some professional Ints, who sometimes chose to do simultaneous interpreting. This happens particularly in psychiatric consultations in which the Pt's talk was long and emotional and it was inconvenient to stop them in the middle even for the need of translation. In this case the Int would move closer to the Dr and translate while the Pt is talking at the same time. This could be further investigated with more data in the future.

6.2.2 Non-strategic overlaps

When one interlocutor strategically overlaps with another interlocutor, he or she is aware of it and is aiming at achieving a certain communicative result, such as repair, regaining the floor, etc. However, the interlocutors can also overlap without having a clear communicative purpose. These overlaps are what I call the **non-strategic overlaps**. This kind of overlap is more commonly seen when premature and illegitimate entries occur. Since they do not differ from each other when causing overlaps, I shall refer to both types of entries as P-I entries. There are two types of P-I entries that can cause overlaps: *self P-I entries* and *other P-I entries.* As I have discussed both premature and illegitimate entries in Chapter 5, I will use the same examples to illustrate overlaps. Ex35 and Ex36 in Ch5 are two examples of other P-I entry causing the overlap. In Ex35 the Pt entered the talk right after the Int had just translated for him (L2-3). According to the prototype this turn should be taken by the Dr. The prototype is not just one of the turn-taking organisations observed in the data but it is also the way participants expected the turn to be disseminated. That is to say all participants have the presumption that others will follow the prototype to take turn to talk. That is why sometimes they need 'strategies' to break the prototype. In Ex35 the Dr considered the turn after the Int to be due for him to undertake; she therefore began to speak, which occurred in overlap with the Pt. In Ex36 the Dr overlapped with the Pt also because the Pt entered the talk at a point where either the Dr would continue to talk or the Int would take the turn to translate.

Ex12 below gives an example of overlap caused by the self P-I entry. The Int and the Pt were following the prototype turn-taking sequence during their conversation but the Int took up his turn in L5 before the Pt had finished his in L3-4 and thus the overlap.

EXCERPT 12 (01150910HOR 16:50.0, MIRPURI, FAMILY)

1. Int.: akhne sick note leia se?
2. *Int.: did you get the sick note?*
3. Pt : na na, k[oi nai kinda?
4. *Pt: No no, didn't get any sick note*
5. Int.: [he doesn't no he has not a sick note. No no

The next section is about pauses which are another kind of deviation from the norm of taking turn to speak. Compared with overlaps, pauses are much more straightforward and their benefits for the interpreted conversation are significant.

6.3 PAUSES

Although frequent pauses are not observed as a dominant phenomenon in monolingual talk-in-interaction, they are found in this research to have played a significant role in keeping the rhythm of the turn-taking organisation among the interlocutors. When pauses are used, people tend to follow the prototype turn-taking organisation, allowing each one a turn to speak; overlaps are reduced because more time is given for each speaker to finish their turn; people's understandings are improved and so is the quality of communication. Across the data the use of pauses by the Dr and skilled professional Int to facilitate communication is significantly higher than that of the Pt and ad hoc Ints. I will concentrate on the pauses used between the Dr and Int, which provide the most useful information for developing communication strategies. As I mentioned at the beginning of this chapter, there are two types of pauses: **inter-turn pauses** and **intra-turn pauses**. The benefits of the inter-turn pauses stand out the most.

6.3.1 INTER-TURN PAUSES

An inter-turn pause, as the name suggests, locates in between two turns by different interlocutors. Here I am focusing on those either after or before the Dr's turn. An after-turn pause can be used by the Dr and understood by the Int, professional Ints in particular, as a sign of the change of speakership or a request for translation. Such a pause is also seen to occur between the Dr and the ad hoc Int but the same function does not seem as obvious. A pause before the Dr's turn allows the Int to finish translation and the Pt to add more information and significantly reduces the chance for overlaps.

Ex2 in Ch5 is taken from the consultation with the professional Int. In this stretch of talk the Dr was using a series of chunked extended turns to deliver a big package of information and in between the utterances she left pauses to signal the Int when she was ready to hand over the turn (L2 (0.97), 7 (0.3), 17 (0.6), 24 (0.5), 33 (0.4)). The Int read the sign accurately and soon adjusted her pace with that of the Dr. As one can see, the lengths of the pauses became a lot shorter after the first instance. It indicates that once the professional Int realised that this Dr tended to use short utterances, she became more sensitive to the pauses; therefore, whenever there is an observable pause she would recognise it as a sign for changing speakership. Because of both interlocutors' collaborative use of inter-turn pauses, the conversation flowed smoothly, no overlaps occurred, less information was lost and the translation tended to be more accurate. The same Dr also used inter-turn pauses with the family member Int but it was carried out in a more troubled manner.

EXCERPT 13 (01150910HOR 10:47.2, MIRPURI, FAMILY)

1. Dr: Have you ever taken this sort before.
2. (0.98)
3. Int: No, nopehle tai nai kindya (tablets)
4. *Int.: did you take these before (tablets)?*
5. Pt: No [No
6. Int: [no no it's just since yesterday

As shown in Ex13 above, the family member appeared to be less sensitive to the pause. It took him 0.98 sec (L2) to realise that the Dr had passed the turn to him. However, he did not take the turn to translate at first but rather to speak for himself (L3). He had been reminded by the Dr several times that he should translate instead of speaking on behalf of the Pt so here he might have remembered the previous reminders and therefore, stopped giving response and began to translate for the Pt. However, the family member did not seem to remember that his preferred role is an interpreter so he did not always take the Dr's inter-turn pauses as a sign of changing speakership for translation. In this case, the Dr had to explicitly request a due translation to be delivered either by verbalising the request (as in Ex14) or using body language (as in Ex15).

EXCERPT 14 (01150910HOR 6:24.0, MIRPURI, FAMILY)

1. Dr: that's right (.) em (0.4) we call it em a clearout really?
2. Int: yeah yeah
3. Dr: and it's to get rid of all the poo (.) so that they can look in the gut and see (0.3) so
4. the diarrhoea is to be expected really.
5. Int: uhm
6. (0.9)
7. **Dr: d- do you want t explain that now, I will come back to-=**
8. Int.: =Ae akhni :: k tusan ne eis tarh baya se k tusan na ander pura saaf v ta camera ne
9. which saie result awe
10. *Int.: she is saying they put inside to clean inside you, and it show clear result in the*
11. *Camera*

EXCERPT 15 (01150910HOR 3:26.0, MIRPURI, FAMILY)

1. Dr: .hhh E::m (0.9) I understand that yo::u come today because you got some concern
2. about diarrhoea since you had an opera:: not an operation(e) .hh e::m investigation
3. yesterday
4. (1.14)
5. **Dr: ((nod to the Int))**
6. Int.: Ae samjni ye k aaj tusan idher aye o (1.0) kal tusaan ne (0.3) wich camera baia se jis
7. ni waja tusaan ki pechas lagye ( ) ne kole
8. *Int.: she understands that you came here yesterday they put a camera inside. Because of*
9. *that the loose motion started near the ( )*

Ex14 is an example that the family member failed to recognise the inter-turn pauses as a request for interpreting. Instead he took over the turn but responded to it himself with continuers (L2 & 5). The Dr noticed that so she did not respond to that but instead she left a long (0.9sec) pause, which however failed to trigger the due translation so she had to explicitly request a translation in L7. Ex15 is even more obvious. In L4 there is a long 1.14sec pause which failed to trigger a due translation so the Dr had to raise her eyes and nod to the Int to suggest that he need to translate.

The above examples revealed a contrast between the professional Int and family Int who responded to the pauses differently. It is observed that inter-turn pauses are more likely to be acknowledged by the professional Int as a sign to take over the turn to translate and the Ints tend to learn the patterns of the Dr's use of pauses and reduce the time gap between the Dr's utterance and a translation. In contrast it may take extra efforts for the Dr to convey the same message to ad hoc Ints. The family member is less sensitive to the pauses and usually needs a much longer pause to start a due translation or even an explicit reminder.

The inter-turn pauses before a Dr's turn are also important but have different functions as opposed to the pauses after the turn. Leaving a pause before taking over the floor from the Int can avoid Dr's premature entry. Without knowing what the Pt had said to the Int it is difficult for the Dr to anticipate where the Int should stop and pass the turn to the Dr. Leaving a pause could ensure the Int had finished. This pause can also give the Pt a chance to use several extended turns to add more information. This strategy is particularly useful when ad hoc Ints are used. In Ex16 the Dr left pauses and used continuers to allow more talk from the ad hoc Int. This allowed the Int to be able to finish the long translation (such as, L4-6, 12-13) and enabled the Pt to add new message into the talk (L22-23).

EXCERPT 16 (01150910HOR 8:20.0, MIRPURI, FAMILY)

1. Int.: So >what is my you know my< dad is saying actually in the morning my big brother
2. (0.56) basically he did ring the hospital people (0.45) before they did give him a date

3. because obviously he's got very severe arthritis in his two knee cups
4. (0.35)
5. Dr: right.
6. (0.47)
7. Int: an::de:: obviously he's on the list for the operation
8. Dr: ye::s I [remember seeing him about [it
9. Int: [but [yeah yeah so fir::st obviously the doctor did
10. want to see him on third of September (0.4) but before that they th::: sort of they think
11. that he obviously needs a camera (.)
12. Dr: Yes
13. (0.28)
14. Int: going inside to see if everything's okay before the operation so they did it
15. yesterday (0.4) and today my big brother did ring about the operation but they said it
16. could be anytime may be next month October (0.3) we can't get any time (0.4) because
17. what it iz:::eh (0.3) my dad normally does work and obviously he can't go work because
18. of his pains (0.5) so another reason why he's here to see you is he needs some sort of a
19. letter (0.5) obviously saying that (0.3) he cannot be able to work you see
20. (0.6)
21. Dr: °right°
22. Pt: paie bimari kai ae?bimar[i likhi
23. *Pt: what's the disease? write a disease*
24. Int.: [yeah so BASICally on the:: obviously on the letter
25. obviously he needs ehh doctor you yourself (0.45) to write (0.44) briefly what's the:: sort
26. of a:: (0.5) you know like a:::
27. [If-
28. Dr: [the problem=

An interesting observation in the consultation with the professional Int is the different lengths of pauses before and after the Dr's turns. It is noticeable that the before-turn pauses (with Dr not taking the turn) are longer than the after-turn pauses (with the Int not taking the turn). That is to say, the Dr gave more time before taking over the turn than the Int. In Ex2 in Ch5 we can see such before-turn pauses in L11 (0.3), 15 (1.08), 20 (0.7) and 29 (2.47). Apart from the (0.3) short pause others are quite long. This may be attributed to the fact that the Dr could not ensure whether the Int's translation is finished without knowing what the Pt had said. Also it could be attributed to the fact that chunking information into several turns increased the cognitive burden on the part of the Dr, who had to juggle several things in her mind at the same time. On the one hand she had to remember the several things she planned to deliver while still thinking when to pause for translation and yet remembering where she had left off in her last turn. Leaving a longer pause after the Int's turn may help the Dr to remember

what has been said, what still needs to be said and how to say it in the next turn. This analysis is supported by the video where I can see the Dr look away from other participants to think during the pauses.

6.3.2 Intra-turn pauses

Initially intra-turn pauses did not appear as interesting as inter-turn pauses. They seemed to be just different styles participants demonstrated when they talked. They were used by all participants and in different occasions for various purposes so at first sight they seemed quite random and trivial. However, when I compared their reoccurrence in the two Drs' consultations, more interesting observations emerged. The Hor Dr (HD) used a lot more intra-turn pauses than the Ken Dr (KD) and the communication seems to proceed much more smoothly with the HD. An immediate observation of the use of intra-turn pauses is that they affect the speed of speech. The more pauses there are in the speech, the slower the speech is. One with experience of learning a foreign language would agree: speed can affect the non-native speaker's comprehension in a conversation and slow speed helps comprehension (I suppose this is also true even with native speakers). The intra-turn pauses not only slowed down the HD's speech but also reduced her self-repair. Examples of this kind can be easily found in the excerpts quoted from Hor in ch5 (e.g. Ex7-9) and this chapter. In contrast the KD's speech is much faster with significantly less intra-turn pauses and he frequently repaired himself within a turn either because of false start or slip of tongue. In some occasions this is harmless but in others it may be the cause of misunderstandings.

Excerpt 17 (1020710Ken 2:04.4, Czech, semi)

1. Dr: °it's really-° and how long has that been going on for?
2. Int: Ako dlho to máte takto?
3. Int: *How long have you had it like this for?*

Excerpt 18 (1020710Ken 7:40.0, Czech, semi)

1. Dr: Does she have glasses in- made recently, are they are they (.) are they a fresh
2. prescrip-, what we call a fresh prescription
3. Int: [huhm
4. Dr: [we in we know that they are the right sort of glasses
5. Int: Chcem sa vás opýtať, aké vlastne okuliare nosíte, kúpila ste si ich sama?
6. Int: *I want to ask you what glasses do you actually wear, have you bought them yourself?*

In Ex17 the Dr started with '°it's really-°', which he gave up before finishing and moved on to ask a question. This self-repair appears to be harmless but Ex18 is different. The Dr repaired his words several times in L1-2 and L4, which may have confused the Int who then produced a translation that is very different from what the Dr had said. Analysing the cause by putting myself in the position of a non-native English speaker and second language teacher, I attempt to reach the conclusion that the difficulty in this case is caused by phonological confusions due to the Dr's self-repair. The Int, whose English proficiency is low, may have failed to distinguish whether '*in-made recently' (L1)*, '*fresh prescript*-'(L1-2) and '*we in we know*' (L4) are legitimate expressions she needed to translate or self-repairs she should ignore[13]. A similar situation happened in Ex19 (also Ex38 in Ch5) as well.

EXCERPT 19 (1020710KEN 8:17.9, CZECH, SEMI)

1. Dr: =In fact, I'm going to put this bloo- prescription on repeat prescription for her the
2. tablets, so she can get them (cough) when she needs them without having to see a doctor
3. (1.3)
4. Pt: Tak pondelok by ma moch (dialect) ako o dva týždne, ale v pondelok že by to bolo.
5. Pt: *So, on Monday he could, I mean in two weeks time, but preferrably on Monday.*

Here '*bloo- prescription on repeat prescription'* may have confused the Int in this case so that the due translation was missing, leaving a 1.3sec pause. The Int returned to request clarification later in the talk and understood what a '*repeat prescription'* was immediately when the Dr mentioned it again in clear language (see Ex6 in this chapter). I tend to think, if KD had taken more time to think about what he was going

[13] Note: the Dr also did not use any linguistic signs to mark the self-repair

to say and how to say it by using some intra-turn pauses, the repairs might have been reduced and the communication could have been improved.

This comparison between HD and KD suggests that intra-turn pauses can reduce the speed of speech and gain the Dr time to consider the construction of their utterances so as to reduce the chance for self-repair caused by false start or slip of tongue, which may impede the Int's comprehension and affect the quality of translation.

6.4 Pauses vs overlaps

Pauses and overlaps are the twin unique components in the turn-taking mechanism. In interpreted discourse the benefits of using pauses evidently outweigh that of overlaps. Although there are occasions when overlaps are found useful for the communication, it is a double-edged sword that should be used with discretion.

Whether it is beneficial or harmful all depends on how utterances are co-constructed in the ongoing turn-by-turn interaction. It is not the researcher's subjective judgement, nor an assertion by any of the participants; but rather it is a consequence of the jointly constructed interaction. In the next chapter I will elaborate on how people are designing what they say in relation to the turn-design of others in the interpreted talk-in-interaction.

CHAPTER 7 FINDINGS—INTERACTIONAL TURN-DESIGN

7.1 OVERVIEW

In the previous chapters I elaborated on the mechanisms of turn-taking in interpreted conversations. In this chapter I will discuss how the interlocutors design their turn when they obtain the turn to speak. Turn-design is closely related to turn-taking. Interlocutors in an interpreted conversation do not design their turns independently but rather in collaboration with each other in the turn-by-turn interaction. The current speaker's turn is influenced by what is said in the previous turn and also influences what will be said in the next turn. In an interpreted conversation the Int is situated in the centre of the interaction because the primary speakers (the Dr and Pt) (PSs hereinafter) cannot communicate normally with each other without the involvement of the Int. Their behaviour, or their *turn-design*, significantly affects how well the Dr and Pt can communicate with each other. Therefore, my analysis of turn-design concentrates on revealing the interdetermination of the Int's turn-design in relation to that of the other PSs. The findings reveal that the Int's turn-design is affected by two types of factors—interactional factors and autonomous factors. The interactional factors come from the verbal exchanges with other PSs and the autonomous factors are the agendas the Int might have in the consultation and their language proficiency in both languages. The finding suggests that the Dr's turn-design is a significant component of the interactional factors, which can be tactically used by the Dr to improve the Int's turn-design so as to improve the communication. In addition the Dr can anticipate the autonomous factors each Int possesses. They can also interfere with them to minimise the negative impact of these factors on the Int's turn-design and improve the communication.

7.2 TURN-DESIGN IN INTERPRETED MEDICAL CONSULTATION

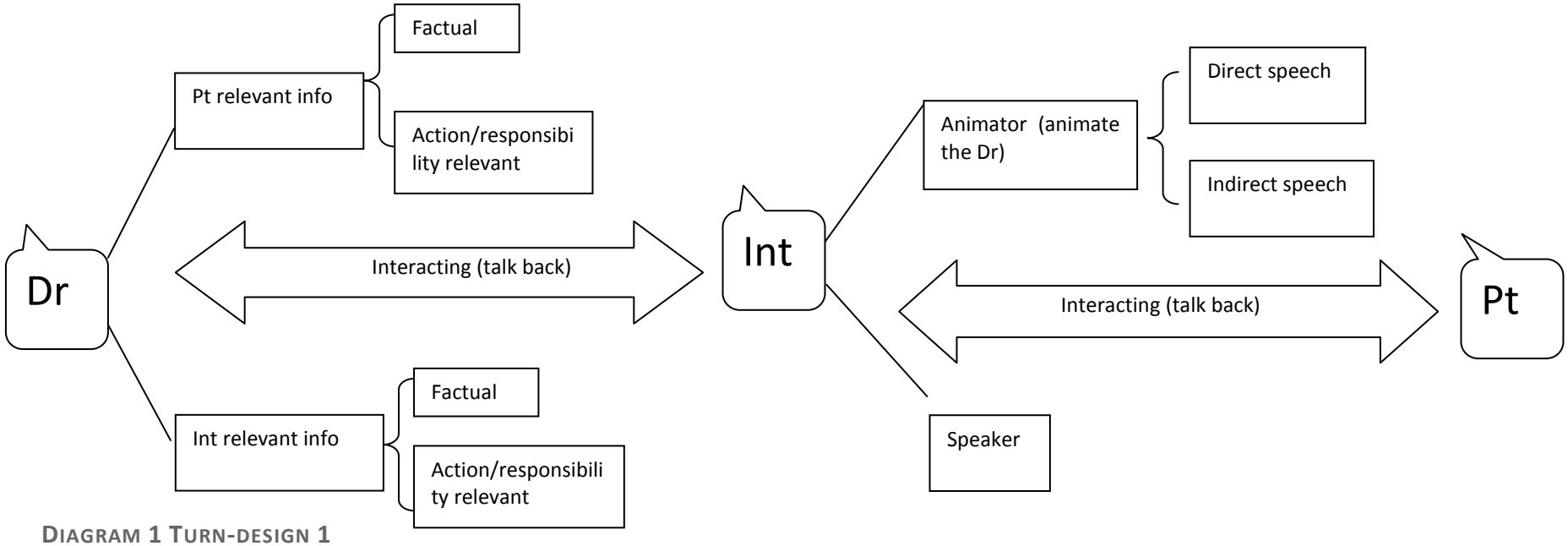


DIAGRAM 1 TURN-DESIGN 1

Diagram 1 illustrates the turn-design of each participant, with Dr as the starting point of a series of turn-taking in the conversation. The focus of the diagram is the interaction between the PS and the Int in order to emphasise how the PS' utterance would affect the Int's turn-design and what kind of *actions* the Int undertakes in their turns; therefore, the Diagram does not consider the situation when the Dr talks directly to the Pt (the same as Diagram 2) as it will be discussed in section 7.3 where all participants are considered. The type of information of PSs is noticed to have an impact on the reactions of the Int in the following turn. The Dr's utterance may convey two types of information: Pt relevant info (PRI) (e.g. Ch5[14] Ex2) and Int relevant info (IRI) (e.g. Ch5 Ex9 L10 &12). However, the distinction between PRI and IRI is not always clear-cut and sometimes the information could be relevant to both of them (e.g. Ch5 Ex16).

[14] Ch5=chapter 5

In the context of a medical consultation, Dr's PRI is either factual or action/responsibility relevant. Action relevant information is about the actions the Dr is responsible for (e.g. to do blood test; to refer the Pt to a specialist; or do an onsite physical exam) or actions the Pt is responsible for (e.g. to drink more water; to use a cream on the arm; or to make a new appointment with the receptionist). Responsibility relevant information is normally attributed to a specific participant by using personal pronouns (e.g. '***I*** *can't* ***walk*** *properly*'). All other information can be considered as factual information (e.g. The Dr's general introduction to a treatment as in Ex1 & 9 below).

EXCERPT 1 (01150910HOR 6:50.0, MIRPURI, FAMILY)

1. Dr: that's right (.) em (0.4) we call it em a clearout really?
2. Int: yeah yeah
3. Dr: and it's to get rid of all the poo (.) so that they can look in the gut and see (0.3) so
4. the diarrhoea is to be expected really.

The IRI can also be categorised using the same dichotomy. Action/responsibility relevant info is normally about requesting the Int to render a due translation. Only in a few occasions factual info is designed by the Dr to be relevant to the Int. This happens, for instance, when the Dr is setting up the ground rules (e.g.: Ch5 Ex7) or introducing each other as in Ex2; or when Dr has to team up with the Int to explain complicated concept for the Pt (e.g.: Ch5 Ex21).

EXCERPT 2 (5020710KEN 0:00.0, CZECH, SEMI)

1. Dr: So, Alice[15]? (0.3) [I'm
2. Int: [Takže, vy ste Alice.
3. *So, you are Alice.*
4. Dr: I'm doctor Baton.
5. Int: To je doktor Baton. Ja som Zusana. Interpret, ok?
6. *This is doctor Baton. I am Zusana. Interpret, ok?*

[15] All names used in the excerpts are pseudonyms.

As shown in Diagram 1, according to different types of information, the Int either chooses to be an '*animator*'[16] (Goffman, 1981: 226) translating the Dr's words or a *speaker* talking back to the Dr or the Pt. When choosing to be an animator, the Int can choose to use either *direct speech* or *indirect speech*. An interesting observation in this research is that factual PRI is likely to be reproduced by the Int using direct speech (Ex3), while action/responsibility relevant PRI is likely to be reproduced in indirect speech (Ex4), which may enable the Int to distance themselves from the PSs who are the main characters responsible for the action.

EXCERPT 3 (1020710KEN 2:04.4, CZECH, SEMI)

1. Pt: Tak teraz je to asi druhý mesiac.
2. Pt: *So, now it is about the second month.*
3. Int: Now
4. Pt: Tretí
5. Pt: *The third.*
6. Int: it's about two:::, second or third of months

EXCERPT 4 (01150910HOR 20:56.0, MIRPURI, FAMILY)

1. Dr : but **I** have to be honest and say **my** opinion as a doctor is that **I** kno::w how
2. long people get take to get better from the operations (0.6) and that your father
3. had thee:: problem with the stomach anyway so **I** am trying to be realistic,

(a few lines omitted)

4. Int.: akhni waise 13 hufte tan liksi chonke tora luma time ae na
5. *Int.:* ***she*** *said that* ***she*** *will write 13 weeks because it's short period of time*

The type of information is not solely decided by the speaker but also has to do with the Int's understanding. The speaker can orientate to a certain type of information but the Int may understand it as a different type, especially when the distinction is not clear, in which case it is open for the Int to interpret what type of information is given and what action s/he is going to take in their turn. If the Int decides that it is PRI then the action s/he is likely to take is to translate for the Pt (as an animator).

[16] Goffman distinguishes the production roles of an utterance as *animator*, *author* and *principle*. The animator is 'the sounding box', who is speaking on behalf of a principle; the author is both the source and speaker of the words; and the principle is 'the party to whose position the words attest' (Goffman, 1981: 226).

On the contrary if the Int perceives what is said is IRI then the subsequent action of the Int is likely to be talking back to the Dr but not translating (Ex5); or not taking any action but not translating for the Pt either (see Ch5 Ex17, passive transition). On the other hand, the Int also assesses the relevance level of information, which also affects the action they take in their turn-design. **Soft information**, such as signposting (Ex6) or evaluation of Pt's response (Ex7), can be considered as insignificant so even if the Int considers it as PRI s/he may still ignore or omit it in the translation.

EXCERPT 5 (1150910HOR 18:10.5, MIRPURI, FAMILY)

The Dr was asking a question to the Pt but the question was answered by the Int.

1. Dr: = right, em do you work for yourself or do you work fo::r somebody
2. (0.68)
3. Int.: basically he does a taxi he works for eiya-

EXCERPT 6 (3020710KEN 4:51.2, CZECH, SEMI)

1. Dr: I just want to (.) check the pulses (1.16) °just a:: wait°
2. (8.4) ((Dr is checking the legs))

EXCERPT 7 (1020710KEN 7:16.0, CZECH, SEMI)

1. Dr: An(d) (0.5) **there's couple of other things that I need to ask her**. Does she drink
2. any alcohol?
3. Int: Pijete nejaký [alkohol?
4. Int: *Do you drink any [alcohol?*

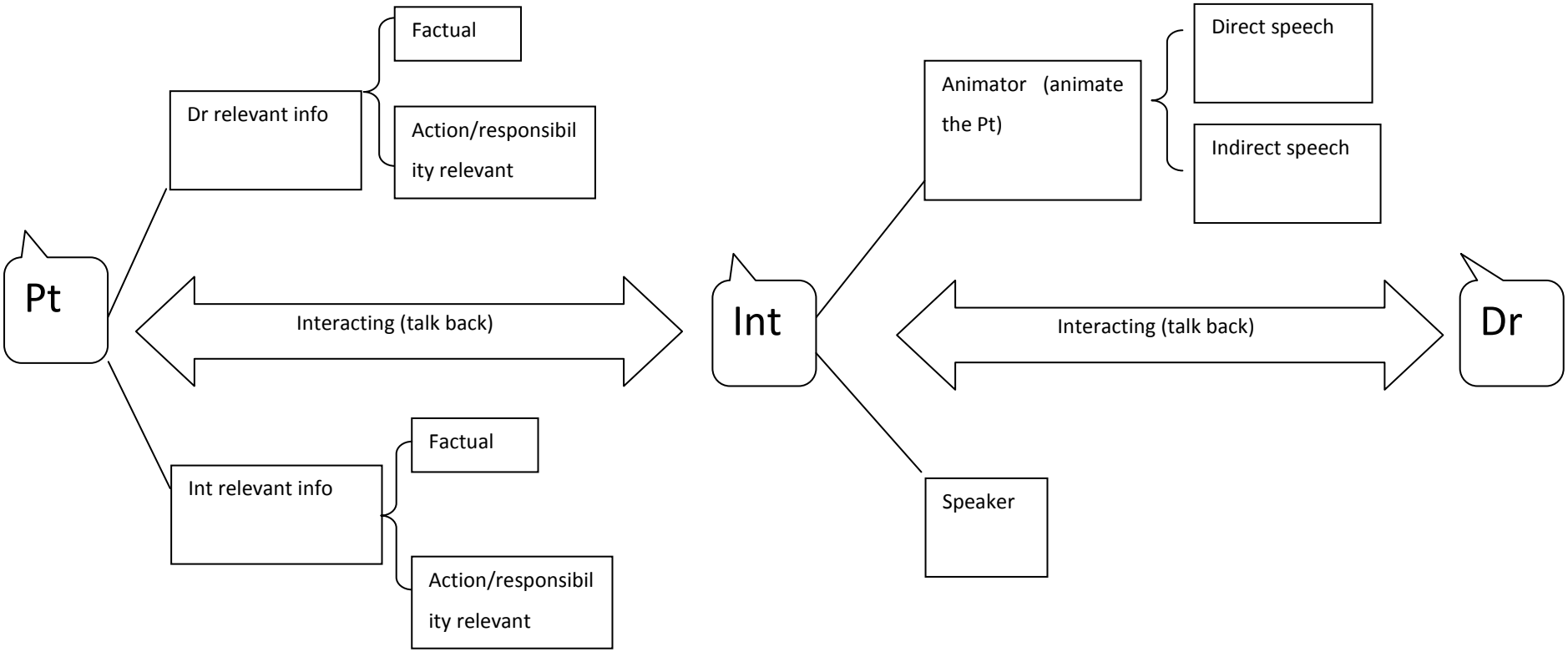


DIAGRAM 2 TURN-DESIGN 2

Diagram 2 demonstrates the participants' turn-design, with the Pt as the initial speaker (or the *principle* and the *author* (see footnote 14 above)) and the Int being in the centre. At the first sight this diagram looks similar to Diagram 1 apart from the sequence of speakers being reversed but because the Pt's role is opposite to that of the

Dr, the content of each turn and the way it is produced are different. The Pt's utterances can include two types of information: one relevant to the Dr (DRI) and the other relevant to the Int (IRI). Both DRI and IRI can be subdivided into factual and action/responsibility relevant information. In the data most of the IRI was action/responsibility relevant and used to request a translation. Factual IRI is only produced for making clarification such as in Ex8 below, in which the Pt talked to the Int to respond to the Int's request for clarification; however this kind of IRI ultimately became relevant to the Dr. Pts produced most of the information relevant to the Dr. The factual DRI was mainly used to describe ailments (e.g. *[…] sometimes there would be a swelling, sometimes there wouldn't be a swelling (quoted from 01170910Hor)*). It is observable that the way the Pt described the ailment was quite different from that of the Dr. The Dr tended to present the disease as a general issue for every patient (Ex9) without attributing it to this particular patient. On the contrary the Pt tended to present it from a personal perspective so they tended to use explicit linguistic markers—the 1st person pronouns--to associate themselves with the problem they were presenting (e.g. ***I** also have pain in my shoulder and this (sometimes) it even gets quite (bad) .hh and then in **my** throat at night it's like something has fallen into it and **I** have problems with breathing (quoted from 01170910Hor)*). Another type of action/responsibility relevant DRI used by the Pt is to explain what kind of actions s/he has taken (e.g. history of seeking medical care) or request actions to be taken by the Dr (e.g. asking for a prescription), for which they tend to use 1st person pronouns to associate themselves with the actions in discussion.

EXCERPT 8 (1020710KEN 7:16.0, CZECH, SEMI)

1. Int: Chcem sa vás opýtať, aké vlastne okuliare nosíte, kúpila ste si ich sama?
2. Int: *I want to ask you what glasses do you actually wear, have you bought them yourself?*
3. Pt: Ne, ne, ne, oni mi dali spesavers (tries to say specsavers but keeps mispronouncing
4. it)
5. Pt: *no, no, no, they gave them to me, spesavers*
6. Int: Z kadiaľ?
7. Int: *Where from?*
8. Pt: Spesavers (mispronounced again)
9. Int: Neviem.
10. Int: *I don't know.*

11. Pt: Neviete? To
12. Pt: *Don't you know? It*
13. Int: z mes…
14. Int: *from (it seems like she is trying to say 'town')*
15. Pt: to je očná optika.
16. Pt: *it is an optics*
17. Int: eh she was been already in da shop eh eyes optic which are the checking your eyes

EXCERPT 9 (01150910HOR 12.40.0, MIRPURI, FAMILY)

1. Dr: yes an infection in the stomach causes upset stomach chronic upset of stomach and
2. when they find it and when they do the endoscopy (.) they give people this course for a
3. week (0.4) it's quite high dose but it cures it is great, really- really [works well. And we
4. give it to- lots of people

Based on the type of information produced by the Pt, the Int in this sequence also has two roles to play: as animator or speaker. As an animator the Int would translate the Pt's utterances using either direct or indirect speeches; while as a speaker, the Int can talk back to the Pt or talk to the Dr, depending on the type of information produced. If the previous turn contains factual IRI, the Int will speak back to the Pt. Ex10 is another example, in addition to Ex8, where the Pt designed his turn containing factual IRI for the son in order to check whether the Dr had issued him a sick note while he already said he wanted a letter not a sick note. In this case the Int understood the utterance as IRI and therefore, responded to the Pt directly.

EXCERPT 10 (01150910HOR 19:55.0, MIRPURI, FAMILY)

1. Pt : sick note tai na banan lagi
2. *Pt: she is going to make a sick note*
3. (0.4)
4. Int.: bus waise ae sick note hi hona, likhia oper hona brhal mini kol chek kerai
5. keno
6. *Int.: it's same like sick note, written on the top but still you check with the mini*

Pt's action/responsibility relevant information for the Int is normally a request for translation, which normally triggers a corresponding action--translation. When the Int is interpreting they are likely to take up the role as an animator and use indirect speech rather than direct speech to animate the Pt. This is because most DRI is

action/responsibility relevant, that is, the information produced by the Pt is attributed to either the Dr or the Pt (e.g. '*I also have pain in my shoulder…'*). There are only a few occasions where the Pt's presentation did not explicitly hold either of the PSs responsible for the action so the Int chose to use direct speech to translate (Ex11).

EXCERPT 11 (01170910HOR 5:40.9, URDU, PROFESSIONAL)

1. Pt: nahi pehle bi swelling kab:hi ho jati hai kab:hi nahi hoti
2. *Pt: No also before sometimes there would be a swelling, sometimes there wouldn't be a*
3. *swelling*
4. Int.: sometimes it swells and sometimes [it doesn't

From these two diagrams one can see that the Int is essential for enabling the communication between the Dr and Pt and that the Int's behaviour is interrelated to that of other participants. The next sections put Int in the centre of the analysis and look into details of the factors that determine how the Int understands the turns before and after his or her current turn, how this affects the Int's turn-design and how other factors come into play in determining the Int's turn-design.

7.3 FOCUSING ON INT'S TURN-DESIGN IN INTERACTION

How well the Int performs in the interaction determines the quality of the communication between the Dr and Pt. However, their performance is not solely determined by themselves but also by that of the PSs both in the preceding and next turns. The Int takes three major steps to design a turn (either to translate or talk back). In order to translate, the Int has to understand what the previous PS has said in the preceding turn and then anticipate how the next PS is going to understand the translation. In order to inform the next stage of the research—communication skills development, I investigated the relationship between the Dr and the Int's turn-design, during which I concentrate on the sequentail talk demonstrated in Diagram 1 and highlight the influencing factors of the Int's turn-design.

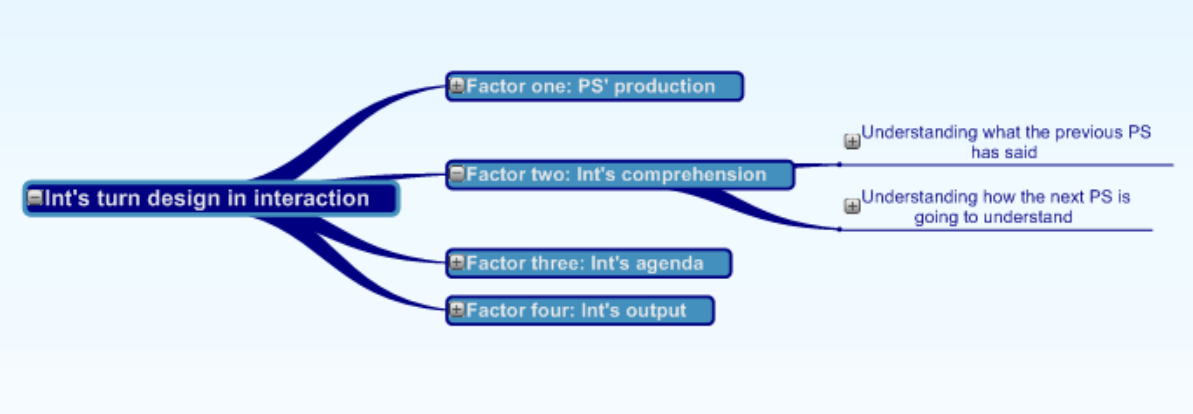


DIAGRAM 3 INT'S TURN-DESIGN IN INTERACTION

Diagram 3 shows the four major factors that contribute to the Int's turn-desgin—PS' production, Int's comprehension, Int's agenda and output. The first factor is the PS's production, which, as discussed above, is interrelated to the second factor, the interpreter's comprehension. These two factors can be called *interactional factors*. However, the Int's turn-design does not depend on them alone but is also affected by two *autonomous factors* of each individual Int: the Int's agenda and output. I will first discuss Factors two to four in this Diagram. Then I will go back to Factor one with a focus on how the PS' (Dr) turn-desgin can be improved to improve that of the Int.

7.3.1 INTERACTIONAL FACTORS--INTERPRETER'S COMPREHENSION

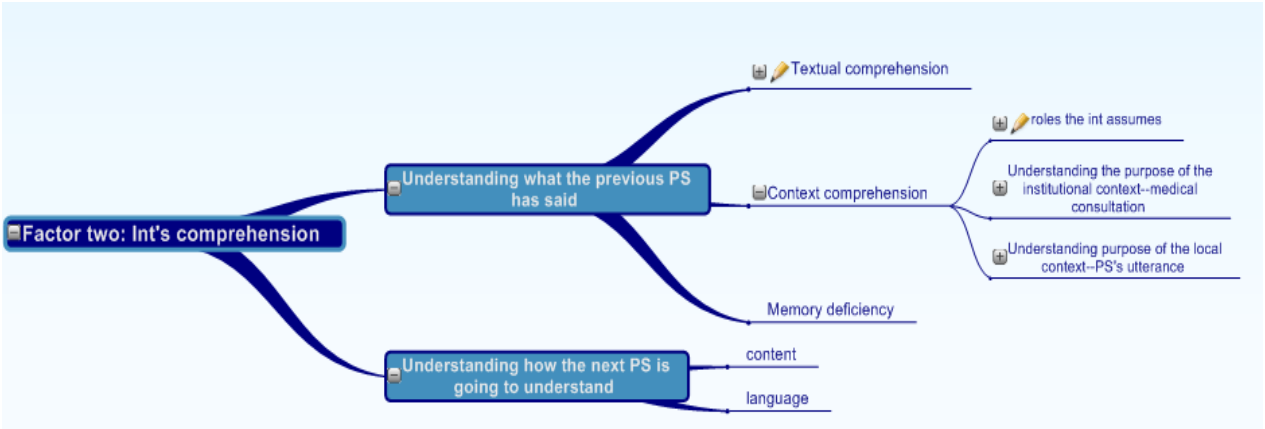


DIAGRAM 4 FACTOR TWO: INT'S COMPREHENSION

The Int's turn-design involves a complex comprehension mechanism. Firstly the Int needs to understand what the Dr has said, which does not happen like a photocopy machine that copies indiscriminately from the original text to the duplicate. Secondly the Int's turn-design also has to do with his/her understanding about how the Pt may

understand what the Dr has said. I will discuss the two aspects of comprehension respectively.

7.3.1.1 UNDERSTANDING THE DR—TEXT, CONTEXT, MEMORY

To understand the Dr, the Int has to understand the language first. I call this the **textual comprehension***,* which is to understand the vocabulary, sentence structure, pronunciation, and intonation conventions in the English language. Most of the Ints speak English as their second language and may have difficulties with any of these linguistic elements of English, which would consequently be reflected in their utterance.

EXCERPT 12 (3020710KEN 2:55.3, CZECH, SEMI)

1. Dr: Does she get co::ld feet?
2. (1.6)
3. Int: What you mea::n
4. Dr: do- do her feet feel cold.
5. Int: ALL RIGHT (0.4) Cold feet. °hehehe°, >Sorry<
6. (0.4)

Ex12 demonstrates how the unfamiliar pronunciation caused problem to the Int's comprehension ('co::ld feet' in L1) and lead to a repair initiation in L3. In another occasion (Ex13), the Int's comprehension is troubled by the complicated sentence structure which leads to an incorrect translation.

EXCERPT 13 (01170910HOR 2:40.0, URDU, PROFESSIONAL)

1. Dr: .hhhh (0.6) the thyroid (0.59) which is the gland in your neck (0.27) that
2. causes tiredness and feeling weak and changes in your hair and weight gain (0.9)
3. that is improving but slowly.
4. (0.5)
5. Int.: Yea jo thyroid hain na jo glands main hoti hain jis ki waja se aap ke baal ghirte
6. hain or wazan bar jata hai yea jo hoti hain nishanian, yea na behtr ho rahi hain
7. *Int.: You know the thyroid, which is in the glands, because of which your hair*
8. *falls out and you gain weight, these symptoms, they're getting better.*

Int's comprehension is not only determined by their ability to understand the surface structure of the language but also by **contextual factors** or the Int's **contextual comprehension**. Three factors stand out from the collected data; namely the understanding of the **Int roles**, the **institutional context**—the medical consultation, and the **local conversational context**. As I have discussed in the Methodology chapter, context for conversation analysts is not an overarching concept independent of the conversation but instead is a consequence of the verbal interaction. It is a dynamic element that is 'locally produced, incrementally developed and, by extension, transformable at any moment' of the ongoing talk-in-interaction (Drew and Heritage, 1992a: 21). This is how I perceive contexts and the Int's contextual comprehension.

The Int's understanding of their **role(s)** determines the consequent actions s/he is going to take—to translate closely or with edition, or to talk back to the Dr. Investigating the roles could help to understand the reasons why sometimes the Int chooses to speak back on behalf of the Pt even if the Dr's utterance contains action or responsibility relevant information directed to the Pt. People have different social and institutional roles, such as father, son, husband, teacher, patient etc. Different roles become relevant to the conversation in different circumstances and affect people's language use. When participating in institutional activities, people's social roles will become less relevant, while their institutional roles will come into play. The more formal the activity is the less social roles are relevant in the interaction. However, in some semi-formal occasions social and institutional roles are not exclusive of each other, such as in an medical consultation (Heritage and Maynard, 2006a). This is also true with an interpreted medical consultation.

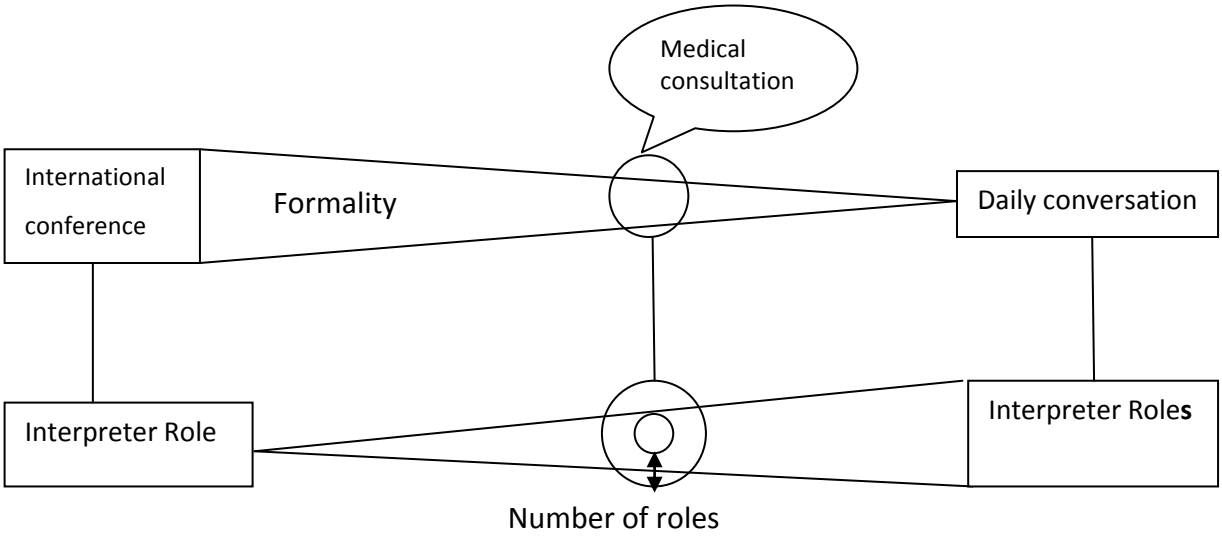


DIAGRAM 5 INTERPRETER ROLES AND ACTIVITY FORMALITY

The above diagram illuminates the relationship between the formality of an activity and the number of social roles an Int is allowed to orient to in their participation of the activity. The more formal the activity is the fewer roles an Int can assume in doing interpreting. Medical consultation is somewhere in the middle of this scale. The elastic ring of the Int roles indicates that although in a medical consultation an Int is allowed to orient to more than one social role, the actual number of roles one chooses to undertake may differ because of the types of relevant knowledge they possess, their understanding of the contextual restriction on the roles and the types of knowledge the Dr chooses to rely on, etc.

In this research there are three Ints involved, a professional Int, a semi-professional Int and a family member. The professional Int in the consultation 01170910Hor demonstrated to possess two types of knowledge that were relevant to the interaction, namely, the knowledge of the two languages as an Int and the knowledge of the healthcare system possibly obtained from her training and her experience in doing the work. The Int understood her function as being to facilitate the doctor and patient's interaction by using her knowledge of the languages but not to get involved as an interlocutor when not needed. Therefore, she chose only to orient to her Int

role. The doctor also understood her role as such and only relied on her knowledge of the languages so she did not request the Int to explain things on her behalf (see excerpts taken from 01170910Hor).

The semi-professional Int in all consultations labelled with 'Ken' demonstrated to have the knowledge of the languages as well as the knowledge of the healthcare system. However, she conceived herself not only as an Int but also a healthcare mediator speaking as a PS herself. As a result, she oriented to both types of knowledge and thus the two different roles. Due to the long-term working relationship with this Int, the doctor also accepted her dual roles so even if the Dr could see the Int was mediating beyond the role of an Int, he did not take action against it. Consequently the two roles she was playing became valid.

The family member in the 01150910Hor consultation is observed to have the knowledge of the languages and the knowledge of the Pt. This enables him to play two roles, one as the Int and another as a caregiver. In the recording, he oriented to both roles, sourcing from the two types of knowledge he possessed. However, contrary to the Dr in Ken, this Dr treated the Int's deviation from an Int to a family member with caution. She applied various strategies to prevent and redirect the Int's undesirable role orientations. Only in some rare occasions did she explicitly acknowledge the legitimacy of the Int's role as a family member and allow him to talk back.

In addition to the roles, contextual comprehension also includes the Int's understanding of the purposes, tasks and requirements of the **institutional context of a medical consultation** and also the **conversational context** locally constructed in the interaction, such as the purpose or the logic of the PS' specific utterance. It is observed that all the interpreters were constantly judging whether a particular piece of information is necessary to be translated. This judgement was made based on their understanding of these two contexts. For instance the Int often considered the Dr's explanation about, say, the function of medication as insignificant as opposed to what medication to take; therefore they were more likely to omit or reduce the former

information as soft information and only keep the latter in the translation. For instance, in Ex14 (also Ch5 Ex16) the Dr confirmed with the Int that he was going to give the Pt the medicine as she required (L1-2). This piece of information is actually relevant to the Pt; however, the Int understood it as relevant to herself so she passively transmitted the Dr into a monolingual conversation. Here the Int may have understood the task of her job as to assist the Pt to get the medication she wanted. Since this task was accomplished as a result of the Dr's confirmation on giving the requested medicine, her job as an interpreter was finished. Facilitating the communication between the two PSs, which is what the medical Int is supposed to do, did not seem to be the main task for her.

EXCERPT 14 (1020710KEN 6:16.0, CZECH, SEMI)

1. Int: Yeah? As well, she just stray (.) she just say straight away she wanna
2. eh some tablets
3. → Dr: yeah, yeah, there's no problem. I'm gonna give her some [tablets as well.
4. → Int: [OK.
5. → Dr: They are very good for headache too.
6. → Int: ehm
7. Dr: An(d) (0.5) there's couple of other things that I need to ask her. Does she drink any
8. alcohol?

Apart from the textual and contextual comprehension influencing the Int's turn-design, there is another factor that is very unique to the interpreted conversation—**memory**[17]. Memory is the premise of comprehension and then translation. Without remembering what is said it is not possible to understand, let alone to translate. It was found that a long turn or extended turn or turns with difficult content would burden the memory of the Int and cause translation difficulties, resulting in the Int to resort to translation edit. There is one kind of edit the Int makes in the translation particularly after a very long extended turn. In Ex15 the Dr mentioned three topics: she forgot the implant; it could be the reason for light periods; hormones could be a reason as well.

[17] Here *memory* refers to the result of remembering not the actual ability to remember, which would be an autonomous factor.

However, the Int translated the *hormones* first, and then the implant, leaving the Dr's comment on her memory omitted. I call this reordering the sequence of topics *repositioning*, which was not reported in other studies but commonly seen in my data. When repositioning occurs, the Int normally starts interpreting the topic they heard the last and move backwards to translate the other topics. It is not difficult to imagine if different topics are interrelated in certain logic, repositioning will eventually alter the meaning of the original utterance.

EXCERPT 15 (01170910HOR 8:35.0, URDU, PROFESSIONAL)

1. Dr: I've forgotten about the implant. That might be the reason that the periods
2. are so light. but it might also be the hormones, >yeah<
3. (1.7)
4. Int: °keh rehi hai shahid hormones ki waja se bhi ho skta hai liken implant ki waja se bhi
5. ho skta hai na?°
6. *Int.: she is saying it might be because of hormones but it might be because of the*
7. *implant as well*

7.3.1.2 UNDERSTANDING THE PT—CONTENT, LANGUAGE

In order to translate, not only does the Int need to understand the previous PS but also has to anticipate the level of the Pt's understanding of the **language** and **content** based on what the Dr has said. Ints were found to use English words in their translation, with or without an explanation assisting the Pt's understanding. The different treatments are attributed to the Ints' anticipation of the Pt's ability to understand the English words.

EXCERPT 16 (1020710KEN 3.40.0, CZECH, SEMI)

1. Int: čo to spôsobuje. Takže na to budete potrebovať, že by ste prišli párkrát ešte sem ()
2. Int: *what causes it. So you will need for it to come here again couple of times*
3. Pt: ehm
4. Pt: *ehm*
5. Int: za ním sem na krvné testy, na '**sample**' krvné testy, **sample**
6. znamená eh jednotlivé krvné testy
7. Int: *to see him here for the blood test, for the 'sample' blood tests, 'sample' means eh*
8. *particular blood tests*
9. Pt: ehm ehm
10. Pt: *ehm ehm*

11. Int: že by vám zisťovali napríklad jednu chorobu
12. Int: *that they would try to detect for example one illness*
13. Pt: ehm
14. Pt: *ehm*
15. Int: počas jedného odbratia krvi, druhú chorobu
16. počas druhého odbratia krvi, dobre?
17. Int: *during the first blood test, the second one during the second blood test, ok?*

In Ex16 the Int did not find the Slovak equivalent of 'sample'; therefore, she 'borrowed' the English word in her translation. She may have anticipated that the Pt did not understand it so she had to explain it for her, although her explanation was not very accurate. In contrast in Ex17 the Int used two English words 'result' and 'record' in her translation without giving any explanation. In this consultation both the Dr and the Int were aware that this Pt could speak some English so the Int used English words several times in the translation without explaining their meanings. This did not seem to be a problem in the communication as the Pt sometimes also used these words in her own utterances.

EXCERPT 17 (01170910HOR 0:00.0, URDU, PROFESSIONAL)

1. Int: Unhonne dobara bulaya tha na:: aap ko **result** ke bare main?
2. *Int: Did they call you again regarding the result?*
3. Pt. Ji ji
4. *Pt: Yes, yes*
5. *(3.03)*
6. Dr: I just have to remind myself and look at the records.
7. Pt: Ok
8. Int: Ye dekh rahi hai **reco:rd**.
9. *Int.: She is looking at the records.*

The Int is also gauging the Pt's understanding of the content. If they believe what the Dr has said may not be understandable or sufficient for the Pt when translated without edition, they may add information into the translation. Ex18 shows how the Int added information when the Dr's utterance was considered insufficient. This excerpt occurs at the beginning of the consultation when the Dr was introducing each other. However, the Dr did not introduce the Int to the Pt so the Int added an introduction to herself in the translation. The amount of 'necessary' information is also evaluated by

the Int. If they consider the information is 'too much' or 'of little interest' for the Pt, they may omit it in the translation, even if sometimes the information is actually very important. An example can be seen in Ex19, where the Dr's explanation about the side effects of a medicine was largely reduced in the translation.

EXCERPT 18 (2020710KEN 0:00.0, CZECH, SEMI)

1. Dr: °OK° So, Zuze:(0.5)I'm Dr Johnson[18]. [And=
2. (a few lines omitted)
3. Dr: A::m I'd like you to just tell me what what I can do for you today.
4. Int: Dobre. Takže, toto je doktor Johnson. (0.6) Vy ste Zuze a ja som Zuze tiež?(0.7)
5. Int: *OK. So, this is doctor Johnson. You are* Zuze *and I am* Zuze *as well.*
6. Takže, chce od Vás vedieť, ako Vám môže pomôcť dnes.
7. *So, he wants to know from you how he can help you today.*

EXCERPT 19 (01150910HOR 12:58.8, MIRPURI, FAMILY)

Dr: For instance sometimes people get dry mouth with it or a bit of abdominal pain or even a bit of diarrhoea .hhh but it's nothi::ng to worry about you just (0.3) take them for a week and it cures that problem in your stomach.

(1.0)

Int.: akhni k koi musla nai tusan hfte waste kaso na tae musla hl ho jasi

Int.: she is saying that there won't be any kind of problem, if you take for one week, everything will be ok

7.3.2 AUTONOMOUS FACTORS—AGENDA AND OUTPUT

Apart from the interactional factors, each individual Int has their own features that can affect the translation. Different types of interpreters were found having different agendas that contribute to their turn construction. For instance, the family member interpreter was found getting impatient by the end of the consultation; therefore, he reduced and omitted a lot of information the Dr had given to the Pt (Ex19 & 20). In

[18] All names mentioned in the excerpts are pseudonyms.

Ex20 L1 the Int's spoke out his impatience: '*we nearly finished yeah*?' After that the Dr was explaining the length of time she put on the sick note, which, however, did not get translated to the Pt. Even when the Pt requested a translation in L12-13, the Int ignored that and continued his monolingual talk with the Dr, trying to get things done between him and the Dr as soon as possible. In the end when the Dr asked him to translate in L35, he just told the Dr the Pt understood. From the Pt's response in L27, one could see the Pt might have understood some but not all. Professional interpreters were not free from the influence of their own agenda. It occurs to me that they would like to present themselves as a reliable, trustworthy and authoritative professional to the Dr and the Pt, which results in them adding information into the talk. Ex21 is an example to demonstrate the Int's agenda. Prior to the extracted talk in Ex21 the Dr asked whether the Pt's glasses were freshly prescribed, which the Int did not understand and thus translated it as whether the Pt got the glasses from the opticians. Subsequently the Pt's reply did not quite answer the Dr's question so the Dr did not seem to be satisfied when the Int said that the Pt got the glasses from the optician. Then the Dr initiated a repair in L5 & 7, which the Int might have taken as a doubt about her translation so she talked back to the Dr to explain how she had obtained the information from the Pt (L8-9), in order to establish herself as trustworthy. Ex21 also reveals that not only did the Int want the Dr to consider her as a professional but also the Pt. In several consultations, the same Int was found to ask Pt extra questions on behalf of the Dr and use 'we' to group her and the Dr as a professional team rather than 'he' or 'she' to attribute the actions or responsibilities only to the Dr.

EXCERPT 20 (1150910HOR 24:01.0, MIRPURI, FAMILY)

1. Int.: °we nearly finished yeah°?
2. (0.49)
3. Dr: We are nearly finished, yea. (0.6) what I've done is an unusual thing here (0.55) I've
4. em given you a note that says that you were un unable to work from 4th of the 8, which
5. is when I saw him till today (.) and then 13 weeks ahead so it goes back (0.5) and ahead
6. (0.8) the note (0.3)
7. Int.: [okay
8. Dr: [are you with me? And it says arthritis of both knees are waiting surgery left knee
9. (0.3) anaemia due to stew- stomach proble::ms

10. (1.2)
11. Dr: okay?
12. Pt: kae baanie?
13. *Pt: what is she saying?*
14. Int.: °okay°
15. (1.0)
16. Int.: so you know the::: date that you wrote [13 weeks
17. Dr: [These are all details on the back you have
18. to fill in yeah? (0.3) 13 weeks from toda:::y (0.43) he's covered (.) off sick (.) for 13
19. weeks now and (0.3) before the end of the 13 wee:::ks that's about 3 months, so we are
20. talking (0.5) just before Christmas (0.5) and he needs to come back and see us but he's
21. probably likely to be seeing us anyway but come back and say he needs another note
22. now (0.57) or he may be fit to work by then (0.9) do you understand (1.0) time is limited
23. (0.4)
24. Int.: so I think- are they- (0.4) 2010 ( )
25. (0.8)
26. Pt : [kaddu wapas achna paysi wai?
27. *Pt: when do I have to come*
28. (2.6)
29. Int.: Is that 1 month ()
30. (1.2)

(A few turns between the Dr and Int are omitted)

31. Dr: That makes sense?
32. Int.: Yea yea [no problem
33. Dr: [Ok (0.8) alright
34. (1.0)
35. Dr: Do you want to just check that with your dad?
36. Int.: Yea yea he understands

EXCERPT 21 (1020710KEN 8:10.9, CZECH, SEMI)

1. Int: eh she was been already in da shop e::::h eyes optic (0.27) which are the::checking
2. your eyes
3. Dr: [yeah
4. Int: [and that was make f[or her
5. Dr: [So they are fresh
6. Int: yeah, [is a fresh one
7. Dr: [they're right they're right glasses, [ok that's good that's fine
8. Int: [yeah, they're right one because I was ask
9. her straight away if she buy herself or she been seen somewhere
10. Dr: no, no she has proper ones that's fine. So, I'll give her the tablets and we'll book her
11. in for the blood test.
12. Int: OK

Apart from these divergent agenda, there is another autonomous element playing a significant role in the Int's turn-design—the Int's language proficiency in the target language, which I call the output. Even if an Int stays in role as an interpreter,

understands both languages and the context of the Dr's utterances and has as little personal agenda as possible, s/he may still not be able to translate one language into another in line with the original utterance simple because of his/her low interpreting skills. This would lead the Int to resort to editorial behaviours. Ex22 is an example in which the Int has little problem with comprehension but failed to render a proper translation for the Pt because of her inefficient target language, Czech. She explicitly verbalised her difficulty in L5 and there were a lot of hesitations, self repairs and omitted information in her speech, all of which mark out the troubled production of a translation.

EXCERPT 22 (1020710KEN 2:52.2, CZECH, SEMI)

1. Int: cetéčko hlavy, čo sa týka na (wrong preposition) seriózne (in Slovak the right term
2. would be 'vážne', referring to illnesses) v preklade, je to vlastne na hlavné alebo
3. najnebezpečnejšie alebo v tom význame, ako by som Vám to preložila
4. Int: *CT scan of the head regarding serious translated as, it is actually the main or most*
5. *dangerous or in this sense,* ***how would I translate it for you***
6. Pt: ehm, viem
7. Pt: *ehm, I know*
8. Int: e::h choroby, ste už testy mala, čo sa týka, krvné.
9. Int: *e::h illnesses, you had the tests done, regarding, the blood ones.*
10. Pt: ehm
11. Pt: *ehm*
12. Int: Cétečko je v poriadku, všetky krvné tieto ako čo choroby by sa by sa mohli ukázať
13. Int: *CT scan is ok, all the blood errr, illnesses might be might be shown*
14. Pt: ehm
15. Pt: *ehm*
16. Int: bolo všetko v poriadku
17. Int: *everything was ok*

7.4 DR'S DESIGN—GETTING CONTROL IN INTERACTION

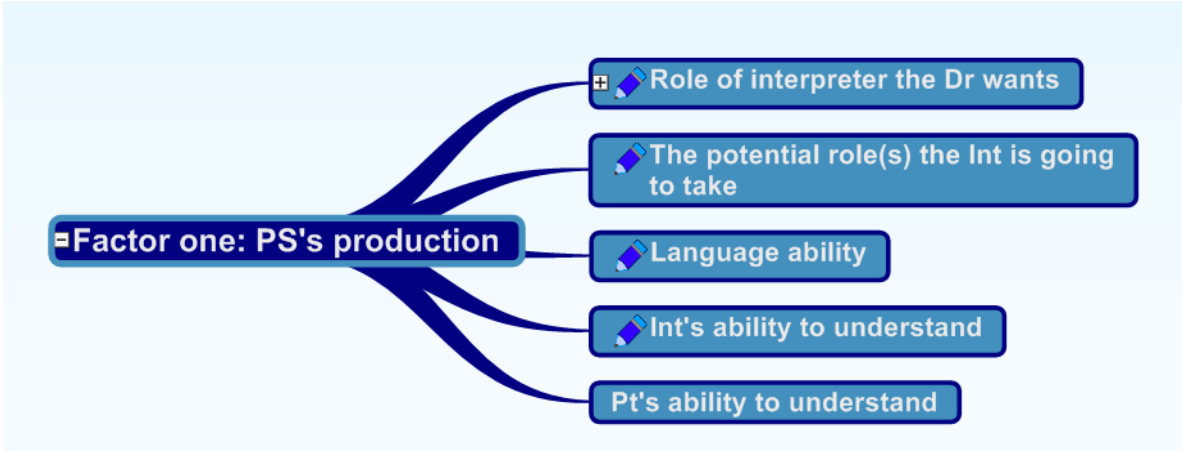


DIAGRAM 6 DR'S TURN-DESIGN

In this section I will explore the Dr's turn-design, particularly in relation to that of the Int. There are couple of things the Drs were found to be doing while producing a turn (see Diagram 6), although they were not consciously doing them all the time. Firstly the Dr will have in mind a role or roles that they want the Int to play. At the same time the Dr will also estimate what roles the Int might play. If the two roles are consistent, there is no need for the Dr to do anything but if not the Dr may take action to align the roles. For instance, in the case of the professional Int (1170910Hor), she demonstrated great adherence to the Int role throughout the consultation, from which the Dr gained confidence that the Int would always stay in the desired role so the Dr just talked without having to take extra efforts to align the Int roles. However, if this is not the case, the Dr may have to explicitly verbalise the role they wanted. Such examples are mostly found with the family member. In Ch5 Ex28 due to the absence of a due translation, the Dr had to remind the Int: '*you perhaps want to say that to him maybe?*' (L20).

Secondly the Dr is also evaluating the Int and Pt's language ability in order to choose their own language. One of the reasons the Dr self repairs within a turn can be to replace a complicated expression with a simpler one. For instance in Ex23, the Dr cut off in the middle of saying the word '*indigestion*' and changed to elaborate on the symptoms, speculating about a potential communication difficulty for the Int. In

another occasion (see Ch5 Ex29) the Dr believed that the Pt could understand English so she decided to opt out of the interpreted conversation to a monolingual conversation with the Pt.

EXCERPT 23 (5020710KEN, CZECH, SEMI)

Dr: right (4.4) Eeeeh, right. Does she get any indiges- eh any discomfort in her chest until after she eats food.

Thirdly the Dr is also evaluating the Int and Pt's ability to understand the content. One example for this is Ch5 Ex21 when the Dr was trying to explain the function of a sick note the Pt needed for claiming benefits during his sick leave, she found that both the Int and Pt were confused with the function of a sick note but the Int, also the son, understood better than the Pt. Therefore, the Dr explained to the son first before she requested a translation to be delivered to the Pt. In the same episode of the same consultation in Ex24, the Dr explicitly mentioned that she was not sure that the Pt understood; therefore, she explicitly talked back to the Int without the intention for the Int to translate (Note in both cases the Dr oriented to the Int's social role as a son not an Int).

EXCERPT 24 (01150910HOR 20:00.1, MIRPURI, FAMILY)

1. Dr: .hhh and I am not sure that your dad is clear what he needs to do to get some
2. money
3. (0.6)
4. Int: uhm
5. (.)
6. Dr: you see what I mean
7. Int.: yeah
8. Dr: I think he doesn't understand the system that's why I asked (0.5) are you employed
9. or are you self-employed (0.9) and it's a different system but you need a note °yes° to
10. cover it
11. (1.2)
12. Int.: so in here you are gonna write what's his problem and every[thing
13. Dr: [exactly and I'll I am
14. going to write the knee surgery and it is a waiting surgery but I am also going to write
15. (0.6) the stomach problem
16. (0.3)
17. Int.: yea

18.Dr: Is that okay? °Do you want to check that?°
19.Int.: akhni ae k knee ni problem vi vich baasi te stomach ni vi vich likh si
20.Int.: she is saying that she will write about your knee problems and stomach as well

It occurs to me that a successful round of interpreted talk among the three participants is always associated with the Dr's successful evaluation of the above discussed five elements in Diagram 6. They give an insight into the development of communication skills, which will be discussed in the next chapter.

7.5 UNDERSTANDING THE LIMIT

The investigation of the interdetermination between the turn-designs of the Dr and Int reveals that Int's behaviour is key to the quality of the communication and proves that it is possible to improve the communication by improving the Dr's turn-design which can have positive impact on that of the Int. Moreover, it also reveals the limitation of what the Dr can do in a consultation. They alone cannot completely change the dynamics of the communication. While the Dr can interfere with the interactional factors, there is less they can do to the autonomous factors to influence the Int's turn-design. Ex25 is a good example where the Dr could do little to improve the seriously distorted translation due to the Int's misunderstanding of the institutional context of the conversation.

EXCERPT 25 (3020710KEN 0:00.0, CZECH, SEMI)

Int: She just laughing because when they're outside when they been waiting in the waiting area, somebody was told them there's camera there and her daughter just saying: oh, and bing bing bing [we will be on television. [hehehehe

Dr: [you gonna be on television [We:::ll, yeah, you can be sure you won't be on [television. hehe

Int: [hehehehe Budeš, ale budú na teba pozerať študenti. (0.7) Dobre? hehehehehe
You will be but students will be watching you. OK?

In this conversation, the Dr was trying to reassure the Pt and her accompanying daughter that the recording would not be put on TV. Confidentiality, of which all participants should be informed, is not only a requirement for ethical research but also

an important means to protect the participants. Informing the participants of confidentiality is part of procedure in data collection. However, without understanding such a context the Int's translation is completely the opposite of what the Dr had said. Here all participants were following the prototype sequence to take turn to speak. The Dr was not using complicated words or sentence structure that may cause understanding problem. The Int was seemingly interpreting when the translation was due. Apparently there is no sign that allows the Dr to see the problem and therefore take action against it.

In summary participants design their turns while taking turns to speak in an interpreted consultation. Their turn-designs are interrelated or co-constructed in interaction. The key to communication in the interpreted consultation is the turn-design of the Int which is determined by their interactions with the Dr and Pt and also their autonomous factors. There are things the Dr can do during the interaction to enhance the Int's turn-design. However, what the Dr can do is limited, especially when it comes to the Int's autonomy. The findings reveal that the Int is not always the one to blame when communication breaks down and improving Dr's communication skills can optimise the Dr-Pt communication outcome, despite its intrinsic limits. Problems in interpreted consultations concern all participants, the Dr, Int and Pt. Drs, who have the privilege to access training and education, should learn new skills and do their best within their capacity. In the next chapter I will discuss the series of communication skills (which I call *strategies*) developed based on the knowledge of the interpreted consultation obtained from the detailed conversation analysis as I have presented in the previous chapters.

CHAPTER 8 IMPLICATIONS FOR PRACTITIONERS—12 COMMUNICATION STRATEGIES BASED ON A CA STUDY

8.1 OVERVIEW

Based on the understanding of the turn-taking and turn-design of the participants in an interpreted medical consultation, this chapter aims to achieve the **second research goal to develop communication skills.** According to dictionary.reference.com, '*skill*' is 'the ability, coming from one's knowledge, practice, aptitude, etc. to do something well', which I found not adequate to explain the characteristics of the 12 'skills' this chapter is going to present. Apart from having knowledge, practice and aptitude, these 'skills' also require the Dr to be strategic so that they are able to plan ahead, design their actions, anticipate the situation and deal with spontaneous incidence in the course of achieving the goal of a medical consultation. They are not listed as a checklist for people to tick each fulfilled item; instead they form an integrated system, the use of which needs to be tactical. Therefore, the word '**strategy**', which means 'a plan, method or series of maneuvers strategems for obtaining a specific goal or result', is used to refer to the **12 communication strategies** I have developed here.

The development of the strategies not only sourced from the turn-taking and turn-design frameworks but also from the inspirations I have obtained from the focus group interview with the GPs, my observations as facilitator and simulated patient in communication teaching workshops and also my own expertise in language as a linguist, second language teacher and interpreter. The reason for combining these discursive knowledge sources is that *developing* communication strategies itself is an innovative process that goes beyond the facts the conversation analysis reveals. In other words, the two theoretical frameworks of turn-taking and turn-design do not explicitly say what the strategies are and how they can be presented in a way the trainers can use for teaching and trainees can learn for practice. They only provide a tool for the researcher to highlight the beneficial and harmful behaviours, based on which the communication strategies can be developed. Each strategy is relevant to a

certain phenomenon described in the turn-taking and turn-design frameworks; therefore, they are also presented below following the same sequence as those phenomena appeared in the previous chapters. For the need of the presentation, I grouped them in boxes followed by explanations and examples.

8.2 TURN-TAKING RELATED STRATEGIES

1. **Use prototype turn-taking whenever you can**
   a. **Keep the prototype turn-taking whenever possible.**
2. **Use extended turns if necessary**
   a. **Chunk the information into several extended turns.**
   b. **Give a complete sentence. Don't chunk in the middle of a sentence. It may not make sense in another language. A bad example would be 'What I am trying to say is…'.**
   c. **Avoid using a long turn to say everything at one go.**

Prototype turn-taking is the ideal way for the interlocutors to take turn to participate in an interpreted conversation. It is associated with smoother interactions, less overlaps, omissions and reductions. Ints are found more likely to adhere to the Int role following the prototype. However, one should be alerted that the prototype is not the only way an interpreted conversation can be conducted. Deviations may occur and can also be the legitimate forms of interaction.

In a situation when complex information needs to be delivered within a long turn, the Dr is advised to chunk the long turn into several extended turns as in Ch5 Ex2. In each small turn the Dr should give a complete sentence for the Int to translate. An incomplete sentence may not be translatable in another language due to the grammatical differences. A long extended turn should be avoided whenever possible. In the data long turns are always related to distorted translation, even with the professional Int. Ex1 (also discussed in Ch7 Ex13) below shows how the professional Int misinterpreted a long extended turn. The Dr's turn in L1-3 is not only long but also complicated in its structure. I will discuss the structure in Ex7 below.

EXCERPT 1 (01170910HOR 2:31.0)

1. Dr: .hhhh (0.6) the thyroid (0.59) which is the gland in your neck (0.27) that causes

2. tiredness and feeling weak and changes in your hair and weight gain (0.9) that is
3. improving but slowly.
4. (0.5)
5. Int.: Yea jo thyroid hain na jo glands main hoti hain jis ki waja se aap ke baal ghirte
6. hain or wazan bar jata hai yea jo hoti hain nishanian, yea na behtr ho rahi hain
7. *Int.: You know the thyroid, which is in the glands, because of which your hair falls out*
8. *and you gain weight, these symptoms, they're getting better.*

3. Monolingual talk
- **a. Continuers**
  - **i. Use continuers with ad hoc Ints to show attentiveness, establish rapport and encourage the Int to speak but keep it to the minimum. Don't need to use continuers with professional Ints.**
  - **ii. Keep continuers short and brief. Do not attempt to complete the sentence when you are not sure about what the Int intends to say.**
  - iii. **Ask the Int to translate if you think you have said enough. Don't continue talking just because the Int is using continuers**.

Monolingual talk is also part of the interpreted consultation. The above strategies have to do with the use of c*ontinuers*. Continuers can show the listener's continuous attention, interest and understanding of the speaker. However, the use of it should differentiate the situation. Normally the professional Int would adhere to the role as an interpreter who normally stays in the background of the conversation, passing information between the PSs. They expect minimum attention from the PSs in order to allow the PSs to talk with each other as if the Int was not there. Therefore, they do not expect PSs to use continuers with them. As seen in 01170910Hor the Dr seldom used continuers. Instead, she was able to directly address the Pt using second person pronoun 'you' without confusing the Int with the identity of the addressee. In contrast, the less experienced Ints participate in the interpreted interaction as if they are in monolingual talk. Therefore, the Dr's use of continuers has a positive impact on the behaviour of the Int. As explained in Ch5 Ex4, the Int spoke back to the Dr to mark out the difficulties she was having in producing a translation. By using continuers the Dr demonstrated his support, encouragement and understanding. Another form of monolingual talk which also shows the listener's attentiveness and collaboration is to finish the speaker's turn. Compared with continuers, which are short and brief,

finishing the speaker's turn can end up in overlaps, interfere with the flow of the conversation and impair Dr's understanding of what the Int has to say. Apart from Ch6 Ex6, Ex2 below is another example of this kind. The Dr attempted to finish the Int's turns twice (L1 & 7) but both were rejected by the Int. In a monolingual conversation the attempt to finish each other's turns has much higher success rate, due to the fact that the interlocutors understand each other's words. However, in an interpreted conversation the Dr does not know what the Pt has said so the attempt to anticipate what the Int may say on behalf of the Pt is more likely to fail. As shown here, the Dr's utterances did not help but actually interfered with the Int's translation and the flow of the conversation (see L1 & 8).

EXCERPT 2 (3020710KEN 4.51.1)

1. Int: [She been at a::: in Slovakia [she's been in Slovakia for eight months. No::↑
2. Dr: [seeing a specialist alright.
3. Int: She just saying I've been in Slovakia for eight months and I don't have nothing
4. problems [and now
5. Pt: [A ja už viem, že to je vo[da
6. *I already know that it is water*
7. Dr: [it's come back [again
8. Int: [She just thinking it's of water

As explained in Ch6 Ex6, the Int can also use continuers. However, this should not be taken as an encouragement for the Dr to continue talking in that this will lead to long extended turns and cause translation problems. As an extreme example, in Ex3 the Int did not start interpreting until the Dr had fully stopped talking and left a long (1.46) pause (L19). Because there was too much information, the Int was not able to remember all of it; therefore, she explicitly told the Dr 'it was telling me too many things' (L23).

EXCERPT 3 (4020710KEN 8:36.0)

1. Dr: I know. What, well, blood pressure is linked to the heart. And what we clearly need
2. to do is increase his blood pressure treatment. He's on very very mild tablet really, I want
3. to give him a more normal strength, full strength tablet.
4. Int: OK.
5. Dr: ((utterance omitted))

6. Int: uh hum
7. Dr: ((utterance omitted))
8. Int: uh hum
9. Dr: ((utterance omitted))
10. Int: OK.
11. Dr: ((utterance omitted))
12. Int: OK.
13. Dr: ((utterance omitted))
14. Int: OK.
15. Dr: Now, hopefully, when the cardiologist is seeing him (0.77) some of those other extra
16. treatments will be added in (0.52) when the cardiologist sees him. But you know I can do
17. them too, but it is easier if we had there all the tests done. He hasn't had done all the tests
18. yet.
19. (1.46)
20. Int: OK. Takže, prvá vec, čo sa týka. Takže, ten vysoký krvný tlak, že ešte stále máte.
21. Dobre, poberáte tabletky, ale sú minimálne. Dá Vám niečo silnejšie, čo je originál na tento
22. tlak, ktoré vlastne sú silnejšie ako tamtie, plus pomôžu aj ku srdcu. To je jedná vec. Druhá
23. vec, ehhhhh **it was telling me too many things**.
24. *Int: OK. So, the first thing, regarding, so this high blood pressure that you still have. It's good*
25. *you are taking tablets but they are not enough. He'll give you something stronger that are*
26. *exactly for this blood pressure, which is specifically for this high blood pressure. that are*
27. *actually stronger than those, plus they'll help your heart. This is one thing.The second thing,*
28. *ehhhh **it was telling me too many things**.*

b. Passive transition
- **i. Request a translation if you are passively transmitted into monolingual talk by the Int.**
- **ii. Even if the question you ask can be answered by the Int, still make sure Pt understands what's going on.**
- **iii. Check whether the Pt has been passively transmitted.**

Another type of monolingual talk is *passive transition*. When it happens, the prototype must have been violated and becomes observable to the Dr due to the explicit absence of a due translation (see Ch5 Ex16-17). A strategic action the Dr may take to rectify this is to talk back to the Int and request the translation to be delivered. Ex4 below is not an example of passive transition but the lesson can be learned from this Dr. Here the Int is a family member who has the background knowledge of the Pt so he may be entitled to answer the question the Dr asked about whether the Pt had asked for a sick note before (L1 & 3). Instead of accepting his answer, the Dr insisted that he translate for the Pt (L9). There are two things worth noting here. Firstly, the Dr asked a similar question twice but in different words (L1 & 3) (also the Dr kept using 'you' to refer to

the Pt). When the first question was responded to by the Int, the Dr may have asked the second question to suggest that a translation was needed. Secondly the Dr not only asked the Int to translate in L9 but also explained to the Int why she asked the question. In so doing the Dr may help the Int understand the importance of getting the correct information from the Pt and avoid making the Int feel that he was forced to translate without being acknowledged as a proper participant in the conversation (this analysis is based on the principle of the *negative politeness strategy* of the politeness theory of Brown and Levinson (1987: 129)--avoid imposition on the hearer).

EXCERPT 4 (01150910HOR16:30.0)

1. Dr: Have you not had any sick note
2. Int: No no
3. Dr: Ok did you not ask before for one
4. (0.5)
5. Int.: no no he hasn't.
6. Dr: Right,
7. Pt: ( )
8. (0.5)
9. Dr: **Do you want to check that with him** I can't find any record that he's had one, but he
10. should've had one, you've not been able to wor::k (0.5) an::d because of his anaemia
11. and because of his knee, then you should've been claiming and fill them the sick note

c. If necessary, talk with the Int to form a team to explain complicated concepts
  i. Explain to the Int and make sure they understand before you ask them to interpret
  ii. Take Int's concerns on board and address them properly before moving on with the consultation. Make sure Pt understands what is going on.

Sometimes talk with the Int is beneficial and even necessary. To team up with the Int is seen mostly with the family member as shown in Ch7 Ex23. However, the strategies listed in the box can also be applied with other Ints. Explaining for Ints and addressing their concerns are also seen with the semi-professional Int. In Ch6 Ex6, the Dr had to explain what repeat prescription was before the Int could interpret. In Ch7 Ex21 the Int was trying to convince the Dr that her translation was trustworthy and the Dr had to talk back to acknowledge this. Although these monolingual conversations violate the

prototype turn-taking organisation and excluded the Pt, they are significant parts of an interpreted consultation that the Dr should be aware of and know how to use them properly, especially when less skilful interpreters are used. The Dr should also remember that monolingual talk with the Int will leave the Pt unattended; therefore, it is also important to make sure the Pt understands what is going on. Otherwise they may feel frustrated as is demonstrated in Ch5 Ex37, in which the Pt was constantly asking the Int 'what does she say', when the Int and the Dr were having a long conversation without interpreting for him.

d. Repair
- **i. Repair grammatical mistakes as a way to clarify understanding**
- **ii. Assist Int with their English if they struggle**
- **iii. Don't rush to provide assistance. Only assist when it's a real struggle not just a delayed search-for-words process.**
- **iv. Confirm with Int that's what they were trying to say.**

Due to the language deficiency and insufficient interpreting skills, the Int may make grammatical mistakes which can impede the Dr's understanding. What a Dr hears may be different from what the Int is actually trying to say. In this case, if the Dr can provide certain help with the Int's English, they can speed up the consultation (as in Ch5 Ex15) and also confirm what they understand is correct (as in Ch5 Ex12-13). When assisting with language, the Dr should be aware not to do it prematurely (as in Ch5 Ex14).

e. Allow the Int to talk back to you or the Pt for good reasons such as:
- **i. If the Int talks back to Dr to:**
  1. **Coordinate communication (to repair or initiate repair) which the Dr needs to take corresponding actions**
  2. **Explain conversational situation (e.g.: oh it's hard on me/this is difficult for me)**
- **ii. If the Int talks back to Pt to:**
  1. **Repair misunderstanding, confirm understanding or request clarification.**
- **iii. You should check with the Int that the monolingual talk has happened because of the above reasons (but not exclusively). But check only when the conversation between the Int and Pt is finished. Do not interject unless it is very necessary.**

As discussed in Chapter 5 and earlier in this chapter, monolingual talk is unavoidable and, in some occasions, beneficial in interpreted talk. It is important that the Dr know that sometimes the Int can talk back for good reasons, for instance, to coordinate communication (Ch5 Ex5, 21, 33) or explain conversation situation (Ch5 Ex20), which the Dr should take on board and act upon. Monolingual talk can also happen between the Int and Pt (Ch5 Ex6). In order to prevent unnecessary monolingual talk the Dr should check what they have talked about. However, this should be done only when the Int and Pt finish talking.

f. Take action if the Int talks back for illegitimate reasons:

i. If they Talk on behalf of Pt

1. **Do not respond to the Int. Instead, request a translation politely and if necessary, reiterate the ground rules.**
2. **Explain to the Int why it is important for you to know what the Pt has to say and why a direct translation is necessary.**
3. **This should not be encouraged. However, there are some occasions, esp. with family member Ints. This can be valid if the family member is believed to have legitimate reasons to know the answer. Always make sure the Pt understands what's going on.**

ii. If they talk on behalf of Dr

1. **Do not ask them to explain on your behalf. Even if you have explained to the Int first you still explain it again for the Pt with the Int interpreting.**
2. **Although you cannot always tell whether the Int is speaking on your behalf, you can always reduce the chance for it to happen by maintaining prototype turn-taking sequence, using short and clear sentences, extended turns and setting ground rules.**

As I discussed in Chapter 7, there are autonomous factors that are affecting the Int's turn-design and therefore they can speak on behalf of the Pt and Dr without being delegated. Such examples can be seen in Ch5 Ex22 and Ex4 in this chapter. In both cases the Dr did not accept the answer from the Int directly but requested a translation. She made such request in a very skilful way which was less likely to make the Int feel uncomfortable. In most cases this illegitimate delegation should not be encouraged. However, as discussed in Chapter 5 and advised in the above box, sometimes family member interpreter's responses on the Pt's behalf can be valid due to their unique social relationship with the Pt. Acknowledging such contribution of the Int as legitimate can speed up the consultation and improve the rapport with them. However, it is a difficult balance for the Dr to maintain between speeding up the consultation by accepting the Int's delegation and improving the Pt's empowerment by

ensuring their participation. In my opinion, a family member Int (or other caregivers) is in a very unique position as opposed to other types of Ints. Their active participation may not result in compromised Pt's empowerment. However, this needs to be further investigated in future research.

It is noticed that a long extended turn normally results in the Int speaking on behalf of the Pt rather than interpreting for them and significantly editing the information. It is worth presenting a lengthy excerpt which will speak for itself in this regard. In Ex5 the Dr explained to the Int about a repeat prescription. Since the explanation is designed with the Int as the addressee it is expectable that the Int would not translate but only speak on behalf of the Dr to explain to the Pt.

EXCERPT 5 (1020710KEN, CZECH, SEMI)

1. Int: [and before I was not hear you properly about for what you say about for
2. prescription. You meant with [that the prescription is she
3. Dr: [Yeah. The the prescription is now what we call on a repeat
4. [prescription. So it means she
5. Int: [Oh::: All right. Is that, is that if her tablets finished, she just bring prescription back
6. here=
7. Dr: =ask for [more
8. Int: [and after [one day or something like that- Al:right
9. Dr: [She doesn't need to see a doctor.
10. Int: Takže, čo sa týka, lebo som ho prepočula predtým, keď rozprával (laughter)
11. o recepte. Dal vám takýto recept, že teraz si vyberiete tabletky, lenže zadnú stranu si
12. nechajte. Na zadnej strane máte, vlastne, je to 'repeat', znamená to, že si môžte zase znova
13. objednať sama.
14. *So, regarding, because I did not hear him before, when he talked about the prescription*
15. *He's given you this prescription that now you will collect the tablets with, but keep the back*
16. *page. On the back page you have, actually, it is 'repeat,' which means that you can order it*
17. *again by yourself.*
18. Pt: Aha, v poriadku.
19. *Aha, OK.*
20. Pt: *Oh, Ok.*
21. Int: že už nemusíte ich k lekárovi. Takže, vyberiete tabletky, tú jednu stránku si necháte,
22. skončia vám tabletky, prídete sem, odovzdáte ehh
23. *and you don't have to see the doctor again. So, you collect tablets, you keep this one page,*
24. *(when) you run out of them, you come here and hand it in ehh*
25. Pt: ehm
26. Int: no?
27. Pt: na recepcii. (laughter)
28. *At the reception.*

29.Int: Odovzdáte na recepcii tento recept.
30. *You hand this prescription in at the reception.*
31.Pt: ehm
32.Int: Oni vám povedia, kedy sa máte vrátiť. Vytvoria vám nový recept a vy si vlastne
33.nemusíte už robiť 'appointment' u lekára.
34.*They will tell you when you need to come back. They will produce a new prescription and*
35.*you actually don't need to make an appointment with the doctor.*
36.Pt: ehm
37.Int: Len si vyzdvihnete tento recept na **l**e na **r**ecepcii a idete zase do lekárne, dobre?
38.*Just collect this prescription at the le at the reception and you'll go to the pharmacy again,*
39.*OK?*

Without knowing what the Int was saying, the Dr was not able to see any possible problems. However, the problems could be prevented, following the above strategies.

g. Use Dr-Pt talk effectively
- **i. If Pt volunteers to talk in English when they understand the Dr's question or/and when the due translation is absent,**
  1. **Use this opportunity to establish rapport**
  2. **Don't stretch the Pt too far. Encourage Pt to speak through the Int whenever necessary.**
- **ii. Dr invites the Pt to speak**
  1. **Talk with the Pt at the beginning of the consultation to establish how much English the Pt speaks and also to establish rapport.**
  2. **If possible invite Pt to join small talks to establish rapport.**
  3. **Do not overestimate Pt's English ability. Always use an Int to talk about important issues.**

More often than not the Pt can also speak limited amount of English even though their English is not enough to fully participate in a medical consultation. Direct conversation with the Pt is a good opportunity for the Dr to establish connection with them and how much English the Pt can actually speak and when to invite them to talk in English without translation. However, it is advisable to use the Int to talk about issues of clinical significance. As shown in Ch5 Ex29 if the Pt's language is stretched too much, the Pt may either miss the information from the Dr or miss the chance to speak to the Dr.

4. Use backup translation
- **a. Understand that if you talk with the Pt for too long, the Int may do a backup translation to summarise your talk for the Pt.**
- **b. If you invited the Pt into a monolingual talk and are not sure if the talk has become too complicated, you should either ask for a backup translation or redo the talk with the Int involved.**

Strategy 4 is developed on the basis of the Dr-Pt talk. A professional Int would take interpreting as a responsibility so even if the PSs opt for monolingual talk the Int may still do a backup translation as in Ch5 Ex29. However, ad hoc Ints are not likely to do so. If the Dr realises that the talk has become complicated they should ask the Int to do a backup translation or talk again with the Int interpreting.

5. Be careful with Ignored turns
- **a. Don't just ignore Pt and Int**
  - **i. when the Pt brings up new topics during the physical examination**
    1. **Stop and ask Pt to initiate new topics later**
    2. **Assure Pt that they will have chance to raise their concerns**
    3. **Make sure you give them the chance later**
  - **ii. when it is close to the end of the consultation**
    1. **Be patient and hear what the Pt still has to say**
    2. **Even if you cannot address all their problems this time, let them finish so that you can help the Pt plan for the next visit.**

It is noticed that there are two stages at which Drs tend to ignore the Pts and Ints, that is, during the physical examination (Ex6) and at the end of the consultation (Ch5 Ex39), if they bring up new topics. The physical examination in a medical consultation is a very special stage, during which the conversational topics are naturally restricted to things only relevant to the ongoing exam. Drs constantly comment on what they observe. Such comments should be made in keeping with the ongoing exam in order to make sense to the hearer. That is to say, when the Dr is saying 'this is getting smaller', 'this' can only mean the body part which the Dr is feeling. The reason why the Dr invited the Pt to speak English with her in Ch5 Ex29 is because the translation would break the link between the meaning of the language and the action the language was affiliated to. Due to this special feature of physical examination, the Pt is not likely to succeed in bringing up irrelevant topics at this stage. Ex6 is another example of the Pt and the Dr talking past each other. The Pt's words were completely ignored by the Dr, who was concentrating on the exam.

EXCERPT 6 (3020710KEN 4:51.1)

1. Int: [because they give her like small electroshock (.) to fingers. That was help her about

2. for pain. And she now saying now it's a [problem with leg
3. Dr: [°yes with her legs° (1.9) °there's no varicose veins
4. or anything to see°
5. Int: hovorí, že nevidí tam žiadne tieto kŕčové žily >°[že by ste mali niečo°<
6. *He says that he cannot see there any these varicose veins*
7. Dr: [She's got a bit of eczema ((pointing at
8. affected area))
9. Pt: To sa mi toto robí stale
10. *It happens to me all the time*
11. Int: She has that all the time
12. Pt: Jak som bola tehotná a pri každom pôrodu
13. *When I was pregnant and with every delivery*
14. Dr: Did she put anything on that?
15. Int: err: She just saying all the time when she did pregnant and when she born baby
16. Dr: Yeah
17. Int: that was ( ) her em-
18. Dr: I can give her some cream for that
19. Int: Dá Vám na to krém, ak chcete
20. *He can give you cream for that, if you want*
21. Pt: Hej, ale teraz sa mi tu robí zase od vody [taký ((pointing at her arms))
22. *Yeah, but now I am having this because of water, like*
23. Dr: [Yeah she can (give it on)[anywhere else.

Expecting the Pt to fully understand the function of the Dr's talk during physical examination is not practical and also unnecessary. However, the above situation can be improved if the Dr stops the consultation, explains why he cannot answer the Pt's other enquiries at the moment and provide a later opportunity for the Pt to talk so that important information as in Ex6 will not be missed. Even if there is no later chance, at least the Pt knows the Dr's plan, instead of feeling that the Dr is not listening. In my individual interview with this Dr in Ex6, he acknowledged that the information missed here is clinically significant and the Pt should have been given a chance to talk later even if it was not 'right now'.

Another stage where Pts are found to bring up new topics is at the end of the consultation, which again had very low success rate for the new topics to be continued. In a monolingual conversation, the new topics may not get the chance to be dealt with either but they are more likely to be taken on board by the Dr, who may suggest that the Pt make another appointment for other issues. However, non-English

speaking Pt may not even have the chance to let the Dr know that they still have issues unaddressed in this consultation.

Ignoring Pts and Ints is very risky and it not only happens in these two obvious places but also in other parts of a consultation for various reasons as discussed in Ch5. Apart from Strategy 5 in this box, keeping the prototype and using pauses will also reduce the chance for the Pts' turns to be ignored. Pauses are what I will talk about in the next box.

6. Use pauses
- **a. Intra-turn pauses**
  - **i. If you want to say several sentences in a turn, pause in between the sentences to give yourself time to consider how to construct each sentence in order to ensure the language you use is easy for the Int to work with. Remember to use chunked extended turns not one long extended turn.**
  - **ii. It gives the Int a chance to take over the turn to start the translation if they feel you have spoken for too long.**
  - **iii. It slows down the pace so the Int has more time to think how to translate each sentence and ask you for clarifications.**
  - **iv. Int also needs to use intra-turn pauses to gain time to think of translation. Do not chime in to speak until the translation is finished.**
- **b. Inter-turn pauses**
  - **i. After you finish leave a pause to signal that you are ready to pass the turn to the Int.**
  - **ii. Leave enough time for the Int to take over to translate. Do not repeat yourself immediately if the Int does not start translation right after your turn. The pause does not mean they haven't understood but they may be just thinking how to translate.**
  - **iii. Don't feel frustrated with long pauses. They are normal in interpreted discourse.**
  - **iv. You can request a translation if it is too much delayed, esp with the ad hoc Ints.**
  - **v. Don't take the turn immediately after the Int stops talking. Avoid taking over when the Int is not finished yet.**
  - **vi. Use inter-turn pauses to enhance the chance for using the prototype turn sequence organisation.**

The benefits of pauses are elaborated in Chapter 6. They help interlocutors keep the prototype turn-taking, reduce overlaps, and allow the use of chunked extended turns. However, because long pauses are uncommon and can indicate problems in a monolingual conversation, Drs may not be comfortable to use them as a strategy. What I observed when I was teaching communication skills was that students felt frustrated even if there was a very short pause before the Int took over the turn to interpret. They tended to consider the pause as a manifestation of Int's

comprehension difficulties and therefore repeated themselves immediately but in different words. This repetition is not always necessary and sometimes can even be harmful. It may confuse the Int to think that the Dr is saying two different things. As I explained in the previous chapter, interpreting is a sophisticated cognitive activity that takes time for the Int to accomplish so pauses are a natural component of an interpreted conversation. On the other hand, an Int, if in the Int role, is not an active interlocutor but instead they follow the lead of the PSs; which means, they do not actively take over the floor to translate but will wait until the PS finishes talking. Therefore, long pauses are normally recognised as a sign of completion. Drs should also be aware that professional Ints are more sensitive to inter-turn pauses than ad hoc Ints. Comparing the pauses in Ex13-15 in Chapter 6 and those in Ex2 in Chapter 5, one can see the professional Int (Ch5 Ex2) recognised the pauses as a sign of change of speakership but the family member would need verbal reminder to remind him of the speaker change intended by the Dr (Ch6 Ex13-15).

7. Minimise overlaps or use them carefully
- **a. Use pauses rather than overlaps as the latter may cause information loss and ignored turns.**
- **b. Strategically use overlaps**
  - **i. Use overlaps to regain the floor if the Int takes over the turn when you are not finished yet. But make sure you are not burdening the Int with too much information at one go.**
  - **ii. Use overlaps if the Int's turn has gone too long but is already repeating what has been said (this happens when the Int's language is insufficient).**
  - **iii. Use overlaps if they break the prototype turn-taking sequence and entre the conversation illegitimately (when it's not their turn to talk according to prototype)**
- **c. Be aware that an Int can overlap legitimately**
  - **i. when an ongoing translation is interfered by another speaker's illegitimate or premature entry**
  - **ii. to stop an inappropriate response to the previous PS**
  - **iii. to stop a too long turn**
  - **iv. to interpret simultaneously as the PS is speaking**

Overlaps are not encouraged for many reasons as I discussed in Chapter 6. However, there are occasions when limited use of overlaps may help improve the communication. For example, if the Int takes over the turn to speak while the Dr has not finished (and does not intend to speak for an extended turn), the Dr can overlap to

regain the floor. In Ch6 Ex5 the Dr was just summarising what the Pt had told her. However, before she had finished the Int chimed in in L9 so the Dr overlapped with him in L10 in order to finish her summary.

Sometimes when the low skilled Ints is interpreting they may say the same thing several times but in different words. In order to move forward with the consultation, the Dr may use overlaps to take over the floor (see Ch6 Ex10). However, there are occasions when the Int chimes in for legitimate reasons (e.g.: to repair) (see Ch5, p119 for explanations about *legitimate* and *illegitimate entries*). In that case the Dr should give away the floor. Just like in Ch6 Ex10, although the Dr took over the floor with overlap, she did not overlap until she was sure that the Int's interference was illegitimate.

8.3 TURN-DESIGN RELATED STRATEGIES

8. Initiate Role orientation
   a. Negotiate the Int role at the beginning of the consultation.
   b. Anticipate the role the Int may take (particularly with family Ints), if it may be different from what you want, verbalise what you want.
   c. Explain why you want them to take a particular role.

As discussed in Chapter 7, Ints can play different roles, particularly ad hoc Ints. Some of these roles can be relevant to the consultation but some should be avoided. The 01150910Hor is a good example, in which the Dr made it clear before the consultation began, that she wanted the son to be an Int. This made it a lot easier for the Dr to remind him of his role later. If the Dr anticipates that the Int may take a role other than an Int, they could redirect the Int back to this role by requesting them to interpret. It was not uncommon in the communication workshops, where I taught, to hear the simulated patients say that they felt uncomfortable when the Dr still wanted them to interpret while they had already answered the question on behalf of the Pt; but they would do so if the Dr could explain why they needed the Int just to interpret but not to speak for the Pt.

9. Initiate context orientation

- **a. Anticipate whether the Int will misunderstand the context. If so, explain. For instance, you may want to explain confidentiality at the beginning of the consultation and the importance of letting the Pt know it as well. Or you may not want the Pt to interrupt or ask questions when you are examining them.**
- **b. Soft information (things like, signposting, showing empathy, or evaluating what the Pt has said) may be omitted. Therefore, it is useful to let the Int know they are important. Instead of saying 'I understand', you may say 'can you tell him, I understand'.**

If the reason for the Int not to translate is because they do not share the same understanding of the context (for instance, the Pt relevant information is taken as Int relevant information), the Dr can talk back to the Int and explain the context. In the conversation about sick note in 01150910Hor the family Int thought the Dr's explanation about how to claim benefit during his sick leave was relevant to himself because he was the caregiver who could be the actual person to claim the benefit for the Pt. Although the result would be the same that the Pt would eventually get the benefit with or without understanding the process, this Pt did not get the equal opportunity to be informed of the healthcare system as an English Pt would have. Directing Ints to their appropriate roles could potentially reduce their misunderstanding of the context and the negative influence of conflicting agenda of the Int, such as this situation with the family member Int.

Soft information is very likely not to be translated. It would be useful if the Dr could mark the need for a translation before soft information is produced. As the example I give in the above box, instead of saying '*I understand'* to show empathy for the Pt's worries, the Dr could say '*Can you tell him, I understand*'.

10. Build linguistic awareness—know three types of sentences

- **a. Simple sentence—a sentence with one verb (prescribe, take, examine, am/is/are).**
- **b. Compound sentence—two or more simple sentences linked with and, or, but, for, yet, nor or so. (e.g.: I will give you the prescription and you can get an appointment from the reception.)**
- **c. Complex sentence—one independent clause jointed by one or more dependent clauses with because, since, after, although, when, that, who or which. (e.g., The thyroid which is the glad in your neck is improving.)**
- **d. The complexity increases from a to c.**
- **e. Easy tip: be aware of how many verbs you are using in each turn. When you have used more than one verb, the sentence is no longer a simple sentence.**

Previous communication models advise the Drs to use simple sentences but do not explain what simple sentences are. The above box provides a quick tip for distinguishing the three types of sentences in English—simple sentences, compound sentences and complex sentences. It is worth noting that most linguists would distinguish sentences as for written language and utterances for spoken language and argue that grammatical rules based on written language is not appropriate for describing the features of the spoken language (Brown and Yule, 1983). However, 'sentence' is still used in place of 'utterance' in here in order not to cause confusion to the non-linguist audience, for whom the strategies are written. Although the distinction of simple, compound and complex sentences is based on written language, many utterances people use can be categorised according to them (Halliday and Hasan, 1976) and the knowledge of them is still valid for Drs to learn about the level of complexity of language they use. Ex7 is revisited below to demonstrate a combination of complex and compound sentences that have caused mistranslation. According to what is suggested in the above box, within the Dr's one sentence turn, there are relative pronouns, such as 'which', 'that', introducing clauses in the complex sentences; and also the conjunction, 'and', used in compound sentence. There are also several verbs, 'is', 'causes' and 'is improving'.

EXCERPT 7 (1170910HOR 2:30.0)

1. Dr: .hhhh (0.6) the thyroid (0.59) which is the gland in your neck (0.27) that causes
2. tiredness and feeling weak and changes in your hair and weight gain (0.9) that is improving
3. but slowly.
4. (0.5)
5. Int.: Yea jo thyroid hain na jo glands main hoti hain jis ki waja se aap ke baal ghirte hain
6. or wazan bar jata hai yea jo hoti hain nishanian, yea na behtr ho rahi hain
7. *Int.: You know the thyroid, which is in the glands, because of which your hair falls out and*
8. *you gain weight, these symptoms, they're getting better.*

Following the advice of the strategies, this sentence can be reduced to several simpler sentences in several extended turns as below:

IMPROVED EX7

1. Dr: The thyroid is the gland in your neck.
2. Int: *translation*
3. Dr: It causes tiredness and feeling weak and changes in your hair and weight gain.
4. Int: *translation*
5. Dr: But all is improving.
6. Int: *translation*

An interesting observation in the data is that when sentence structure is too complicated, the Int may not be able to even ask for clarification. In the data, the Ints normally requested clarifications if a word (jargon) was not understood but not much for a sentence. The reason could be that second language speakers are more likely to attribute their incomprehensibility to unfamiliar vocabulary rather than the sentence structure. If they know all the words in a sentence, they tend to believe they know the meaning of it. Another reason could be that sentences can consist of a mixture of comprehensible and incomprehensible aspects, which make it difficult for a non-native speaker to immediately distinguish one from the other and form a targeted request for clarification. Using simple sentences, as shown above, does not have to compromise the complexity of the content but would reduce the chance of misunderstanding by increasing the Int's chance to identify understanding difficulties.

11. Understand that you alone can't change the world. As much as the Dr tries to improve the communication, there are always things that can go over the control. If it does not go well, see next time.
12. Be aware of the danger of using poorly skilled Int. If possible always use a trained interpreter.

Last but not least, the turn-design framework reiterates the fact that an interpreted conversation is the co-construction of all interlocutors in the interaction. There are things in the interaction that the Dr cannot control. This is the nature of the interpreted discourse, which has to be acknowledged and treated with a positive attitude. Students should not blame themselves if they have tried their best but the consultation is still not going far. As this and other studies have evidenced, professional Ints are associated with improved communication outcome. Therefore,

choosing to use a professional Int is always a remedy and should also be a preferred mode of an interpreted medical consultation.

8.4 Preventive strategies, remedial strategies and necessary knowledge

The 12 strategies can be further classified into two types of strategies and one knowledge, namely the **preventive strategies**, **remedial strategies**, and **necessary knowledge**. Preventive strategies are the proactive measures the Dr take to prevent problems from happening. Keeping the prototype, using pauses, using simple sentences, role and context orientations, etc. are of this kind. However, problems and communication difficulties are the natural components of an interpreted consultation; therefore, other strategies should apply to remedy the problems. They include the use of overlaps, way to deal with illegitimate monolingual talk, use of backup translation and so on. I have also provided necessary knowledge adjacent to relevant strategies, which aims to aid the application of the strategies, such as points 10-12 about the possible omission of soft-information, information about the interpreting mechanism, etc.

The strategies and useful knowledge should be treated as an integrated system rather than independent points separate from each other. These strategies, especially the remedial ones, are context based, which means Drs should understand the generic linguistic contexts as provided by the necessary knowledge and apply the strategies according to different situations. The skilful application of the strategies cannot be achieved only by reading the 12 strategies but rather through extensive practice in order to improve their understanding of the strategies and the different contexts, in which these strategies are used.

However, the caveat cannot be overstated: an interpreted consultation is not only the work of the Dr alone but rather, just like any talk in interaction, an outcome of the

joint efforts of all participants. When a consultation cannot move forward, the Dr should always think of making another appointment and use a skilled Int.

8.5 GPs' VIEWS ON THE NEW STRATEGIES

The strategies presented in this chapter have been improved after the discussion with the GPs in a focus group interview. As explained in Ch4, this interview is part of the member checking, which was mainly to check the usefulness and accessibility of these strategies. Three GP trainers were invited to comment on the strategies, prior to which they were asked to rate the strategies against their usefulness and level of clarity. However the ratings were not used as statistic data in the research but rather as a stimulus activity to generate discussions about the reasons they rated each strategy and see how their views changed in the course of the group discussion. The interview obtained thoughtful opinions as for how to improve the accessibility of the language for non-linguistic audience and how the strategies can be disseminated to different types of recipients: the trainers and trainees. They also inspired the design of the teaching of these strategies.

The issues they have raised can be summarised as the *clarity of the language*, *recipient design* and *delivery*. Given the fact that the strategies are rooted in a linguistic investigation, terminologies commonly used in linguistic theories are not immediately accessible to medical professionals. This imposed a big challenge on the design of the interview Handbook—how to make it short but interesting enough for the busy GPs to read and yet still provides sufficient information, with which the GPs are able to understand the terminologies needed for understanding the strategies. The *Handbook* is obviously restricted by the limited space and therefore many details have to be left out. As a result the GPs found it quite difficult to comprehend some of the strategies and therefore scored them down. The interview allowed me to clarify their confusions and help them understand the strategies better. However, the gap is big between the level of linguistic knowledge and the level of the GPs understandings without training on the former. This leads to the second issue about 'recipient design'. The GPs

suggested that one Handbook cannot suffice the needs of the two different types of audiences—trainers and trainees. They felt that the *Handbook* is too complicated for trainees but too simple for trainers. They suggested that a bigger document with detailed explanation of terminologies in linguistics (e.g. conversation analysis) and examples would be useful for trainers. They all agreed that it is important for the trainers to understand the theories and terminologies, which can enable them to fully understand the strategies, internalise them and use them in practice and teaching as a comprehensive and systematic whole. On the other hand, they also felt that a much simpler document with a set of selected hands-on strategies students can immediately take away with can be more attractive to trainees. Other more sophisticated strategies can be learned from the trainers when certain contexts emerge in the teaching (such as in simulations). We also discussed the need to develop a corresponding teaching method, which can combine the teaching of the linguistic theory and the practice of strategies.

Enlightened by the focus group discussion, a GP Workshop was developed and conducted for a small group of GPs who were new to the research. I took a bottom-up approach to teach them the strategies. Instead of giving the participants the strategies straightaway, they were presented with several conversation excerpts carefully chosen from the data. Each excerpt was preceded by several directive questions for the participants to think about while reading. They were allowed to work in a group to analyse the excerpts, answer the questions and come up with their own communication strategies they learned from each excerpt. They were given the relevant strategies from the 12 for them to compare with theirs. As the facilitator, I was only there to guide the group discussion to make sure it was focused. This inductive teaching strategy appeared to be very effective. All of them were able to write down the most key strategies each excerpt attempted to demonstrate and all expressed their understanding of the strategies without any problems. Terminologies and concepts were well received by the GPs thanks to the excerpts and the directive

questions. Therefore they did not come up as problematic in the workshop as in the focus group interview.

8.6 Summary

In summary, the 12 strategies are evidence-based and behaviour-oriented. They can be further divided into preventive strategies, remedial strategies and useful knowledge according to their functions. Preventive strategies enable Drs to minimise communication problems; remedial strategies target on solving the emerging problems when the preventive strategies fail to work; and useful knowledge enables the Dr to use the strategies as a dynamic and systematic whole. The complexity of the linguistic knowledge underpinning these strategies is necessary but has been a challenge to the accessibility of the strategies. In order to make it useful and accessible for different audiences—the trainers and trainees, they need to be tailored and taught with appropriate pedagogy. A bottom-up approach using illustrative examples and probing questions seems to be an effective way to enable the understanding of the linguistic knowledge as well as the strategies based upon it. It is worth exploring how other teaching methods, such as using simulated patients or watching videos, can be used to improve the learners' learning experience of the 12 strategies.

CHAPTER 9 DISCUSSION AND CONCLUSION

9.1 A BRIEF REVIEW

The use of either professional or ad hoc interpreters in primary care and other healthcare departments due to the increasing population of LEP patients in the UK, has imposed challenges on medical communication and its education. There have been studies striving to establish new communication models to guide medical professionals to work with interpreters but their applicability are limited mainly for a lack of sufficient understanding of the interpreted medical consultations. My research proposes that a useful communication model should focus on improving people's verbal behaviours, which sit at the core of communication. Conversation analysis, having a unique focus on the mechanisms of people's turn-by-turn verbal interaction, is chosen in this research to investigate the interactional mechanisms in the interpreted GP consultations, aiming at providing a systematic understanding of people's verbal behaviours in interaction and enlightening the development of a new behavioural oriented communication model. Using CA, I provided a systematic analysis in chapters 5-7 of the mechanisms of turn-taking and turn-design in interpreted consultations, which reveals the universality in the turn-taking system in interpreted discourse. The interlocutors' interactions share the most fundamental features in monolingual talk—people take turns to speak and they design each turn in collaborative interaction—but the realisations of turn-taking and turn-design in the interaction demonstrate unique characteristics that are not typical in monolingual conversations. The analysis also reveals that the features identified in the research are generic and do not vary even if the language used by the interlocutors changes. In Chapter 7 I highlighted the significant role the Int's turn-design plays in determining the quality of the communication and more importantly I investigated the interactive and autonomous factors that contribute to the Int's turn-design. This provides a plausible explanation of the occurrence of different types of turn-taking illustrated in Chapters 5-6. The new knowledge of the interlocutors' interactional mechanism enables me to identify the recurrent beneficial behaviours of the Drs and develop

communication strategies as shown in Chapter 8. These strategies are sourced from the evidence coming out of the linguistic investigation, my expertise in various areas and GPs' insight into teaching and practice in primary care. This chapter gives a summary of the findings in the previous chapters and highlights the contributions this study has made to the theory and practice, by referring to previous studies in literature.

9.2 FROM CA TO DIALOGUE INTERPRETING TO TWO FRAMEWORKS

This research has drawn largely on conversation analysis, which proposes that talk-in-interaction is not random and unpredictable but rather conducted by the interlocutors in a systematic manner and such systematicity can be formally accounted for (Sacks and Jefferson, 1992). This methodological assumption underpins mine and other's studies of *dialogue interpreting* (Mason, 2000). Interpreted discourse normally occurs in institutional settings, such as international conferences, business meetings, courts or medical consultations. Talk in institutional settings, as Drew and Heritage (1992b) point out, shares many features with daily conversations but has unique features that need further investigation. Scholars of CA also point out that understanding the systematicity of people's talk in a particular institutional context can help improve the participants' ability to participate in this particular social activity in which the talk takes place (e.g.: Drew et al., 2001, Bhatia et al., 2008). At the beginning of the thesis I have pointed out that a lack of clear understanding of the way people participate in an interpreted consultation has hindered the teaching of communication skills for doing interpreted medical consultations. Therefore, I argue that a clear understanding of the mechanisms or the patterns of the verbal interactions of the Dr, Pt and Int was needed to help develop medical professionals' communication skills. The investigation into the interactional mechanism of the interpreted discourse is rather a new phenomenon, starting from the late 1990s when Wadensjo's book '*Interpreting in Interaction'* (1998) inspired the trend of studying interpreting as an interactive process. Following this more scholars have taken a discourse analytical approach to investigate dialogue

interpreting, using naturally recorded data (Bolden, 2000, Davidson, 2002, Mason, 2006, Merlini and Favaron, 2007, Gavioli and Baraldi, 2011).

These studies have set sound basis for future investigation of interpreted discourse but they are not yet satisfactory in terms of providing a fundamental understanding of the overall picture of the interpreted discourse. The first problem for me is that they put too much emphasis on the interpreters, leaving the other interlocutors under-researched although they acknowledge that the interpreted discourse is an outcome of interactions. Most of them chose to look at a specific aspect of the interpreter's participation or functions in the interaction, without investigating how the interpreter's behaviour is influenced by that of other interlocutors. Another problem stems from their exclusion of the ad hoc interpreters and being selective of the interactional phenomena to investigate and report. For instance, most studies have looked at only a few turn-types for the purpose of investigating a certain function or functions of the interpreters in the interaction. Gavioli and Baraldi explicitly state that they are not looking at 'code-switching or code-mixing mechanisms where the interpreting is shaped by a (partial) knowledge of the 'other' language on the part of (one of) the participants' (2011: 209). It also occurs to me that all these studies, standing on the side of the interpreters, have an agenda (either explicitly or implicitly) to promote the significance of the active role of an interpreter in the discourse, which may have biased their view of the overall picture of the interpreted verbal interaction. Even if some of them have touched upon the unskilled interpreters, relevant issues are not given enough attention. There seems to be a gap between research of the positive and negative effects of the interpreters. As opposed to the abovementioned researchers in interpreting, scholars from other social disciplines, particularly medical education studying medical consultations, focus on interpreting errors, with limited consideration of the positive side of an interpreter. These scholars are more likely to criticize the facilitator and mediator roles the interpreter is playing as discussed in Ch2.

In this research I therefore took a holistic approach to explore the fundamental mechanism governing the turn-taking and turn-design with a goal to develop communication skills and improve communication. Without discriminating any particular types of turn-taking or having any particular political agenda in investigating the turn-design, the frameworks of turn-taking and turn-design I have established provide a generic understanding of the talk-in-interaction in interpreted discourse, which is more comprehensive and systematic than the predecessors. Next I will give a detailed explanation on how the new frameworks have filled the gap left by the abovementioned studies.

In my turn-taking framework, I identified 7 types of turn-taking organisation, namely the prototype, extended turns, monolingual talk, backup translation, semi-interpreted talk, backtrack talk and ignored turns. As part of the turn-taking system, the generic patterns of pauses and overlaps were also investigated. The first type, prototype turn-taking, is mentioned by several authors (Davidson, 2002, Bolden, 2000, Merlini and Favaron, 2007). The findings from this research echoes with those in these studies which reported on the finding of what I call the prototype turn-taking and at the same time pointed out the prototype is not a common practice in many institutional occasions. However, this research further explored how keeping the **prototype** turn-taking organisation has the positive effect on the outcome of the communication, which is not mentioned by other authors as an issue that concerns them. Only one study by Merlini & Favaron (2007) presented a type of turn-taking, which resonates with the features of the **extended turns** in my framework. However, the extended turns in their case are a representation of the potential speech difficulty the Pt may have so they only occur when the Pt fails to take up the turn to speak when their turn is due and the speech therapist has to reword what they have said in order to elicit the desired answer from the Pt. **Monolingual talk** in my data is so rich that it demonstrates dynamic interactional features that appear in difference circumstances for various purposes. Other authors (Gavioli and Baraldi, 2011, Bolden, 2000, Davidson, 2002) have also noticed monolingual talk but they mainly focused on the talk between

the interpreter and the primary speakers. None of them considered the talk between the primary speakers. Gavioli and Baraldi (2011) intentionally excluded this phenomenon in their research. The functions of monolingual talk for them are merely continuers, seeking clarifications and/or explaining the situation, all of which are represented in my data. In my framework monolingual talk is discussed according to the circumstances in which it occurs and I also distinguished the situations, according to whether the interpreter is involved. **Backup translation** and **semi-interpreted talk** in my data are based on the finding of monolingual talk between the primary speakers. Now that most of other studies have excluded this phenomenon, none of them have investigated these types of turn-taking. **Backtrack talk** is not mentioned in any other studies either. Again Gavioli and Baraldi acknowledged the existence of such phenomenon in their data but intentionally excluded it in their investigation. Mason (2006) has mentioned that the interpreter is actively selecting the quantity and quality of the words of the primary speakers to translate, because of which ignored turns can be one of the consequences of this selective process. Instead of considering the **ignored turns** as a result of the interpreter's active choice, I emphasise their interactive relation with other interlocutors' participation. **Pauses** and **overlaps** do not seem to have attracted enough attention and are only briefly mentioned in Merlini & Favaron. For them, pauses are another representation of the speech difficulty of the patient. They briefly described the location of the overlaps according to the distance between the occurrence of the overlap and a TRP. Contrarily their significance is fully recognised and carefully examined in this research, which has taken the whole Chapter 6 to describe their features. They are found to play a very significant role in maintaining the flow of the conversation and achieving certain communicative goals. The benefits of intra-turn and inter-turn pauses are highlighted.

The term *turn-design* is not explicitly used in the previous studies. Instead the authors talk about actions or activities of interpreters in the interaction. They normally focus on a few specific types of activities designed in the turns-in-interaction and the corresponding functions. On the contrary I look at turn-design as a generic

phenomenon in interpreted spoken discourse, focusing on how the primary speaker's (Dr's in particular) behaviour can influence that of the interpreter. My focus is on the interactional determination (or as I prefer, interdetermination) of actions of the interlocutors, which can help to understand how doctors can adapt their behaviour in order to improve the communication. This is different from the other authors whose goals are to research for interpreting education or political purposes. Despite the divergent research goals however, I share several key concepts with these authors, that is: 1) the interpreter is an active participant in the interaction and 2) they are significant in enabling the conversation between the PSs. Turn-design in interaction is the fundamental theoretical construct I am orienting to for my analysis. On the other hand I agree with other authors that the interpreter's turn-design is essential to the quality of the communication, which I reiterated in Ch7.

A few authors have pointed out that the Int's activity (or *turn-design* in my term) is affected by the '*framing contexts'* (e.g. the contexts of hospital, the consultation, etc.) and '*local context'* (e.g. the conversational contexts created and renewed in the conversation) (Mason, 2006) or by the Int's understanding of the goals of the ongoing activity (or in Mason's words, *local context*) (Bolden, 2000). They mention that the mutual understanding of meaning and local conversational contexts is only achieved through negotiation among the interlocutors in the ongoing interaction (Davidson, 2002, Mason, 2006). Despite the possible mutual accessibility to the contexts, there can always be misalignment of understanding of the contexts (Mason, 2006). Gavioli and Baraldi (2011) explicitly point out the interrelationship between the interpreter's activity and that of other interlocutors but they only investigated how 'different types of interpreter-mediator contributions are *promoted* or *prevented* in different ways in the medical and in the legal sets of data, in line with different contextual expectations' (205). When these authors talk about interpreter roles they emphasize two different roles following Wadensjo: mediator & facilitator, as the components of the interpreter role.

My framework of turn-design has not only *integrated* the findings of the previous studies but also *enriched* the understanding of turn-design in a more generic way. Firstly I point out that there is a relationship between the type of information of the primary speaker in previous turn and the corresponding actions the Int is undertaking in the current turn. I investigate this relationship not as a static phenomenon but rather a dynamic interaction which can be influenced by many factors. I concentrate on the factors that affect the interpreter's turn-design. I distinguish two types of factors, which have not been considered in such an integrated way in previous studies, namely the interactional factors and autonomous factors. In this framework, not only do I consider the comprehension of different contexts and the Int's institutional roles but I also take into consideration the Int's language ability and memory ability. I have also talked about Int's roles in a broader sense, the role as an Int (for which they can interpret but not necessarily interpret correctly), as a professional or as a social actor (for which they can talk back to the PSs). I also point out the link between the Int's design and their understanding of the comprehension ability of the Pt. Apart from talking about the Int alone, I also look at the factors that affect Dr's turn-design which will then affect that of the Int. The whole framework of turn-design reveals a complete circle of how the Int's turn is actually designed in the turn-by-turn ongoing interaction, which, nonetheless, is not achieved in the previous studies.

Compared with other studies, my framework does not presuppose the positive impact of the Int. I take a neutral stance to explore why sometimes the interpretation is troubled or the interpreter is not acting as is supposed to; why at other times the interpreter can enable the communication to progress smoothly. Therefore, this framework can not only explain the positive interactional episodes but also interpreting errors, which are largely neglected in the abovementioned linguistic studies of interpreted discourse. As discussed in Ch2 and early this chapter, the discussion about interpreting errors or problems is mainly proposed by the medical professionals and educators who can only point out that there are errors but cannot explain the reasons of their occurrence by using traditional research methods. This

research hopes to have bridged this gap and provided a better insight into the cause and effect relationship between actions in interaction and consequences of such actions, be it positive or negative.

In summary, my turn-design framework has not only integrated the insights of different studies that look at different types of the factors affecting the Int's turn-design into an interrelated dynamic mechanism but it has also gone beyond these factors. In this study not only is the Int's turn-design explored but also that of the Dr, which gives a more comprehensive view of the interdetermination in the interpreted discourse. Due to the limited time and space of the PhD, the Pt's turn-design is not discussed but it is worth investigating in the future.

The two frameworks of turn-taking and turn-design provide a comprehensive understanding of the interlocutors' behaviours in an interpreted consultation and the reasons for the occurrence of the behaviours. They have also provided sound evidence for developing a set of communication strategies that can improve the communication outcome by improving people's interactional linguistic behaviours, which of course will need further trialing and refinement after the initial trialing. In next section I will discuss how the 12 strategies in this study fit within the existing communication models.

9.3 From traditional communication skills, new communication skills to 12 communication strategies

I need to clarify that the communication strategies developed from this study do not tend to replace the existing traditional communication models (Cohen-Cole, 1991, Mead and Bower, 2000, Silverman et al., 2005, Kurtz et al., 2003, Pendleton, 2003, Neighbour, 2005). Contrarily they are expected to be a useful supplement aiming at tackling the new situations and related issues the involvement of a medical interpreter brings to a consultation. In other words the traditional communication models are still valid as the foundation of the education of medical communication but medical professionals and students who need to work with interpreters need to learn extra

skills. In Chapter 2 I have discussed at length the importance of the traditional communication models as well as the need for a new model to inform the communication where an interpreter is involved. I have also mentioned the current attempts in the literature to propose new communication models for work with interpreters (Bischoff and Loutan, 1998, 2008, Kai, 2005, Kai, 2006, Tebble, 1998) and discussed their deficiencies (see Ch2). The skills mentioned in these models cover the **managerial** (e.g.: make sure the interpreter gets paid properly; allow enough time), **ethical** (e.g.: clarify confidentiality; check whether the interpreter and patient are happy with each other) and **behavioural** (e.g.: speak slowly and clearly; look at the patient not the interpreter) aspects of a consultation. Here I want to briefly reiterate the key arguments I made in Ch2 in order to highlight the advantages of the 12 new communication strategies. These models provide useful information for the medical professionals to manage a consultation from before the consultation to after it. However, some of them are desirable but not practical, especially in primary care, such as talking with the interpreter before and after the consultation. They have mentioned some behavioural strategies but they are too vague to be actually put into practice—they specify several specific things the Dr needs to do but do not say how to do them. Some of these behavioural strategies even run the risk of being oversimplified, such as the advice on using 'you' rather than 'he' to address the patient. As I found in my study, the interpreter is playing an active role and their relationships with the Dr and Pt are very complicated. Which personal pronouns to use needs to be negotiated among the interlocutors in the ongoing interaction rather than being predetermined by the Dr. The applicability of these strategies are also restricted by their exclusion of situations where ad hoc interpreters are used, which is still a common practice in healthcare departments in many countries like the UK.

Compared with these models, the 12 communication strategies developed in this study have four unique features, which make them more useful than their counterparts. Firstly they are targeting on the behaviour, which has been mentioned but not well explored in other studies. While I agree that having proper logistic

management and getting ethical issues correct is essential, I would argue it is the behaviour of the Dr that actually improves the outcome of the communication and hence the outcome of healthcare, once the Pt and Int are seated in the consultation room. A behaviour-based communication model has the potential to remedy the problem of previous models that only tell what to do but not how to do it. Secondly the 12 strategies are developed according to actual behavioural evidence found in the data. Whether certain behaviour is improving or impeding the conversation is evidenced in the ongoing talk-in-interaction. The evidence is not based on a single anecdotal episode but rather on an investigation of systematically reoccurring phenomena in the data. Thirdly the 12 strategies are based on a CA study, which has taken a dynamic interactional approach to data; therefore, the strategies are also dynamic, whereas in other models the strategies are rather static. The 12 strategies are further classified into 3 sub-categories, preventive strategies, remedial strategies and necessary knowledge. They can not only prevent problems from happening but also enable problem solving had any problems occurred. Fourthly the aim of the 12 strategies is not to provide a simple checklist for Drs or students to take away. Instead, they aim to provide a series of dynamic interactive strategies that can help students develop their abilities to skilfully deal with the sophisticated changing situations in an interpreted consultation. To borrow Salmon and Young's words, the 12 strategies aim to develop not '*communication skills'* but '*skilled communication'* (2011).

9.4 LIMITATIONS

Despite the contributions the study has made, it has several limitations needing to be discussed. The first limitation is the small number of data, which is limited in the number of recorded consultations and the types of participants. There were only two general practices, two GPs and 3 types of interpreters included. That could mean that the early saturation of new interactional phenomena might be an indication of the same participants' coherent behaviours but does not eliminate the possibility that there would be new phenomena if different GPs, types of interpreters and languages are involved. As I discussed in Chapter 7, different people taking the role as an

interpreter demonstrate different relationships with the patient and Dr and thus will have different impact on the dynamics of the interaction. As mentioned in the literature review, ad hoc interpreters also include other bilingual professionals, patient's friends or even strangers or another bilingual patient. All of them have different type of relationship with other participants and may demonstrate different organisations of turn-taking and turn-design.

The second limitation is that the research was situated in primary care, in which consultations provide the most dynamic communication scenarios for research and the findings may have implications in the broader contexts of health care. However, it is unclear to what extent they can represent the situations in other health care departments and how genenralisable the findings are to other general practices in the UK. Further research needs to explore the generalisability of the findings in a wider range of settings.

The third limitation is the researcher's lack of the knowledge of the languages investigated in the research. Although speaking the ethnic languages was not essential in the analysis, it would be helpful if the researcher can speak the languages so that one can look into issues embedded in the lower level of the constructive units of language, which may provide more insight into the communication problems and extra communication strategies in addition to the existing ones. Additionally this would also help enhance the rigour of research since the researcher would be able to check the quality of transcript translations.

In the light of these limitations, this research attempts to propose the following implications for future research, which may be able to address some of the remaining issues.

9.5 Implications for future research

This study has shed light on many aspects of the interpreted discourse as well as the practice and education of clinical communication. However, many issues around these subject matters are still to be explored. I hope this study will open up a window, through which more issues can be discovered, discussed and researched so that people can understand different types of interpreted discourse in different institutional context better and communicate with each other more effectively.

Although the frameworks of turn-taking and turn-design are developed from the study in the context of GP consultations, they are expected to include all the possible interactional features of the interpreted discourse despite the context in which the conversation occurs. However, whether this generalisation is valid and to what extend it is valid still needs further investigation by trying out the frameworks in different institutional contexts to see how well it explains people's behaviours in the talk-in-interaction. As noticed in this research, some interactional features are more typical to one kind of interpreters than the others. I have pointed out these discrepancies in this research but further research is still needed to find out why there are such discrepancies, how they are constructed in the interaction, how they can affect the communication quality, etc. Understanding these issues may contribute to the education of interpreters.

One of the budding phenomena in the data analysis is the issue of the realisation of *patient-centred care* (see Mead and Bower, 2000, Taylor, 2009) and the hierarchical power relationships in an interpreted consultation. It is noticeable in the data that some behaviours which are unproblematic in a monolingual consultation suddenly become problematised due to the lack of a mutual language between the doctor and patient and the involvement of the interpreter. For instance an important message produced by the patient in overlap with the doctor still has the chance to be addressed in a monolingual consultation but such message, more often than not, becomes lost with the *ignored turn* (see Ch5 Section 5.7). Enlightened by the two theoretical frameworks, more research can be conducted to look into how the patient-centred

care is realised in the interaction, how the hierarchy of power among the interlocutors affects the quality of care and how the involvement of different types of interpreters can empower or disempower the patient.

Based on the conversation analysis of the generic features of interpreted GP consultation, the 12 communication strategies are also expected to be able to provide a generic guidance which can potentially change the behaviours of not only GPs but also other medical professionals who needs to work with either professional or ad hoc interpreters. Yet, how much the change would be still needs to be further researched. The frameworks and strategies developed in this research may also have other implications for other medical professionals, professional interpreters, social workers, managers, educators, that may go beyond my imagination. However, as discussed in the previous paragraph, people's behavioural features may vary quantitatively when the context chances; therefore, it is necessary to further investigate how the 12 strategies can be used by other medical professionals without alteration and whether the quantitative variation can cause qualitative difference in people's behaviour and the result of the consultation.

Another area that needs further investigation related to the strategies is training. During the process of developing and disseminating the 12 strategies, one of the biggest issues was to translate the linguistic knowledge into a language that is accessible to medical professionals and students who have little knowledge about linguistics. A bottom-up approach of teaching as tested in my workshop appears to be effective in teaching both the strategies and terminologies. However, the method is still limited in many ways. For instance, it is very time-consuming for the participants to do group discussion and only a limited number of strategies can be taught in a long period of time. Another limitation is that it does not involve actual practice to use the strategies. Although the two participating GPs reported noticeable changes in their behaviours after the interviews, they are only a very small number of medical professionals, who happen to be highly motivated and active in academic and

educational activities. It is unclear whether most medical professionals can actually use the strategies effectively once they have learnt them theoretically. More research is needed in this regard. Another problem stems out of the GP interview is the design of proper written materials for different audiences. Those for trainers should be different from those for trainees. The documents should also be used in combination with well designed interactive activities, which allow the learners to understand the theories as well as practice the strategies and internalise them in order to use them strategically according to the varying contexts. A possible method of teaching could be a day seminar containing two consecutive sessions: one for theories and another for practice. The theoretical session could be run in a similar fashion as the dissemination workshop I conducted with the GPs. Learners would learn the terminologies, CA transcription symbols and the 12 strategies with the help of sample transcripts and maybe videos (of either real or simulated consultations). The second session will give students the opportunity to practice the strategies with simulated patients. The facilitators of this session need to be trained with the 12 strategies so that they would be able to help students particularly to learn those context-based strategies. This teaching method could be a valuable initiation to integrate the teaching of linguistic knowledge with the teaching of communication. If language is the core of communication, then this teaching method can also be used to teach medical communication in general. This would eventually invite more research taking a linguistic approach into the field of medial communication.

9.6 Conclusion

Medical communication is a significant social activity that involves every participant. There is still a lot more that linguists can contribute to improving the outcome of human communication. Linguistic studies are normally descriptive of what the world is like. They provide us with a lens to look into this world that is interconnected by language. The purpose of seeing the world better is indeed to participate in it better. I have been striving to aim at this end throughout the research. Hopefully the readers would find it to have shed some light on the interpreted consultations or even

interpreted discourse in general, and on the better practice in an interpreted event as discussed in this thesis.

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APPENDIX A TRANSCRIPTION SYSTEM ADOPTED FROM THE JEFFERSONIAN SYSTEM

Convention	Name	Use
[text [text	Brackets	Indicates the start point of overlapping speech.
=	Equal Sign	Indicates the break and subsequent continuation of a single utterance.
(0.78)	Timed Pause	A number in parentheses indicates the time, in seconds, of a pause in speech.
(.)	Micropause	A brief pause, usually less that 0.2 seconds.
. or ↓	Period or Down Arrow	Indicates falling pitch or intonation.
? or ↑	Question Mark or Up Arrow	Indicates rising pitch or intonation.
,	Comma	Indicates a temporary rise or fall in intonation.
conver-	Hyphen	Indicates an abrupt halt or interruption in utterance.
>text<	Greater than/Less than symbols	Indicates that the enclosed speech was delivered more rapidly than usual for the speaker.
<text>	Less than/Greater than symbols	Indicates that the enclosed speech was delivered more slowly than usual for the speaker.
°	Degree symbol	Indicates whisper, reduced volume, or quiet speech.
ALL CAPS	Capitalized text	Indicates shouted or increased volume speech.
underline	Underlined text	Indicates the speaker is emphasizing or stressing the speech.
:::	Colon(s)	Indicates prolongation of a sound.
(hhh)		Audible exhalation
•or (.hhh)	High Dot	Audible inhalation
(text)	Parentheses	Speech which is unclear or in doubt in the transcript.
((text))	Double Parentheses	Annotation of non-verbal activity.

APPENDIX B HANDBOOK FOR TRAINING FOR GETTING CONSENT

Project: Understanding Interpreted Triadic Consultations in Primary Care

Handbook for getting consent

Chief investigator: Mr. Shuangyu Li

Email: s.li08@leeds.ac.uk

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GLOSSARY

Ad hoc interpreters are bilingual staff members and family and friends who are interpreting for a consultation.

Chief investigator (CI) is Shuangyu Li, the PhD student, who is also the main contact person for this research.

Professional interpreters are those who are booked from PCT Interpreting Service Centre to interpret for a consultation.

Professionals is a term used to refer to participating GPs, PCT interpreters (or interpreters from private companies), and staff members who act as interpreters.

PART I INTRODUCTION

BACKGROUND

As immigration increases, a growing number of non- or low English proficient patients are seen by GPs throughout the country. Learning new skills to conduct consultations using professional or ad hoc interpreters (staff or family members) has become increasingly important for today's doctors. It has also become a requirement in *Tomorrow's Doctors 2009.*[19] Confronted with this situation, traditional models of communication in medical consultations are no longer sufficient to give guidance and again communication has become a problem. Funded by the NHS Bradford and Airedale PCT, Shuangyu Li sets up his PhD to investigate interpreted consultations in primary care and develop communication skills. It is a timely response to the call for clear guidance in education of communication skills for doing interpreted consultations. This research intends to use a linguistic tool—Conversation Analysis (CA)—to analyse the naturally recorded interpreted consultations in primary care. The aim is to reveal the patterns of verbal interactions of the doctor, patient and interpreter in a consultation. Such patterns will provide an insight into how and why linguist behaviours can sometimes facilitate the communication and sometimes interfere with it. A better understanding of the patterns by doing CA is a heuristic for developing communication skills training (Bhatia 2008, Paul Drew et al. 2001)[20]. The research findings will be used to develop the teaching and learning of communication skills for primary care doctors and medical students, but not limited to them. Hospital doctors, nurses, professional interpreters and trainers in medical communication should also find this research useful.

METHODS

The research will video record naturally occurring GP consultations, in which either a professional or ad hoc interpreter is used. Three non-English languages are chosen for this research, namely, Urdu and Czech/Slovak (due to the mutual intelligibility of the two languages, they are treated as one in this research). The recording of Urdu and Czech/Slovak consultations will be undertaken in parallel although the analysis will start with 12 consultations using one language, 4 of which will be using professional

[19] General Medical Council (2009) Tomorrow's Doctors 2009: a draft for consultation [Online]. [Accessed 14th Sept 2009]. Available from http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/tomorrows_doctors/tomorrows_doctors_2009.asp.

[20] Bhatia, V. K., Flowerdew, J. & Jones, R. H. (2008) *Advances in discourse studies,* London, Routledge. Drew, P., Chatwin, J. & Collins, S. (2001) Conversation analysis: a method for research into interactions between patients and health-care professionals. Health Expect, 4, 58-70.

interpreters, 4 using staff and 4 using family or friends as interpreters. Another 12 consultations using another language will be analysed in comparison with the first set of data to see whether the patterns of participants' behaviour will change with language. Up to 48 consultations are expected to be recorded in order to test the generalizability of the findings from the initial analysis of the 24 consultations. A video camera will be set up in the doctor's room in advance and only the doctor, patient and interpreter (either professional or ad hoc) are in the room. Physical examinations will be done outside the video recorded scene while the conversation is still recorded. Audio recordings will be transcribed and translated by trained bilingual transcribers for investigation. All the videos will be view only by the chief investigator (CI) for analysis and maybe by the doctor who is in the videos. All participants will be kept anonymous. Any conversation that can possibly identify people's identity will be edited or deleted in any form of publication.

Reflective interviews will be done with doctors and some of the professional and staff interpreters (2 with Drs, 1 with interpreters). Doctors will be shown some of their consultations, learn about the research findings and discuss them with the CI. Interpreters will be shown the transcripts and audio clips and discuss with the CI about the issues coming out of the data.

A meeting with all GPs and professional and staff interpreters will be held by the end of the study. The CI will report the final research findings and elicit evaluations from the participants.

PART II GETTING INFORMED CONSENT

DEFINITION OF INFORMED CONSENT

Informed consent is an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after risks, benefits and alternatives have been adequately explained to them.

Freely given informed consent is central to research involving human participants or the use of human tissues or genetic material. This is because it is essential to ensure that those who participate in research understand exactly what the research involves for them. This applies equally whether they are patients or healthy volunteers. Informed consent helps to ensure that people are not deceived or coerced into participating in research.

In order to give truly informed consent, potential participants need to understand the following:

- the purpose of the research
- the practicalities and procedures involved in participating
- the benefits and risks of participation and, if appropriate, the alternative therapies
- how data about them will be managed and used
- the consent form

- their role if they agree to participate in the research
- how information will be provided to them throughout the study
- that their participation is voluntary
- that they can withdraw from the study at any time, without giving any reason and without compromising their future treatment
- the insurance indemnity arrangements for the conduct of the research where appropriate
- that the research has been approved by a research ethics committee.

They should also be given the following information:

- contact details, should they have further questions or wish to withdraw
- details of the research sponsor and research funding body.

(Reproduced from Caulfield et al (2005)[21])

INTRODUCTION TO THE DOCUMENTS AND PROCEDURES

Poster

A poster in Urdu, Czech/Slovak and English is placed in each practice. As the first approach to potential participants, it helps attract voluntary participants and spread the word about the research to wider public. On the other hand it is a convenient tool for the staff to use to explain to interested people. It contains most of the information the participants are most interested in knowing.

Two important messages to be communicated here are: firstly participants don't need to anything more than attending the consultation with the doctor and their interpreter and, secondly, all the recordings will be kept anonymous and confidential. (Professional and staff interpreters may be asked to participate in follow-up interviews and the final project evaluation meeting together with the GPs)

Information sheet

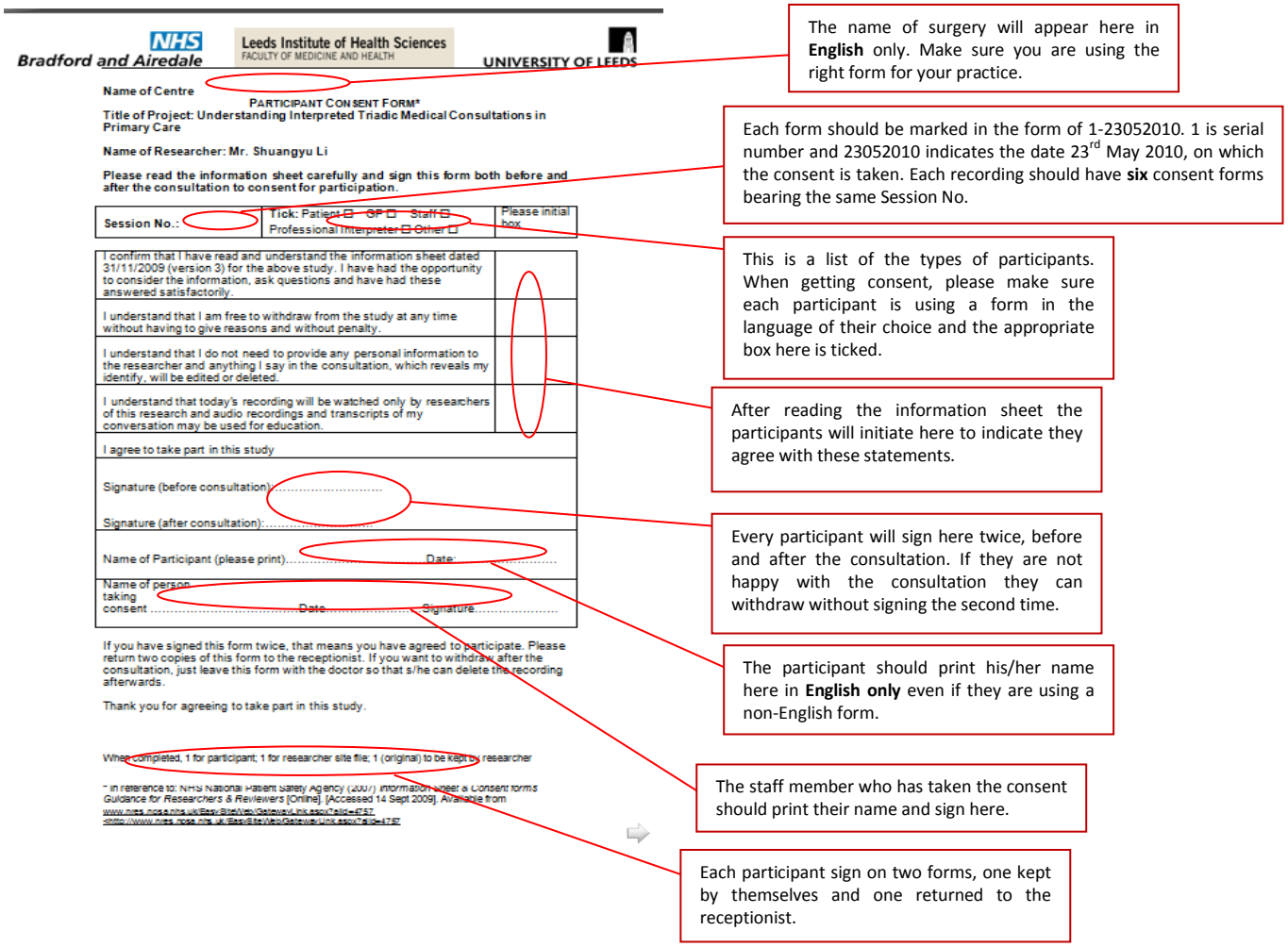
Information sheet is an extension of the poster. Questions given in this document are most likely to be asked and should be known to the participants. Receptionists can always refer to this document when answering participants' questions. Participants can take the info sheet home for their reference. The contact information allows them to contact the CI if they have any queries or would like to withdraw from the study after the consultation has been recorded.

[21] Caulfield, H., Dewing, J., Fairbairn, G., Franck, L. S., Gelling, L., Jones, J., Kenkre, J., King, E., Kirk, M., Maslin-Prothero, S., Mcmahon, A., Pearce, G., Purandare, L., Richardson, J., Tadd, W., Tait, T. & Young, A. (2005) Informed consent in health and social care research. London, Royal College of Nursing.

Consent form for all participants

This form is in English, Urdu and Czech/Slovak. All participants will sign a consent form in their chosen language. Each participant should sign before and after a consultation. They sign on two forms in duplicate, one kept by the participant and another to be returned to the receptionist. The original form should be sent to the CI and the practice can keep a photocopy for their reference. Each recorded consultation should have 6 forms all together (ie. 2 from GP, 2 from patient, 2 from interpreter).

I will take the English form to illustrate how it should be finished.



NHS Bradford and Airedale

Leeds Institute of Health Sciences
FACULTY OF MEDICINE AND HEALTH

UNIVERSITY OF LEEDS

Name of Centre

PARTICIPANT CONSENT FORM*

Title of Project: Understanding Interpreted Triadic Medical Consultations in Primary Care

Name of Researcher: Mr. Shuangyu Li

Please read the information sheet carefully and sign this form both before and after the consultation to consent for participation.

Session No.:	Tick: Patient ☐ GP ☐ Staff ☐ Professional Interpreter ☐ Other ☐	Please initial box
I confirm that I have read and understand the information sheet dated 31/11/2009 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
I understand that I am free to withdraw from the study at any time without having to give reasons and without penalty.		
I understand that I do not need to provide any personal information to the researcher and anything I say in the consultation, which reveals my identify, will be edited or deleted.		
I understand that today's recording will be watched only by researchers of this research and audio recordings and transcripts of my conversation may be used for education.		
I agree to take part in this study		
Signature (before consultation):..... Signature (after consultation):.....		
Name of Participant (please print)..... Date:.....		
Name of person taking consent ..... Date..... Signature.....		

If you have signed this form twice, that means you have agreed to participate. Please return two copies of this form to the receptionist. If you want to withdraw after the consultation, just leave this form with the doctor so that s/he can delete the recording afterwards.

Thank you for agreeing to take part in this study.

When completed, 1 for participant; 1 for researcher site file; 1 (original) to be kept by researcher

* In reference to: NHS National Patient Safety Agency (2007) *Information sheet & Consent forms Guidance for Researchers & Reviewers* [Online], [Accessed 14 Sept 2009]. Available from www.nres.npsa.nhs.uk/EasySite/ViewGateway.Link.aspx?eId=4757 <http://www.nres.npsa.nhs.uk/EasySite/ViewGateway.Link.aspx?eId=4757>

The name of surgery will appear here in **English** only. Make sure you are using the right form for your practice.

Each form should be marked in the form of 1-23052010. 1 is serial number and 23052010 indicates the date 23rd May 2010, on which the consent is taken. Each recording should have **six** consent forms bearing the same Session No.

This is a list of the types of participants. When getting consent, please make sure each participant is using a form in the language of their choice and the appropriate box here is ticked.

After reading the information sheet the participants will initiate here to indicate they agree with these statements.

Every participant will sign here twice, before and after the consultation. If they are not happy with the consultation they can withdraw without signing the second time.

The participant should print his/her name here in **English only** even if they are using a non-English form.

The staff member who has taken the consent should print their name and sign here.

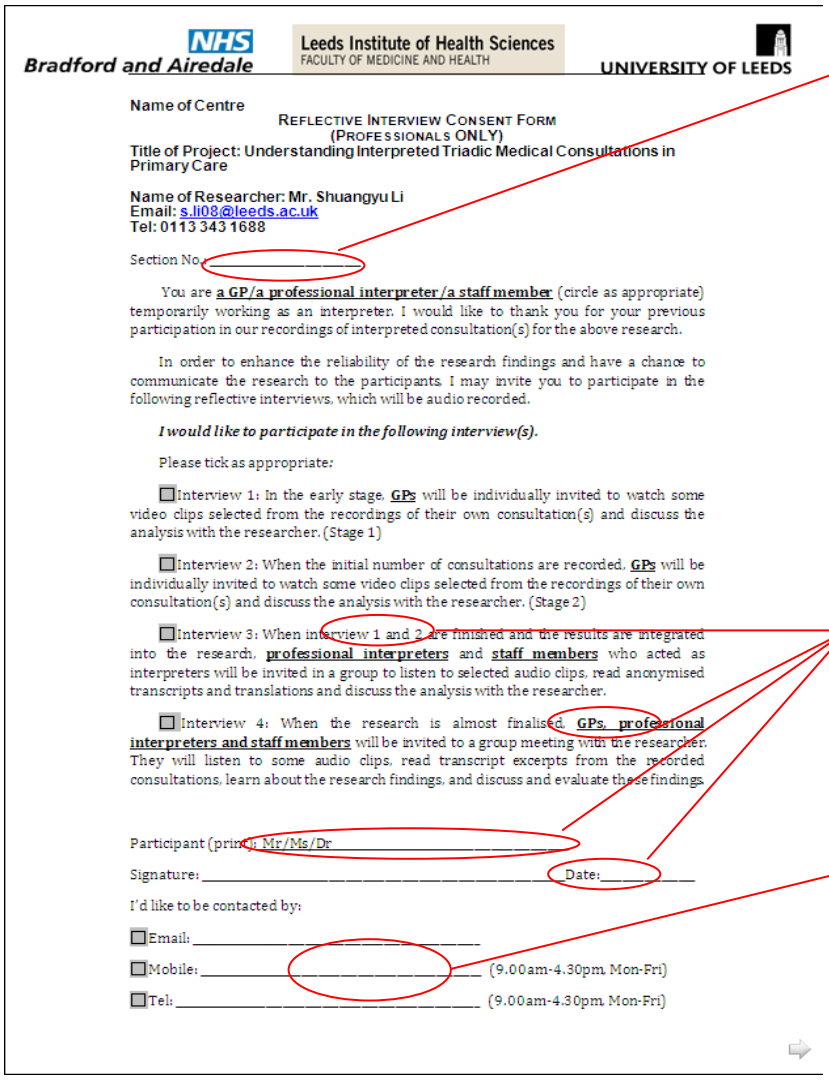
Each participant sign on two forms, one kept by themselves and one returned to the receptionist.

Consent form for doctors, professional and staff interpreters

This form is in English only. This is both a consent form as well as a information sheet about the reflective interview with the professionals. Professional participants, apart

from signing the previous form to consent to the recording, will be asked to sign on this form which allows the CI to contact them for reflective interviews.

Presumably all the participating doctors and staff member interpreters are aware of this research and would agree to participate in the interview. However, they will sign the consent form after each recording so as to give them the chance to avoid being interviewed about a particular consultation they do not want to discuss.



NHS Bradford and Airedale

Leeds Institute of Health Sciences
FACULTY OF MEDICINE AND HEALTH

UNIVERSITY OF LEEDS

Name of Centre

REFLECTIVE INTERVIEW CONSENT FORM
(PROFESSIONALS ONLY)

Title of Project: Understanding Interpreted Triadic Medical Consultations in Primary Care

Name of Researcher: Mr. Shuangyu Li
Email: s.li08@leeds.ac.uk
Tel: 0113 343 1688

Section No.: _____

You are **a GP/a professional interpreter/a staff member** (circle as appropriate) temporarily working as an interpreter. I would like to thank you for your previous participation in our recordings of interpreted consultation(s) for the above research.

In order to enhance the reliability of the research findings and have a chance to communicate the research to the participants, I may invite you to participate in the following reflective interviews, which will be audio recorded.

I would like to participate in the following interview(s).

Please tick as appropriate:

☐ Interview 1: In the early stage, **GPs** will be individually invited to watch some video clips selected from the recordings of their own consultation(s) and discuss the analysis with the researcher. (Stage 1)

☐ Interview 2: When the initial number of consultations are recorded, **GPs** will be individually invited to watch some video clips selected from the recordings of their own consultation(s) and discuss the analysis with the researcher. (Stage 2)

☐ Interview 3: When interview 1 and 2 are finished and the results are integrated into the research, **professional interpreters** and **staff members** who acted as interpreters will be invited in a group to listen to selected audio clips, read anonymised transcripts and translations and discuss the analysis with the researcher.

☐ Interview 4: When the research is almost finalised, **GPs, professional interpreters and staff members** will be invited to a group meeting with the researcher. They will listen to some audio clips, read transcript excerpts from the recorded consultations, learn about the research findings, and discuss and evaluate these findings.

Participant (print): Mr/Ms/Dr _____

Signature: _____ Date: _____

I'd like to be contacted by:

☐ Email: _____

☐ Mobile: _____ (9.00am-4.30pm, Mon-Fri)

☐ Tel: _____ (9.00am-4.30pm, Mon-Fri)

This number will be the same as the one on the recording consent form.

Interview 1 and 2 are only relevant to GPs while 3 and 3 involve all professionals.

They should at least provide one of these.

UNIVERSITY OF LEEDS

Understanding Interactions in Interpreted Triadic Medical Consultation in Primary Care

TRAINING FOR BILINGUAL TRANSCRIBERS

Mr. Shuangyu Li PhD student, Chief investigator of the project
Prof. Mike Baynham Professor of TESOL
Dr. David Pearson Senior Lecturer, Head of Primary Care Learning and Teaching

Email: s.li08@leeds.ac.uk

Tel: +44-(0)-113 343 1688

INTRODUCTION TO THE PROJECT

Due to the increasing number of migrants moving into the UK, more and more non- or low English proficient patients are seen by GPs throughout the country. Learning new skills to conduct consultations using professional or ad hoc interpreters (staff or family members) has become increasingly important for today's doctors and medical students. It has also become a requirement in *Tomorrow's Doctors 2009 (Ong et al., 1995)* and *The New Doctor (General Medical Council, 2007),* two documents regulating the education of medical students. Confronted with the situation, traditional models of communication in medical consultations are no longer sufficient and again communication becomes a problem. Funded by the NHS Bradford and Airedale PCT, this research is to investigate interpreted consultations in primary care and develop communication skills. It is a timely response to the call for clear guidance in education of communication skills for doing interpreted consultations. This research intends to use a linguistic tool—Conversation Analysis (CA)—to analyse the naturally recorded interpreted consultations in primary care. The aim is to reveal the patterns of verbal interactions of the doctor, patient and interpreter. Such patterns will provide an insight into how and why linguist behaviours can sometimes facilitate the communication and sometimes interfere with it. A better understanding of the patterns by doing CA can be a heuristic for developing training for communication skills (Bhatia et al., 2008, Drew et al., 2001). The research findings will be used to develop the teaching and learning of communication skills for primary care doctors and medical students, but not limited to them. Hospital doctors, nurses, professional interpreters and trainers of medical communication should also find this research useful.

Methods

Naturally occurring GP consultations will be video recorded, in which there is a patient with no English or limited English, who uses either a professional or ad hoc interpreter. Czech/Slovakian and Urdu are chosen for the research, given them being the most used ethic languages in the selected research sites. The use of two languages is to see whether language variation has significant impact on people's

behaviour and the techniques applied to conduct the communication. The recording of consultations using the two languages will be undertaken simultaneously despite the analysis to begin with initially 12 consultations using one ethnic language. Up to 48 consultations are expected to be recorded. For the research ethical consideration, the video recordings will be converted into audio files and sent to trained transcribers/translators for transcription in CA fashion. English speeches will be transcribed verbatim while non-English speeches will be transcribed in the original language first and translated into English (marked with italic font). The first few consultations will be fully transcribed in CA fashion for analysis, based on which extracts of talks from the consultations will be selectively transcribed in the same way. If necessary all the recordings may be transcribed but not necessarily in CA fashion.

SPECIFICS

Who are the translators/transcribers?

A group of bilingual professionals speaking both English and another language (Urdu, Czech/Slovak) well enough to undertake the work will be trained with CA transcription methods and research ethics. Ideally there will be at least 2 people working on the same language in order to ensure the work can be done in the due time and also for the purpose of back-translation, which is a tool used to test the reliability of the translations.

What will translators/transcribers do?

Stages	Item	Urdu	Czech/Slovak	Full text	Translation	Back Translation	Transcription
1	Information Sheet	√	√	√	√	√	
	Consent Form	√	√	√	√	√	
	4 consultations	√		√	√	√	√
2	12 consultations	√		√	√	√	√
3	12 consultations		√	√	√	√	√
4	24 consultations	√	√		√	√	√

This table gives information about the potential workload of the transcribers. However, it is not a strict timeline for transcription but rather for the research. It may change as the research moves on and transcription will be done whenever needed.

Translation requirement

Translations should be faithful to the original text in terms of meaning as well as structure. This is not a request for word for word translation, which we understand is never possible, but translators should carefully choose the words and structures that best represent the original text.

Translators are required to keep the content of the consultations confidential, by doing which they agree not to discuss what they hear from the consultations with people who are not relevant to this project or release any information to the third party.

Back translation

It is a process in which an independent translator translates the target language back to the source language, compares the back translation with the original text, discusses discrepancies with the first translator and, in collaboration with the first translator, finalises the translation.

All the text requires back translation, which is a tool to test the reliability of the translations.

Assisting analysis

Translators/transcribers may be consulted by the chief investigator when confusion and difficulties of understanding occur.

WHAT IS CONVERSATION ANALYSIS

Definition: Conversation analysis (CA), in simple terms, is the study of talk. To be more elaborated, it is the systematic analysis of the talk produced in everyday situations of human interaction: talk-in-interaction. CA is characterised by the view that how talk is produced, and how the meanings of talk are determined, are the practical, social and interactional accomplishments of members of a culture (Hutchby and Wooffitt, 2008).

Philosophical stance: conversation analysts believe that talk is not simply the product of two –speaker-hearers' who attempt to exchange information or convey messages to each other. Rather, participants in conversation are seen as mutually orienting to, and collaborating in order to achieve, **orderly and meaningful** communication. The **aim** of CA is thus to reveal the organised reasoning procedures which inform the production of naturally occurring talk (Hutchby and Wooffitt, 2008). It is a methodological approach for us to understand **social interaction** and the **role of discourse** and **communication** in everyday life (Wooffitt, 2005).

Basic features of conversation:

1) Speaker-change recurs, or at least occurs
2) Overwhelmingly, one party talks at a time
3) Occurrences of more than one speaker at a time are common, but brief
4) Transitions (from one turn to a next) with no gap and no overlap are common. Together with transitions characterised by slight gap or slight overlap, they make up the vast majority of transitions
5) Turn order is not fixed, but varies
6) Turn size is not fixed, but varies
7) Length of conversation is not specified in advance
8) What parties say is not specified in advance
9) Relative distribution of turns is not specified in advance
10) Number of parties can vary
11) Talk can be continuous or discontinuous
12) Turn-allocation techniques are obviously used. A current speaker may select a next speaker (as when he addresses a question to another party); or parties may self-select in starting to talk.
13) Various 'turn-constructional units' are employed; e.g.: turns can be projectedly 'one word long', or they can be sentential in length

14) Repair mechanisms exist for dealing with turn-taking errors and violations; e.g., if two parties find themselves talking at the same time, one of them will stop prematurely, thus repairing the trouble.

Criteria we use to analyse conversation

Organisation of turn taking

Turn design

Sequence organisation

Repair

Overall structure of conversation

WHAT ARE WE LOOKING AT IN TRANSCRIPTION

Turn-taking and overlap

Gaps and pauses

Breathiness

Laughter

Requirements for transcription

Use the following abbreviations: Doctor=Dr Patient=Pt Interpreter=Int

Anonymity & pseudonymity: if any names please anonymize them or use pseudonyms.

Laughers are not transcribed but marked with double bracket (()), unless they have significant relevance in the interaction.

Read Hutchby & Wooffitt's chapter 3 for a comprehensive instruction to CA transcription(Hutchby and Wooffitt, 2008).

Read page 265-269 in Schegloff (Drury, 2008) (in your training pack) to learn the transcription symbols.

After you have gained a general understanding of how CA transcription works, let's try to do some exercise to see how well you have understood the techniques.

Go to this website http://www.cambridge.org/catalogue/catalogue.asp?isbn=9780521825726&ss=res and download Data Extracts Appendix 2 or directly use this link http://www.cambridge.org/resources/0521532795/4191_TG.mov .

You can compare your work with the one done by Schegloff (included in the training pack)

Advice for Transcription

- Use appropriate software to facilitate the work
- Use a peddle if possible (it makes the work easier but is not essential)
- Listen to the recording several times before you write anything down
- Transcribe and translate the content first and then transcribe it in CA fashion
- Check your translation and transcription against the recording several times to ensure that the transcription best represents the recording and the translation is faithful to the original text.
- Communicate with the project chief investigator where there is any problems
- Never discuss the project with people not entitled to access the information in the project

SOFTWARE

It is recommended that transcribers use a software—*Audacity*—to do the transcription. It is a free programme commonly used by conversational analysts.

Following the link you will be able to see the download webpage, with instructions to how to use the software.

http://audacity.sourceforge.net/download/beta_windows

This software allows you to listen to a selected segment of talk repeatedly and measure the pause to 0.01 second.

CODE OF CONDUCT/CONFIDENTIALITY

Adapted from http://www.judiciary.state.nj.us/rules/appendices/translators.htm with amendment to suit this project

- Faithful and Accurate Conveyance of Messages
  - Translators should faithfully and accurately reproduce in the target language the closest natural equivalent of the source-language message without embellishment, omission, or explanation, unless it is agreed through discussion with the chief investigator.
- Impartiality and Conflicts of Interest
  - Translators should be impartial and avoid any appearance of bias or favouritism. They should avoid not only conflicts of interest but also the appearance thereof.
- Limitations of Practice
  - Because translators are responsible only for enabling others to communicate, they should not take a primary role in such communications and may take a secondary role (see below) only as necessary for assuring an accurate and faithful interpretation, transliteration, or translation.
- Confidentiality
  - Translators should protect from unauthorized disclosure all privileged or other confidential information that they obtain during the course of their professional duties.
- Abstention From Comment
  - Translators should not publicly discuss, report, or offer an opinion concerning a matter in which they are or have been engaged, even when that information is not privileged or required by requirement to be confidential.

BILINGUAL TRANSCRIBER DECLARATION LETTER

Please sign and send this letter back to the chief investigator at the following address:

Mr. Shuangyu Li
Room G02
Charles Thackrah Building
101 Clarendon Road
Woodhouse, Leeds, LS29LJ

By signing this letter, I confirm that I have attended the training for translator & transcriber for this research titled Understanding Interactions in Triadic Interpreted Medical Consultation in Primary Care, I understand the requirement of the work and abide by the requirement of confidentiality and the code of conduct for transcribers as stated in the training.

Signature:

Name (in print)

Date:

(References omitted)

APPENDIX D GP INTERVIEW DOCUMENT

UNIVERSITY OF LEEDS

SOME OBSERVATIONS TO BE CONFIRMED WITH PARTICIPATING GPS

(CONFIDENTIAL)

PARTICIPANT: DR.

RESEARCHER: MR SHUANGYU LI
EMAIL: S.LI08@LEEDS.AC.UK
PROJECT: UNDERSTANDING INTERACTIONS IN INTERPRETED TRIADIC MEDICAL CONSULTATION IN PRIMARY CARE

Date: 24/03/2011

1. THE BASICS

1.1. WHY THIS RESEARCH?

There have been quite a few influential communication models used in communication training across the health care sectors, such as the Calgary-Cambridge model(Kurtz et al., 2005), Pendleton's model(Pendleton, 2003) and Neighbour's model(Neighbour, 2005). However, these models have said little about communication across language barriers(Li et al., 2010). Recent research has begun to investigate the related issues and proposed new communication models. However, these models have only proposed what should be done in order to improve communication but they have not said how things can be done(Li, 2010).

1.2. WHAT DOES THIS RESEARCH WANT TO ACHIEVE?

This research aims to provide a better understanding of people's verbal interaction, which is generic to all forms of interpreted medical consultations (disregarding the differences of the interpreter types and languages); and thus provide interactional recommendations for the education of communication.

1.3. WHY LINGUISTICS?

Communication as a linguistic activity has to do with people's use of language. The way communication is systematically structured can be studied using linguistics.

1.4. WHAT METHOD WAS USED IN THIS RESEARCH?

This research has used a linguistic approach known as conversation analysis (CA) to investigate 7 naturally recorded GP consultations in which either professional or ad hoc interpreters were involved. Three non-English languages were eventually recorded in this research.

1.5. WHAT IS CA?

CA aims to understand the orderliness of the social world through the study of the orderliness of talk. People take turn to speak and follow a certain sequence while taking turns. In some occasions who speaks first and who comes next is predetermined by the nature of the activity in which the conversation occurs, like in a court or a medical consultation. That's what CA calls turn-taking and turn sequence organisation. CA believes that turn-taking and its sequence organisation

are systematic and can be formally accounted for in order to understand participants' behaviours in a particular social activity. Knowing how the system operates can help participants better participate in the activity.

1.6. What has been found?

Research has found that interpreted conversations are systematically organized. This research has provided a detailed description of the systematicity of an interpreted GP consultation. Certain behaviours were repeatedly found beneficial for the communication, while others were found impeding it. This knowledge can be synthesised and used for communication training.

1.7. What is the purpose of this document and this meeting?

The purpose is to discuss the observations coming out of the data with the participating GPs.

2. Some examples

Example 1

1. Dr: [°ok° Ande (0.4) when she's walking (0.5) up a hill
2. Int: uh hum
3. Dr: does she get any pain [()
4. Int: [Čo sa týka, keby ste mali ísť, tak jak keby že hore do kopca, alebo po schodoch, máte nejaké pálenie alebo bolesti?

   And regarding, if you had to go, for example as if up a hill or stairs, do you feel any burning or pain?

5. Pt: Dakedy ich cítim. Také ťažké nohy.

   Sometime I feel them. Such heavy legs.

6. Int: that time she just feel like he:::r legs will be like too heavy
7. (0.9)
8. Pt: Po schodoch mám problémy.

   I have problems on the stairs.

9. Int: When she was pro errr when she must go:: up to steps↑
10. Dr: ehm.
11. Int: that time she just feel like her legs are proper heavy she can't (lift her daughter)
12. (0.6)

13. Dr: °OK° (0.3) .hhhh And the rest of her does she feel ok with the rest of her body?
14. Int: Normálne, čo sa týka Vášho tela, cítite sa v poriadku?

    Otherwise, regarding your body, do you feel ok?

15. Pt: normálne, len s týma nohama. Také, keď aj porobím niečo, poupratujem, pôjdem niečo nakúpiť, a stačí, že si ľahnem, už nevládzem, vankúše dávam pod nohy hore a trošku to uvoľní.

    Otherwise, only those legs. So, even if I do something, I clean, go to buy something, and when I lie down, I can't make it anymore, I put pillows under my legs and then it (pain) is released a bit.

16. Int: Ehm. Ok. She just saying apart from like daytime yeah? (0.55) She feel normally fine.
17. Dr: yeah.
18. (0.5)
19. Int: If she do some cleaning, cooking, she do shopping, she go somewhere and when she came back, like when she sat down or lay down on the sofa (0.7) that time like straight away start the pai::n that time she need too many pillows under legs
20. Dr: Right. So that that makes it worse. Being active makes [her pain worse.
21. Int: [If she do something and when she lay down or when she stan- errr sit down, that time she need a pillow or something because the pain come.
22. Dr: OK. (0.5) Can I just examine her legs now, please?
23. Int: Môže Vám skontrolovať nohy?

    Can he check your legs?

24. (0.4)

EXAMPLE 2

1. Int: She just saying last year she was having problem with hands same problems like now she said with the::[legs.
2. Dr: [her hands?
3. Int: And she ring and see I think it's physiotherapy
4. Dr: [yeah yeah
5. Int: [because they give her like small electroshock to fingers. That was help her about for pain. And she now saying now it's a [problem with leg
6. Dr: [°yes with her legs° (1.9) °there's no varicose veins or anything to see°
7. Int: hovorí, že nevidí tam žiadne tieto kŕčové žily >°[že by ste mali niečo°<

He says that he cannot see there any these varicose veins

8. Dr: [She's got a bit of eczema ((pointing at affected area))
9. Pt: To sa mi toto robí stále
   It happens to me all the time
10. Int: She has that all the time
11. Pt: Jak som bola tehotná a pri každom pôro[du
    When I was pregnant and with every delivery
12. Dr: [Did she put anything on that?
13. Int: err: She just saying all the time when she did pregnant and when she born baby
14. Dr: Yeah
15. Int: that was ( ) her em-
16. Dr: I can give her some cream for that
17. Int: Dá Vám na to krém, ak chcete
    He can give you cream for that, if you want
18. Pt: Hej, ale teraz sa mi tu robí zase od vody [taký ((pointing at her arms))
    Yeah, but now I am having this because of water, like
19. Dr: [Yeah she can (give it on)[anywhere else.
20. Int:
    [She just saying
    [there=
21. Pt: [To vo::da
22. Pt: *It's water*
23. Int: = is [the
24. Dr: [all the little patches
25. Int: Yeah, as well she just saying that it's of water
26. Pt: Ja som bola doma na osem mesiacov a prešlo to od vody [a nazad to mám.
    I was at home for eight months and it was gone and now I have it again because of water.
27. Int: [She been at a::: in Slovakia
    [she's been in Slovakia for eight months. No::↑
28. Dr: [seeing a specialist alright.

29. Int: She just saying I've been in Slovakia for eight months and I don't have nothing problems [and now
30. Pt: [A ja už viem, že to je vo[da
I already know that it is water
31. Dr: [it's come back [again
32. Int: [She just thinking it's of water
33. (0.64)
34. Dr: I I think it's mh (0.6) it could be it could be the climate too it fines peopel's skin
35. (0.3)
36. Int: uhm
37. Dr: it's sometimes better in sunnier countries (.) and not so good in less sunny countries like England. Can I [check your blood pressure?
38. Int: [Hovorí že(ehr:) môže to byť aj takto, hovorí, netvrdí, že nie.Môže sa =
Int: He says that it can be also that way, he says, he doesn't say no. It can
39. Int: = stať že °v hocijakej krajine všade° je nejak inak, takže::=
be that in any other country anywhere it is different so
40. Pt: =Lebo to nebolí, nesvrbí. Nič. Vôbec.
It doesn't hurt, it doesn't itch. Nothing. Nothing at all.
41. Int: She just saying she no feel scratching for that any pain, nothing for them smaller which one come
42. Dr: Yeah. The big one scratches but not them all
43. Int: Čo sa týka tie veľké, ani tie veľké Vás nesvrbia?
Regarding the big ones, even the big ones aren't itchy?
44. Pt: Vôbec. Keď si dám nejaký krém
Not at all. When I put on some cream
45. Int: Ehm
46. (0.5)
47. Pt: ono to ide dole.
It goes down
48. Int: Ehm.
49. Pt: Lebo je suché. Nejaký krém. Nivea a tak.
Because it is dry. Any cream. Nivea or so.
50. Int: Hovorí, že on Vám dá na to nejaký krém.
He says that he will give you some cream for it.

She just saying she not feel any scratch she nothing and for the big one as well and if she using some cream like Nivea or some normal cream which one women using that come off slowly but

51. Dr: °OK°. (0.95) I mean if she doesn't want anything I'm (.) sure she does have to have anything but I'm happy to give her something.
52. Int: Ak chcete, nemusíte nič dostať od neho. Ale ak súhlasíte, tak chce Vám dať nejaký krém na to.
    If you want, you don't have to get anything from him. But if you agree, he wants to give you some cream for it.
53. Pt: Môže byť.
    All right then.
54. Int: OK. She agreed.

EXAMPLE 3

1. Pt: [Dar-] (0.7) [Ja viem, že oni mi ich zakázali v Leedsi, čo som bola. Tak mi zakázali akože: užívať=
2. Pt: *I know that they forbade them to me in Leeds when I was there. So, they forbade me eh to use*
3. *Int:* [( )
4. Pt: = ten dihydrocodein. Ja som z toho schudla 30 kíl. Ja som mala 80 a mám teraz
5. Pt: *the dihydrocodein. I lost 30 kilos because of it. I had 80(kilos) and now I have*
6. Int: A vy ste brali tra-ten-coneal 20 tabletiek na deň?
7. Int: *And were you taking tra-ten-coneal 20 tablets per day?*
8. Pt: No.(.) 14- 18, kedy ako ma to bolelo.
9. Pt: *Yeah. 14- 18 depending on how strong the pain was.*
10. 4P: Šak takú bolesť [mala.
11. 4P: *She had such a pain*
12. Int: [Can I tell you something?
13. Dr: Yeah. Sure.
14. Int: Before she was [taking on tablets she was have already, yeah? (.)
15. Int: She was taking about 14 or 18 tablets [a day.
16. Dr: [I know. I KNOw I can see that.
17. Int: [And she was lose about 30
18. Dr: [Those are those are the short-acting ones (0.3) because they are short-acting ones you need to keep taking them. (.) The whole point of [giving her
19. Int: [OH Right!
20. ((conversation between the 4P and the patient in the background))
21. Dr: The whole poin of giving her of [long-lasting ones is that you don't [have to take so many.

22. Int: [OK
[Dobre. Takže, čo sa týka, predtým ste brali tabletky, vlastne tie isté, ale sú viaceré druhy.
23. Int: *OK. So, regarding, before you were taking tablets, actually the same ones, but there are more types.*

3. THE FINDINGS

3.1. THE INTERACTIONAL PATTERNS—WHEN WHO TALKS

People take turn to speak. This is called turn taking. In some activities who takes the first turn and who takes the next is determined by the nature of the activity, such as in a court cross examination, or a medical consultation. The turn-taking patterns can be formally accounted for and used to improve people's communication in a particular social activity. An interpreted GP consultation has its own patterns as for who speaks at what time. There are 7 types of turn-taking organisation: *the prototype, extended turns, monolingual talk, backtrack talk, backup translation, semi-interpreted talk* and *ignored turns*. Pauses between turns and overlapping speeches are also part of the turn taking system and they are also found systematic and relevant to the development of communication skills.

3.2. THE SEVEN TYPES OF TURN-TAKING ORGANISATION

3.2.1. PROTOTYPE:

The prototype turn-taking is what is normally expected from an interpreted discourse. One PS[22] starts a turn and then passes it to the Int who translates it into another language. This is followed by the other PS taking over the turn in response to the previous PS in the same language as the Int but different from that of the previous PS. The turn then will be passed back to the Int for translation into the first PS' language and then the same

[22] PS=primary speakers=Dr or patient

sequence circulation reoccurs until the conversation ends. It can be described in the following formula: Dr—Int—Pt—Int--Dr[23]

3.2.2. *Extended turns:*

Extended turns are a series of turns produced by one PS with each turn followed by an Int turn for translation. Another PS will not take over the turn until all the extended turns and their translations are finished. Extended turns were found to be used by PSs to construct complicated utterance and at the same time avoid overload the Int with too much information to translate.

3.2.3. *Monolingual talk*

Monolingual talk, as the name indicates, is the talk between any of the two participants using the same language. Any two people can talk without involving the third person. Different initiators were found to have different reasons to opt out of the interpreted discourse. Some reasons were legitimate and necessary for the smooth flow of the conversation. However others were unnecessary and even hindered the progress of medical consultation.

3.2.4. *Backtrack talk*

Backtrack talk can be considered as a kind of troubled talk. The trouble comes from the Int failing to identify and resolve the problem in the previous PS' turn before the onset of the translation; however, the Int manages to initiate a repair[24] within the same turn to get more information or give the correct information before s/he moves on with the translation. Backtrack talk can be described as a string of monolingual utterances inserted into the prototype sequence organisation.

[23] Dr=doctor, Int=Interpreter, Pt=patient

[24] Repair is any kind of linguistic tactic used by the speaker to deal with communication troubles. For instance when a speaker has a false start in the speech, s/he can self repair. E.g. 'I said, I mean he told me…'.

3.2.5. *BACKUP TRANSLATION*

Backup translation indicates a translation, usually a summarised rendition, is produced as a backup to prevent miscommunication after a string of English monolingual talks between the PSs. This type of organisation of turn-taking was only found with a highly skilled professional interpreter in the data. Backup translations were only rendered for the Pt not for the Dr due to the fact that in the data the PSs had only spoken to each other in English. It would be interesting to see whether and how backup translation would happen if the monolingual talk is in the Pt's language.

3.2.6. *SEMI-INTERPRETED TALK*

It means in a stretch of talk, one of the PSs' turn did not need to be translated. This happens when the Pt could understand what the Dr is saying and respond in his or her own language without having to have the Dr's words translated; or the Pt could respond in English after the Dr's words were translated.

3.2.7. *IGNORED TURNS*

Ignored turns can happen to any of the participants if the turn is produced in a troubled situation. Drs tended to ignore the Pt and the Int at two specific situations. Turns are likely to be ignored if the Pt brought up a topic or an issue that was not immediately related to the ongoing physical examination. If Pt brought up a new topic or complaint close to the end of the consultation, Dr tended to ignore that.

3.3. PAUSES AND OVERLAPS

Pauses and overlaps are related to the timing of the change of speakership. Compared with a monolingual conversation participants' use of overlaps has similar functions. They are normally used to compete for floors or they are just simply the consequence of illegitimate entries into the conversation. There is one function that is peculiar to interpreted discourse, that is, when it is used for simultaneous interpreting by the Int. Pauses are quite outstanding in interpreted discourse, although they might be considered unnatural in monolingual settings. There are two types of pauses, intra-turn pauses and

inter-turn pauses. Observably the use of pauses was mostly related to positive outcomes in the interaction. Long pauses can also be a sign of having trouble to understand the speaker, which may trigger repairs by the previous speaker, especially the Dr. Despite the positive side of using long pauses in interpreted discourse, it has its downside of making it difficult for another speaker to gauge the right time to take over the turn, which may cause overlapping in some occasions.

4. DISCUSSION

1. Do you think professional interpreters should advocate or just translate? How do you think of their advocate role?
2. If a family member is the caregiver can they speak for the patient? To what extent can they do so?
3. Do you refer to the patient with 'you' or 'she/he'? Do you think using different pronouns can make a difference?
4. Do you prefer the interpreter to refer to the patient with 'I' or 'she/he'?
5. Can you describe a good interpreter you once worked with?
6. Was this interpreter in the recorded consultations easy to work with? Why?
7. Is there anything you think this interpreter could have done to improve your communication with the patient?
8. Is there anything you think you could have done to improve your communication with the patient?

REFERENCES (OMITTED)

APPENDIX E DOCUMENT USED FOR GP FOCUS GROUP INTERVIEW

UNIVERSITY OF LEEDS

REFLECTIVE INTERVIEW 2
COMMUNICATION STRATEGY EVALUATION

(CONFIDENTIAL)

PARTICIPANTS:

RESEARCHER: MR SHUANGYU LI
EMAIL: S.LI08@LEEDS.AC.UK
PROJECT: UNDERSTANDING INTERACTIONS IN INTERPRETED TRIADIC MEDICAL CONSULTATION IN PRIMARY CARE

Date: 09/06/2011

Welcome back to the second reflective interview!

When you are reading this document that means we have gone so far in this research that now it's bearing fruit and we are only a few steps away before we can be sure that the research findings will actually improve our communication in an interpreted medical consultation. The purpose of this interview is to get your evaluations of the recommended communication strategies. Your opinions will be a significant contribution to the construction of a practical and effective communication model that can be used in teaching in the future. It has a potential to become a significant supplement to the traditional medical communication models which have not say enough about the skills for work with interpreters.

This interview is composed of two parts. The first part is material reading, which will be done by participating GPs using this document prior to the meeting. The second part will be a one-hour meeting with the researcher to discuss certain issues as designated in this document. This document contains an introduction to the background knowledge and 13 recommended communication strategies. The introduction will give you the knowledge about how the doctor (Dr), patient (Pt) and interpreter (Int) use language to communication with each other in an interpreted consultation and provide you with necessary vocabulary you need to understand the strategies. Afterwards you are invited to evaluate the usefulness of the 13 communication strategies (marked in orange). Further instructions are given at relevant places.

The whole document is using plain language so hopefully you will find it easy to read.

1. How do we talk?

We are doing two things when we participate in a conversation. Firstly we take turns to speak; secondly we design each turn when we speak. Our design of the turn does not stand alone but is rather interdependent with other turns around it. The preceding turn influences how we design our current turn and the current turn determines how the next turn is going to be designed. Here's an example. See if you would agree with this theory.

Turn 1 A: Oh, it's hot in here.

Turn 2 B: Let me open the window for you.

Turn 3 A: That's very kind of you

Turn-taking and **turn-design** are also the fundamental behaviours in an interpreted GP consultation. They are systematically investigated in this research and the findings suggest that some behaviours can improve the outcome of the communication while some can do the opposite. Based on this a series of strategies are proposed. This document will briefly recapture the findings as we talked about in the first meeting and explain the strategies.

2. The seven types of turn-taking organisation

Seven types of turn-taking are identified in the recorded consultations. Pauses and overlaps are also found relevant to the interaction. These features are briefly discussed so as to give you an overview of the findings and the vocabulary which you will need when you are reading for the communication strategies I am proposing.

2.1. Prototype:

The prototype turn-taking is what is normally expected from an interpreted discourse. One PS[25] starts a turn and then passes it to the Int who translates it into another language. This is followed by the other PS taking over the turn in response to the previous PS in the same language as the Int but

[25] PS=primary speakers=Dr or patient

different from that of the previous PS. The turn then will be passed back to the Int for translation into the first PS' language and then the same sequence circulation reoccurs until the conversation ends. It can be described in the following formula: Dr—Int—Pt—Int--Dr[26]

2.2. EXTENDED TURNS:

Extended turns are a series of turns produced by one PS with each turn followed by an Int turn for translation. Another PS will not take over the turn until all the extended turns and their translations are finished. Extended turns were found to be used by PSs to construct complicated utterance and at the same time avoid overloading the Int with too much information to translate.

2.3. MONOLINGUAL TALK

Monolingual talk, as the name indicates, is the talk between any of the two participants using the same language. Any two people can talk without involving the third person, thus opting out of the interpreted interaction. Different initiators were found to have different reasons to opt out of the interpreted discourse. Firstly all participants were found using **continuers** to talk back to the current speaker. Continuers are conversational makers, such as 'uh hum', 'yeah', 'yes' etc. which are used by the listener who responds to the ongoing speech of the current speaker. They function as a way for the listener to show their continuous attentiveness and understanding of what the speaker is saying and to encourage the current speaker to carry on speaking. Another reason for the participants to talk back to initiate a monolingual talk is to **repair** or **initiate a repair.** Repair is the mechanism people use to deal with conversational problems, such as a false statement, a mispronounced word, false start of a sentence, a search for word (e.g.: '*err let me think, what is it…*') or a slip of tongue, etc. In an interpreted consultation, the Dr or Pt can ask the Int for clarification and vice versa. The Int can correct either the Dr or the Pt, if they make mistakes either in

[26] Dr=doctor, Int=Interpreter, Pt=patient

explaining medical information or answering questions. Apart from the participants themselves actively transforming the conversation into a monolingual talk, the Dr and Pt can be passively transformed by the Int. This passive transition is caused by the Int, either consciously or unconsciously, responding to the previous speaker (the Dr or the Pt) on behalf of the addressee without translating.

2.4. BACKTRACK TALK

Backtrack talk can be considered as a kind of troubled talk. The interactional trouble comes from the Int failing to identify and resolve the problem in the previous PS' turn before the onset of the translation; however, the Int manages to initiate a repair[27] within the same turn to get more information or give the correct information before s/he moves on with the translation. Backtrack talk can be described as a string of monolingual utterances inserted into the prototype sequence organisation.

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[27] Repair is any kind of linguistic tactic used by the speaker to deal with communication troubles. For instance when a speaker has a false start in the speech, s/he can self repair. E.g. 'I said, I mean he told me…'.

words translated; or the Pt could respond in English after the Dr's words were translated.

2.7. IGNORED TURNS

Ignored turns can happen to any of the participants if the turn is produced in a troubled situation. Drs tended to ignore the Pt and the Int at two specific situations. Turns are likely to be ignored if the Pt brought up a topic or an issue that was not immediately related to the ongoing physical examination. If Pt brought up a new topic or complaint close to the end of the consultation, Dr tended to ignore that.

2.8. PAUSES AND OVERLAPS

Pauses and overlaps are related to the timing of the speaker change. Compared with a monolingual conversation, participants' use of overlaps in an interpreted conversation has similar functions. They are either used to compete for the floor (the right to speak) or just simply the consequence of illegitimate entries into the conversation. There is one function that is peculiar to interpreted conversation, that is, when the Int speaks simultaneously with the speaker to interpret; that's what is called simultaneous interpreting. Pauses are quite outstanding in interpreted discourse, although they might be considered unnatural in monolingual settings. There are two types of pauses, intra-turn pauses and inter-turn pauses. Observably the use of pauses was mostly related to positive outcomes in the interaction. Long pauses can also be a sign of having trouble to understand the speaker, which may trigger repairs by the previous speaker, especially the Dr. Despite the positive side of using long pauses in interpreted discourse, it has its downside of making it difficult for another speaker to gauge the right time to take over the turn, which may cause overlapping in some occasions.

3. TURN-TAKING RELATED STRATEGIES

Task: *Now please read the following strategies and rate the usefulness of each of them using a scale between 5-0, with 5 being the most useful and 0 the least.*

Please write your rate in the boxes at the front. You may find it helpful to recall a piece of dialogue that can support the strategy. The easier it is for you to find an example the more likely that this strategy is useful. However, this may not always be the case. We will discuss the reasons for your ratings when we meet.

1. Keep the prototype whenever possible

☐ a. Prototype turn-taking helps reduce communication problems (overlaps, omission reduction)

2. Extended turns

☐ a. Use extended *turns* to chunk the information into several turns.

☐ b. Give a complete sentence. Don't chunk in the middle of the sentence. A bad example would be 'What I am trying to say is…'

☐ c. Don't use an extended *turn* to finish everything at one go.

3. Monolingual talk

   a. Continuers

   ☐ i. Use continuers with ad hoc Ints to show attentiveness, establish rapport and encourage the Int to speak but keep it to the minimum. Don't need to use continuers with professional Ints.

   ☐ ii. 'Uhm' or 'yes' is enough. Complicated or too many continuers may cause the Int to talk back to the Dr.

   ☐ iii. Ask the Int to translate if you think you have said enough. Don't continue talking just because the Int is using continuers.

   b. Passive transition

   ☐ i. Even if the question you ask can be answered by the Int, still make sure Pt understands what's going on.

   ☐ ii. Request a translation if you are passively transmitted into a monolingual talk by the Int.

   ☐ iii. Check whether the Pt has been passively transmitted.

   ☐ iv. Unattended passive transition will cause lost information between Dr and Pt.

   c. Repair

   ☐ i. Repair grammatical mistakes as a way to clarify understanding (grammatical mistakes can impede understanding. What you understand may be different from what the Int or Pt is about to say)

   ☐ ii. Assist Int with their language if they struggle (this will help improve understanding and speed up the consultation. Unassisted struggle may cause panic of the Int who may lose confidence in doing their job and therefore, their normal language skills may reduce.)

iii. Don't rush to provide assistance. Only assist when it's a real struggle not just a delayed search-for-words process.

☐ iv. Confirm with Int that's what they were trying to say.

d. If necessary, talk with a family member Int to form a team to explain complicated concepts

☐ i. Explain to the family member and make sure they understand before you ask them to interpret

☐ ii. Take family member's concerns on board and address them properly before moving on with the consultation.

e. Int can talk back to you or the Pt for good reasons.

☐ i. If the Int talks back to Dr to:

1. Coordinate communication (to repair or initiate repair) which the Dr needs to take corresponding actions
2. Explain conversational situation (eg: oh it's hard on me/this is difficult for me)

☐

ii. If the Int talks back to Pt to:

1. repair misunderstanding, confirm understanding or request clarification.
2. You should check with the Int that the monolingual talk has happened because of the above reasons. But check **only** when the conversation between the Int and Pt is finished. Do not interrupt unless it is very necessary.

f. Int can talk back for illegitimate reasons if they

i. Talk on behalf of Pt

☐ 1. Do not respond to the Int. Instead, request a translation politely and if necessary, reiterate the ground rules.

☐ 2. Explain to the interpreter why it is important for you to know what the Pt has to say and why a direct translation is necessary.

☐ 3. This should not be encouraged. However, there are some occasions, esp. with family member interpreters, when this can be valid if the family member is believed to have legitimate reasons to know the answer. Always make sure the Pt understands what's going on.

ii. Talk on behalf of Dr

☐ 1. Do not ask them to explain on your behalf. Even if you have explained to the Int first you still explain it again while the Int is translating.

☐ 2. Although you cannot always tell whether the Int is speaking on your behalf, you can always reduce the chance for it to happen by maintaining prototype turn-

taking sequence, using short and clear sentences, extended turns and setting ground rules.

iii. Dr Pt talk

☐ 1. Pt volunteers to talk in English when they understand the Dr's question or/and when the due translation is absent.
   a. Use this opportunity to establish rapport
   b. Don't stretch the Pt too far. Encourage Pt to speak through the Int whenever necessary.

☐ 2. Dr invites the Pt to speak
   a. Talk with the Pt at the beginning of the consultation to establish how much English the Pt speaks and also to establish rapport.
   b. If possible invite Pt to join small talks to establish rapport.
   c. Do not overestimate Pt's English ability. Always use an Int to talk about important issues.

4. Understand backup translation

☐ a. If you talk with the Pt for too long, the Int may do a backup translation to summarise your talk for the Pt.

☐ b. If you invited the Pt into a monolingual talk and realise the talk has gone too complicated, you should either ask for a backup translation or redo the talk with the Int involved.

5. Ignored turns
   a. Don't just ignore Pt and Int

   ☐ i. when the Pt brings up new topics during the physical examination
      1. Stop and ask Pt to initiate new topics later
      2. Assure Pt that they will have chance to raise their concerns
      3. Make sure you give them the chance later

   ☐ ii. when it is close to the end of the consultation
      1. Be patient and hear what the Pt still has to say
      2. Even if you cannot address all their problems this time, let them finish so that you help the Pt plan for the next visit.

6. Pauses and gaps
   a. Intra-turn pauses

   ☐ i. If you want to say several sentences in a turn, pause in between the sentences to give yourself time to consider construct each sentence in order to ensure the language you

use is easy for the Int to work with. Remember to use chunked extended turns not one long extended turn.

☐ ii. It gives the Int a chance to take over the turn to start the translation if they feel you have spoken for too long.

☐ iii. It slows down the pace so the Int has more time to think how to translate each sentence and ask you for clarifications.

☐ iv. Int also needs to use intra-turn pauses to gain time to think of translation. Do not chime in to speak until the translation is finished.

b. Inter-turn pauses (gaps)

☐ i. After you finish leave a longer pause to signal that you are ready to pass the turn to the Int.

☐ ii. Inter-turn pauses do not always indicate problem as in monolingual talks so do not repeat what you have just said during the pause. Leave enough time for the Int to take over to translate.

iii. Don't feel frustrated with gaps. They are normal in interpreted discourse.

☐ iv. If the gap is too long, request a translation if necessary. Non-professional Ints may need a reminder.

☐ v. Leave a long pause after the Int's turn to avoid taking over at an intra-turn pause.

☐ vi. Using inter-turn pauses can help keep the prototype turn sequence organisation.

7. Overlaps

☐ a. Overlaps are not encouraged as it can cause information loss and ignored turns. Always wait until the Int is finished. Don't enter the conversation prematurely.

b. However, in some occasions overlaps can be strategically used to facilitate the communication.

☐ i. Use overlap to regain the floor if the Int takes over the turn when you are not finished yet. But make sure you are not burdening the Int with too much information at one go.

☐ ii. Use overlap if the Int's turn has gone too long but is already repeating what has been said (this happens when the Int's language is insufficient).

☐ iii. Use overlap if you need to reset the mould of conversation (eg. change from an interpreted conversation to a monolingual conversation, or stop a monolingual talk etc.)

☐ iv. Use overlap if they break the prototype turn-taking sequence and entre the conversation illegitimately (when it's not their turn to talk)

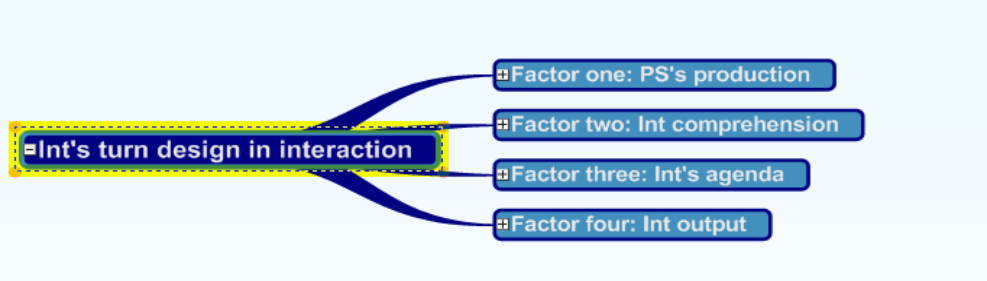
c. Int can overlap legitimately

- ☐ i. when an ongoing translation is interfered by another speaker's illegitimate or premature entry
- ☐ ii. to stop an inappropriate response to the previous PS
- ☐ iii. to stop a too long turn
- ☐ iv. to interpret simultaneously as the PS is speaking

4. WHAT WE SAY IS A RESULT OF INTERACTION

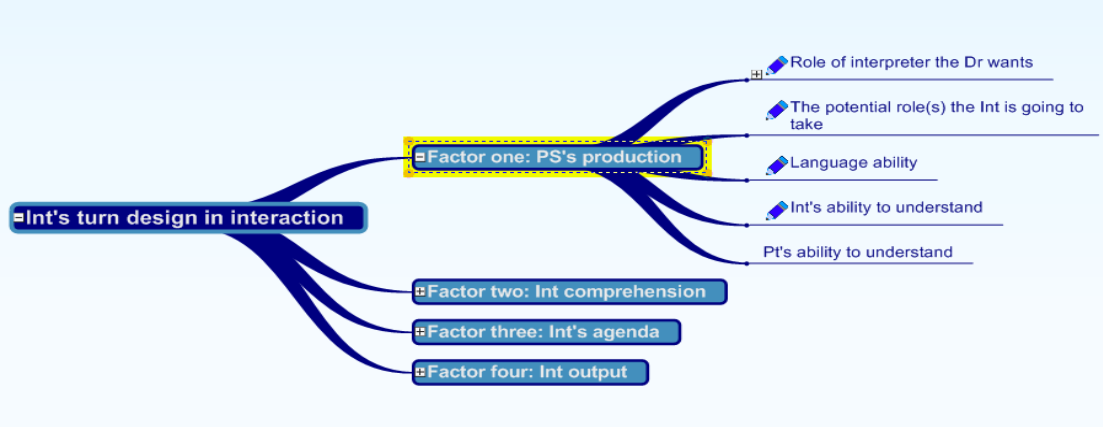
As you have read at the beginning, speakers in a conversation are related to one another. What the current speaker is saying is related to what has been said be the previous speaker and will determine what will be said by the next speaker in the next turn. Provided that the Dr has all the communication skills required in a medical consultation, this research suggests that the key to improve the communication in an interpreted consultation is to improve the work of the Int or the Int's turn-design. It is found in this research that Int's turn-design is determined by two types of factors—*interactional* factors and *autonomous* factors. The interactional factors are related to the Int's understandings which are constructed through the interaction with the Dr and Pt. The Int needs to understand what the Dr has said—both the language the Dr has used and the context in which the language is used. They also need to understand how the Pt is going to understand what they are going to say about what the Dr has said. The autonomous factors are the Int's agenda in the interaction and their language ability. These are independent from other participants but relevant to how the Int design the turn.

The following diagram shows the four factors that contribute to the Int's turn-design: Dr's utterance, the Int's comprehension, the Int's agenda and the output (language).



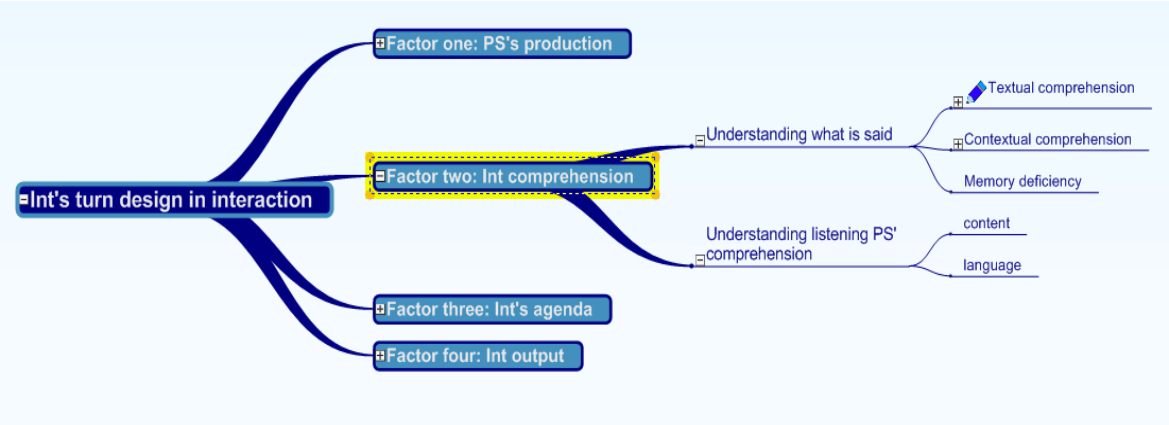
Note: PS stands for primary speakers, the Dr and Pt. Here the PS is the Dr.

The first factor that affects the Int's turn design, as shown in the following diagram, is the Dr's turn-design. When the Dr is speaking, he or she has a role in their mind for the Int to play. The Dr also anticipates the role the Int might want to play. If these two roles are not identical, the Dr may make an effort to align them into one. The Dr is also gauging the Int and Pt's language ability so that they can choose the right language for both of them. If the Dr thinks the Pt can speak sufficient English at some point they may speak to them directly. The Dr is also gauging the Int and Pt's ability to understand the content. Sometimes Dr would choose to explain some complicated concept to the Int first before they explain it to the Pt because the Int can understand better and also without having the Int understand it is not possible for them to interpret for the Pt.



When the doctor has spoken, it's now the Int who is going to understand it (2nd factor). The Int's understanding does not always match what the Dr wants them to hear and therefore, the turn-design will be affected. The following diagram demonstrates the factors involved in the Int's comprehension procedure. There are majorly two types of understandings the Int needs to achieve. They have to understand what is said and also understand how much the Pt can understand. The first understanding is about the language and context. It also has to do with their memory. Most of the time the Int is a non-native speaker of English, therefore, they may have difficulties in either the vocabulary, sentence structure, accent, or intonational cues. These may reflect on their troubled output in turn-design. Context comprehension includes understanding the context of a medical consultation (eg. the purposes and tasks of it) and the local context of what the Dr

is saying (eg: the reason the Dr is asking a particular question). Understanding has to do with the memory as well. If the Dr has said too much the Int may not be able to remember it all, let alone understanding it. Another comprehension is of the Pt's ability to understand the content as well as the language. If the Int thinks the content is too difficult for the Pt to understand they may just omit the difficult part or reduce the translation to something simpler, something they think the Ps would understand. Likewise, they may alter the language they use in translation in order to suit the Pt's understanding.



Note: the 'listening PS' refers to the Pt.

Factors 1 and 2 are interrelated with each other. However, the Int's turn-design is also affected by some autonomous factors—their agendas and their language and translation skills (output in the diagram). Int may have their agendas different from the Dr or the Pt. For instance, the family member may want to finish the consultation quick so that he would omit some information in the translation. A professional Int may add extra words into the utterance to establish themselves as trustworthy and professional to both the Dr and Pt.

Even if the Int has no problem understanding the Dr and has no contradictory agendas, they may still not be able to produce a good translation either because they do not have the language in the target non-English language or their translation skills are poor (translation is not just about knowing the two languages after all).

Up to here, you may have established this: there are things the Dr can do to improve the communication, Dr alone cannot change everything, the Int is not the only one to blame for interpreting errors, but Ints need to be trained.

5. TURN-DESIGN STRATEGIES

Obviously the turn-taking strategies can help improve turn-design (what do you think?). There are other things the Dr can do while designing each turn. Please read some more strategies and also rate them in the same manner as you just did:

8. Role orientation
   - ☐ a. Negotiate the Int role at the beginning of the consultation.
   - ☐ b. Explain why you want them to take a particular role.
   - ☐ c. Anticipate the role the Int may take (particularly with family Ints), if it may be different from what you want, verbalise what you want.
9. Context orientation
   - ☐ a. Anticipate whether the Int will misunderstand the context. If so explain. For instance, you may want to explain confidentiality at the beginning of the consultation and the importance of letting the Pt know it as well. Or you may not want the Pt to interrupt or ask questions when you are examining them.
   - ☐ b. Soft information (things like, signposting, showing empathy, or evaluating what the Pt has said) may be omitted. Therefore, it is useful to let the Int know these are important. Instead of saying 'I understand', you may say 'can you tell him, I understand'. Don't forget to use extended turns and pauses as well.
10. Linguistic awareness—knowing three types of sentences
    - ☐ a. Simple sentence—a sentence with one verb (prescribe, take, exam, am/is/are).
    - ☐ b. Compound sentence—two or more simple sentences linked with and, or, but, for, yet, nor or so. (eg: I will give you the prescription and you can get an appointment from the reception.)
    - ☐ c. Complex sentence—one independent clause jointed by one or more dependent clauses with because, since, after, although, when, that, who or which. (eg, The thyroid which is the glad in your neck is improving.)
    - ☐ d. The complexity increases from a to c.
    - ☐ e. Easy tip: be aware of how many verbs you are using in each turn. When you have used more than one verb, the sentence is no longer a simple sentence.
    - ☐ f. Better not to use one sentence with more than two verbs.
11. ☐ Understand that you alone can't change the world. As much as the Dr tries to improve the communication, there are always things that can go over the control. If it does not go well, see next time.
12. ☐ If possible use a trained interpreter.

Thank you for your time for reading this and rating the strategies. The interview will be guided by a question like: why do you think this strategy is or is not useful?

I am looking forward to seeing you.

Thank you very much for your participation

APPENDIX F PUBLICATIONS AND CONFERENCE PRESENTATIONS

1. LI, S. 2011. Communication: A New Challenge. RCGP. [Online]. [Accessed on 11th Jan 2011]. Available at: http://www.rcgp.org.uk/pdf/Communication%20A%20new%20challenges%20to%20GPs.pdf
2. LI, S., PEARSON, D. & ESCOTT, S. 2010. Language barriers within primary care consultations: an increasing challenge needing new solutions. *Education for Primary Care*, 21, 385-91.

Oral and postal presentations

1. LI, S. PEARSON, D. & BAYNHAM, M. Turn-taking system of interpreted triadic GP consultations and its implications for education of medical communication. Oral presentation at the 3rd International Conference on Conversation Analysis & Clinical Encounters, **2011**, University of York, UK.
2. LI, S. PEARSON, D. BAYNHAM, M. & ESCOTT, S. Understanding interactions in interpreted triadic medical consultations in primary care. Postal presentation at Bradford Institute for Health Research: Inaugural Research Conference**, 2011**, Bradford Institute for Health Research, Bradford, UK. (The **2nd prize** of best research poster)
3. LI, S. Challenges and Solutions to Medical Communication and Education. Postal presentation at Leeds Institute of Health Sciences Postgraduate Students Symposium, **2010**, University of Leeds, Leeds, UK.
4. LI, S. Turn-taking in Interpreted Triadic Medical Consultations in Primary Care. Oral presentation at Leeds Institute of Health Sciences Lunchtime Research Seminar, **2010**, University of Leeds, Leeds, UK.
5. LI, S. Understanding Interpreted Triadic Consultations in Primary Care. In: SARANGI, S., ed. Seventh Interdisciplinary Communication, Medicine & Ethics Conference Proceeding, **2009** Cardiff, UK. Cardiff University. (oral presentation)
6. LI, S. Understanding Interpreted Triadic Consultations in Primary Care. Postal presentation at Leeds Institute of Health Sciences Postgraduate Students Symposium, **2009**, University of Leeds, Leeds, UK.