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Participation and Conversational Involvement in Brokered Medical Interviews: A case of
Iraqi Patients in Southern California

A dissertation submitted in partial satisfaction of the
requirement for the degree Doctor of Philosophy
in Applied Linguistics

by

Afaf Nash

2014

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2014

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Dedication

To Sami, Nadia, and Dalia with love

ABSTRACT OF THE DISSERTATION

Participation and Conversational Involvement in Brokered Medical Interviews: A case of
Iraqi Patients in Southern California

By

Afaf Nash

Doctor of Philosophy in Applied Linguistics

University of California, Los Angeles, 2014

Professor Katrina Daly Thompson, Co-chair

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This dissertation uses the observation of patients' conduct as a basis for conceptualizing the social organization of participation and speakership in cross-linguistic medical encounters. Employing the theoretical foundations of conversation analysis, this study examines the actions of patients with limited English ability who depend on family members to broker their medical interaction. The inception of this research involved six months of field observation and community contact in the Iraqi community of Southern California. The argument developed in this dissertation is selectively based on recorded medical encounters from this fieldwork. Chapter 1

outlines the study and describes the data collection, participants, and the research site.

This chapter also reviews prior research from three relevant areas of interpersonal communication: patient-physician relationship, mediated medical interaction, and language brokering. In addition, the first chapter describes the theoretical and methodological concepts of conversation analysis and embodied communication. Chapter 2 analyzes how patients seek immediate contact with their physicians and language brokers despite limited linguistic abilities. Using a variety of semiotic resources, such as attention to interaction activities, prosody, touch, and minimum English knowledge, language brokereeers are found to override the brokering process and construct their patienthood independently. The chapter also describes the constitution of speakership during patients' interaction with language brokers relying on knowledge of personal experiences and the right to express such knowledge. Chapter 3 uses quantitative and qualitative analyses to study patterns of participation. Quantifying turns in conversation reflects patients' participation in relation to their interlocutors.

Qualitative analysis studies how varying ways of interpretation affect patient participation. Chapter 4 discusses the process of decision-making in the brokered medical encounters. The chapter demonstrates the complexity and sensitivity of reaching medical decisions in triadic interaction, in which roles of participation intersect and overlap in non-conventional ways. Mainly, the chapter demonstrates two factors that influence the process: the doctor expert knowledge and the language brokers' involvement in the interaction. The last chapter, Chapter 5, concludes the dissertation by presenting findings regarding non-English speaking patients' conversational contributions, brokered medical discourse, and the language brokers' influence on the

doctor-patient relationship. The chapter closes with a discussion of the limiting factors that prevent the generalization of the study findings. The chapter also suggests future research and provides recommendations to improve interaction in brokered medical encounters.

CHAPTER 1. INTRODUCTION

Rapid trends in world immigration have propelled researchers to examine the various aspects of the immigration and adaption processes, which include navigating the language and culture of the new environment—an integral part of the acculturation journey. Immigrant children often become the intermediaries for family members with low knowledge in the new language. According to the 2011 U.S. census, over 60 million people in the United States speak a language other than English at home, 15.4 % of this population reported speaking English “not well,” and 7% do not speak English at all. When seeking treatment, those individuals often interact with a system designed for and run by English-speakers. In such encounters, interaction is often facilitated by lay interpreters (e.g. hospital staff who speak the patient’s language), certified interpreters, or language brokers (untrained family members and relatives). Scholars are increasingly interested in analyzing the role of the mediator in facilitating cross-linguistic encounters, but little has been said about the linguistic and social role of the non-English speaking patient. With the increasing population of non-English speaking patients in the U.S. health clinics and hospitals, understanding their contact in such an important venue of life becomes vital. Interaction of Iraqi patients with limited English abilities mediated by family members is the analytical focus of this dissertation.

Based on theoretical and methodological conceptions of conversation analysis, this dissertation uncovers the orderly practices of participants in mediated medical discourse. It aims to understand the interactional role patients play, using the Iraqi patients as a case study, among their interlocutors and the ways in which they manage

their healthcare interactions and medical decisions. In a broad sense, this research endeavor has implications for understanding cross-linguistic communications and the human instinct to interact despite limitations. More directly, discussions presented in this dissertation offer significant implications on mediated encounters and on non-English-speaking patients participation.

Historically, interpreted discourse was viewed as a monologue of translating sequences of isolated utterances, and the interpreter's role as that of a *spokesman* or a *sender*, never a *source* or *addressee* (Nida, 1964, 1969; Reddy, 1979). But more recent studies evidence that mediated discourse involves more than one-way transmission of information and attest to the agency of interpreters, whether professional or untrained (Angelelli, 2004; Davidson, 2000, 2001; García Sánchez and Orellana, 2006; Mason, 2001; Orellana, 2001, 2003, 2009; Reynolds and Orellana, 2009; Eksner and Orellana, 2012; Roy, 1999; Wadensjo, 1998). With such focus on the mediator, less attention has been paid to the agency and accountability of the language novice who needs mediating. The questions, then, remain: what is the framework of non-native speakers' participation in mediated encounters, how do they influence interaction, and at what level are they understood by their interlocutors? Answering these questions elucidate our understanding about communications of non-English-speaking patients and the factors that contribute to, or hold, their satisfaction.

Influenced by pragmatic theories of language competence (Hymes, 1972; Sack, Schegloff & Jefferson, 1974; Goodwin, 1979; Goodwin & Goodwin, 1986), recent studies have argued for understanding competence as an interactional achievement rather than a language expertise (Firth and Wagner, 1997; Mehan, 1979; Goodwin,

2000, 2004, 2012) and a cooperative work of communication rather than an individual phenomenon (C. Goodwin, 1980; M. Goodwin, 1990, 1991; Sacks et al. 1974).

Accordingly, conversation competence is conceptualized as a contextual and negotiated strategy, a byproduct of a person's participation in an activity; thus, it differs by settings and norms of involvement. This conceptualization shifts the attention from the individual to the on-going interaction and centers the analysis on participating opportunities presented and utilized by interlocutors.

Interactional research in contexts of limited linguistic abilities, such as interaction that involve non-native speakers (Bolden, 2012; Mori, 2004; Mondada, 2004), an aphasia patient (Goodwin, 2004; Goodwin, 2003), Autistic children (Ochs et al., 2005), or novice members in a community (Ochs & Schieffelin, 1983) observes that language ability is not necessarily the only indication of how an interaction unfolds. Following a similar line of research, in this dissertation, I examine the interplay between interactional resources (talk, gesture, gaze) and the social role or identity of participants (patient, doctor, language broker) to arrive at understanding participation of patients with limited English proficiency. Whereas the majority of research on novice language speakers have centered on educational or family settings, this study contributes to a small but growing body of research on novice speakers in cross-linguistic medical encounters.

Research dating back approximately three decades has elucidated patient's participation in same-language medical interaction (when patient and physician speak the same language) as well as professionally mediated ones. Doctor-patient relationship has been viewed as a form of pre-established power asymmetry defined by communication between unequal parties in which the medical voice overpowers the

patient voice (Cicourel, 1991; Todd & Fisher, 1993; Heath, 1992; Mishler, 1984; West, 1993). Research on medical encounters mediated by professional interpreters has also viewed patient participation as structured by predesigned norms of institutional discourse (Davidson, 2000, 2001). This delineation of patient participation is in conflict with the recent ideological shift that emphasizes the moral and practical importance of patient-centered care (Anderson & Zimmerman, 1993; Heritage & Maynard, 2006; Institution of Medicine, 2003; U.S. Department of Health and Services, 2000). This dissertation examines patient participation in medical encounters mediated by family members.

Using family and relatives to mediate between two monolinguals is a common practice among immigrant families. This process is known as *language brokering* (Shannon, 1987; Tse, 1995; Orellana, 2003). Language brokers use their bilingual skills to translate, read, write, and do things for their families in everyday situations (Orellana, Dorner & Pulido, 2003). In the past three decades, scholars have been increasingly interested in investigating various aspects of this social, cultural, cognitive, and linguistic activity. Recent studies have conceptualized conversational goals as an activity achieved cooperatively between language brokers and their family members (Eksner & Orellana, 2012; Katz, 2014; Orellana, Martinez & Lee, 2012; Valdez, 2003). Although many facets have become lucid, more research is needed to understand the complexity of this practice. One aspect that has received little attention is the role of the individual who needs brokering. This study aims to fill this gap. In light of the three considerations mentioned earlier—1) theorizing competence as an interactional achievement among interlocutors rather than an individual phenomenon, 2) more specifically,

conceptualizing meaning-making in language brokering as a distributed effort among interlocutors, and 3) the growing population of non-English speaking patients in our clinics—I argue that the role of the novice English-speaking immigrants in healthcare as well as the opportunities presented to them are worth deeper analytical consideration. As language discordance may hinder delivery of good healthcare, this study illustrates the quality of communication in brokered medical interviews.

This dissertation provides an analysis of the micro-procedural issues of simultaneous and sequential participation in three ways. First, it examines simultaneous and sequential participation in bilingual and monolingual conversations: patients' contact with English-speaking physicians (cross-linguistic interaction) and patients' contact with the language brokers (same-language interaction). Second, the dissertation analyzes patterns of participation uniquely shaped, simultaneously and sequentially, by two forms of discourse: institutional discourse (via doctors trained by and working at state-represented institutions) and brokering discourse (via untrained interpreters with divergent linguistic abilities and personal attachment to the relative patient). Third, it analyzes the simultaneous and sequential work of meaning-making through grammatical structure and embodied means of communication. By highlighting these interwoven features of brokered medial interaction, I seek to provide an analytical lens for future research in such a complex, yet increasingly prevalent, context of communication in our modern society. I also aim to provide a tool for practitioners to serve limited-English-speaking patients better.

In the next sections, I will review and summarize literature on patient participation and relevant studies on language brokering. First, however, I start my investigation by

presenting the non-English-speaking individual by using the term *language brokeree*; I justify the use of this term below.

1.1. *Language brokeree*

Thus far, research has privileged the language broker's point of view; as a result, we know little about the individual who needs conversational mediation. This gap is evident in the absence of a specific term to refer to the person for whom language brokering takes place. Previous studies have addressed language novices in this context by referring to their position in the setting of language brokering (e.g., patient, asylum seeker) or by using kinship terms (e.g., mother, father). I start my investigation by referring to the novice individual as a *language brokeree*, a term coined to conceptualize the actions of the individual within the activity of language brokering regardless of position or relation, similar in that to the use of the term *language broker*.

My purpose of using this term is not to privilege the language brokeree in this activity, but rather to place the brokeree on an equal analytical footing with the other participants. Brokered encounters happen on behalf of the individual who needs language brokering; ultimately his or her role has been assumed without much investigation. Instead, scholars' attention has been centered on studying the language broker's mediating role: whether he or she merely transfers information between two monolinguals, or whether he or she may express more personhood. Orellana and her colleagues conceptualized the role of language brokers as "agents" and "social actors" whose role has significant ramifications to self, family, and community (Orellana, 2001; Orellana et al., 2003; Sanchez & Orellana, 2006; Orellana, 2009; Reynolds & Orellana,

2009). Building on this line of research, I study the role and the participation patterns of the language brokeree. I argue, here, that the language brokeree deserves similar attention when achieving meaning-making in brokered interaction. Grammatically, the suffix *-er* suggests an agentive function, though in this word it is part of the word stem itself. The word *broker* is defined as a negotiator, a person who acts on behalf of others, and an agent (OED, 2013). Certainly, the pronunciation of the word *broker* brings to mind a long list of nouns that index agentive functions through adding an *-er* suffix. In contrast, nouns ending in *-ee* represent a receiver of an action rather than an agent of an action. According to the Oxford English Dictionary, the suffix *-ee* is adopted from Anglo-Norman and added to nouns to parallel agent nouns ending in *-er*, or *-or*, and to denote a passive party (OED, 2013). In that sense, it is paradoxical to use a term that denotes passivity when studying an active role of a participant. However, the suffix *-ee* carries a passive value only as it represents a specific part of the activity: the initial receiving of an action, not before, during or after. For example, the noun *interviewee* does indeed denote the person who is subjected to an interview. In that sense it indicates passivity, but this passivity does not extend to actions prior to receiving the interview, or the interactional role and agency expressed during the interview. The term *interviewee* locates the person in the activity of an interview with the interviewer and interviewee being integral parts.

In the same vein, I choose the term *language brokeree*. It is true the person is a receiver of language brokering performed by the language broker, but I use the term to foreground not passivity, but rather participation in an activity of triadic parts. The brokeree is, therefore, an equal participant to the language broker in this triadic

interaction. Rather than calling the novice “the person who needs brokering” and the like. I will, therefore, define a *language brokeree* as an individual with various levels of linguistic proficiency in the dominant language who uses a language broker to facilitate and mediate his or her communication needs.

In the next sections, I will briefly review the language brokering literature leading to a later focus on interpretation in medical settings.

1.2 Literature Review

The analysis of this dissertation was informed by the theoretical and empirical studies from three diverse scholarly disciplines: language brokering, patient-doctor interaction, and mediated medical discourse. In this section, I review literature from these three research inquiries, as it relates to this dissertation.

1.2.1 Language brokering

Children in immigrant families often translate written materials and interpret conversations with native speakers for parents and other relatives (Orellana, 2001; Orellana et al., 2003; Tse, 1995). They perform this complex task in everyday situations (Orellana, 2001), such as healthcare visits (Cohen, Moran–Ellis, & Smaje, 1999; Garcia Sanchez, 2010; Katz, 2014), parent-teacher conferences (Orellana et al., 2003; Orellana et al., 2012), shopping centers (Reynolds & Orellana, 2009), and post offices (McQuillan & Tse, 1995), among others.

Among the first to mention this informal practice of translation were linguists documenting the bilingual development of their own children (Harris, 2008). These early precursors, however, pointed indirectly to young child translation practices in passing remarks and were not necessarily interested in exploring the phenomenon itself (Harris, 2008). Harris (1977) was first to give analytical attention to this untrained act of translation, naming it “Natural Translation”. Influenced by Chomsky, Harris (1978; Harris and Sherwood, 1978) argues that the translating ability is an intuitive and even an innate linguistic competence that exists in all bilinguals regardless of age or level of proficiency. Later scholars conceptualized the practice as a social and cognitive aspect that emerges to fill an essential communicational need. The phenomenon has been increasingly researched and its study population expanded to include children, teenagers, and adults from various bilingual backgrounds. It has been given various terms to emphasize different aspects of the interpretation act.

The term *language brokering* was coined by Sheila Shannon (1987), a researcher with a background in education and anthropology, in a two-year ethnographic study on the language use of five Latino immigrant children. It was not until a few studies were published in major journals (Tse, 1995; McQuillan and Tse, 1995; Tse 1996) that research on language brokering began to receive more focused attention. Besides *language brokering* and *Natural Translation*, the practice has also been referred to as *family interpreting* (Valdes, 2003), and *para-phrasing* (Orellana et al., 2003), and the broker have been referred to as *community interpreters* (Wadenjsö, 1989), and *immigrant children mediators* (Chu, 1999). Each term makes a certain aspect of the

interpreter's linguistic and social knowledge visible; the term *language brokering* is used most widely and is therefore the term I use in this study.

The work and outcomes of language brokering are quite complex. Language brokers do not only translate language for their parents, but they also mediate subtle cultural norms as well as social and institutional systems (García Sánchez, Orellana & Hopkins, 2011; García Sánchez, 2010; Orellana, 2009; Reynolds & Orellana, 2009; Valenzuela, 1999). Scholarship has approached this complexity from two divergent perspectives (Morales and Hanson, 2005). Many studies report positive experiences and outcomes that include feelings of confidence (Walinchowski, 2001) and pride in helping family (DeMent & Buriel, 1999; Orellana 2009; Tse, 1995), development of strong metalinguistic and interpersonal skills (Malakoff and Hakuta, 1991; Valdez, 2003), and gained academic skills (Martinez et al. 2008; Orellana et al., 2003; Valdes, 2002), self-efficacy (Love & Buriel, 2007; Weisskirch, 2005). However, other studies associate language brokering with premature adultification and feelings of stress (DeMent and Buriel, 1999; Hall and Robinson, 1999, Umana-Taylor, 2003, Valenzuela, 1999; Weisskirch, 2006; Weisskirch and Alva, 2002), as well as a shift of authority and power dynamics, which may impinge the parents' ability to manage the family effectively (Cohen et al., 1999). These studies and many others report mostly on the influential positioning of children as language brokers. Recently, adult language brokering has also been explored (Bolden, 2012; Del Toro, 2008; Weisskirch, Zamboanga, Bersamin, Kim, Schwartz, & Umaña-Taylor, 2011). Previous literature has mostly focused on the experiences of the language brokers, but some recent research has begun to study the practice as a family process rather than an individual phenomenon (Eksner & Orellana,

2012; Katz, 2014; Martinez et al., 2008).

A number of studies have situated language brokering within local settings in which people and background information are essential components of the analysis. These studies present language brokering as an ecological process that interacts with and is influenced by its local contexts. Orellana's work (2001, 2003, 2009) is the most comprehensive ethnographic analysis to date of language brokering, focused on immigrant Mexican families. To capture the complexity of the brokering activity, the author documented the child brokers' work at homes, playgrounds, schools, shopping malls, medical clinics, and other places in their community. Orellana's work, individually and with colleagues, explains how familial context, institutional discourse, and ideologies shape language-brokering experiences. Such a research paradigm analyzes the interactional aspects of the activity, looking at important issues such as the construction of morality (García Sánchez and Orellana, 2006), bi-directionality of acquired skills, (Dorner, Orellana, and Grinning, 2007), protection of family members against prejudice and stereotypes (Reynolds and Orellana, 2009), among others.

Although the focus on these studies has been mainly on the language broker, the research method allows for examining the role of other interlocutors in facilitating meaning-making. Orellana (2009), for example, observes how parents work with their children to decipher the language-brokering task at hand. Specifically, Eksner and Orellana (2012) note that parents provide word meaning, grammatical knowledge, and explanations of background information to reach communicational goals. Through this collaborative work, parents and their child brokers develop competencies and influence each other's life trajectories (Katz, 2014; Reynolds and Orellana, 2009; Orellana et al.,

2003; Valdes, 2003). Building on this conceptualization of achieving communicational goals as a task distributed among interlocutors, in this dissertation I study participation patterns in brokered medical interviews and aim to contribute a critical understanding of language brokeree's role during the medical interaction.

Undoubtedly, language brokering is an essential and omnirelevant activity used to compensate for the lack of language competence among immigrant families. Sometimes, however, it may hold back the language brokerees' participation (Bolden, 2012; Del Torto, 2008) and impair their management of outcomes (Cohen et al., 1999). For example, Del Torto (2008) documents not only situations of miscomprehension in which interpretation is directly requested, but also those in which former child brokers will, as adults, intervene and offer brokering even in situations when the older generation can effectively manage interaction with the younger generation. Galina Bolden (2012) also shows that sometimes language brokers use their language and cultural competencies to gain the right to speak on behalf of others.

This dissertation also confirms that language brokers' ways of mediating interactions have significant impact on patients' participation. I certainly found language brokering to be the main strategy by which novice speakers overcome language barrier. However, the extent to which the voice of the language brokeree came through depended on number of variables one of which is the language broker's level of responsibility toward parents. Additionally, this dissertation examines other characteristics, such as institutional discourse, that influence patient participation. This study endeavors to make the role and needs of non-English speaking individuals visible in such a high-stakes domain as the healthcare, which in turn promotes patient

satisfaction. To embark on this task, I will briefly survey the existing literature on patient participation, and then I will sum up findings on the state of non-English speaking patient participation in mediated encounters.

1.2.2 Patient participation in medical interaction

A rich tradition in doctor-patient communication research dating back approximately three decades led to several insights on patient participation in medical interaction. A central theme of research on medical interaction is asymmetry, which is said to be characteristic of the doctor-patient relationship (Circurel, 1983; Frankel, 1990; Mishler 1984; Waitzkin, 1983; West, 1993, 1984; Fisher and Todd, 1983; Wodack, 1996; Drew, 1991). Mishler (1984) discusses doctor-patient relations in terms of conflicting voices that involve fixed roles of dominance by the doctor and submission by the patient. He posits that the voice of medicine has a set of goals to be achieved that restrict patients' participation by means of questions and topic changes.

Questions, as a means of exchange information, play a significant role in the structure of doctor-patient interaction. Due to the relatively fixed roles of doctor and patient, it is accepted as the norm for doctors to ask the questions and patients to give the answers. West (1993) finds the doctors introduce, develop, and exchange topics through questions. In this manner, doctors seem to sustain control over the progression and outcome of the interaction. Some studies posit that patients' questions are treated as less relevant to the interaction than those of doctors'. Paget (1993) finds patients' questions are often ignored, and Shuy (1983) shows that patient requests for

clarification often result in diagnostic labeling rather than providing increased understanding.

The evidence, then, suggests a dispreference for patient-initiated questions. There is, however, also evidence that suggests this dispreference is mutually constructed by both the patient and the doctor. Heath (1992) argues that although asymmetry in doctor-patient relations is institutionally produced, it is, however, interactionally preserved. Ten Have (1991) also argues that while doctors do generally have control in doctor-patient interaction, both parties have opportunities for more symmetrical interaction. For example, patients enacted passive participation by not asking questions even when given the opportunity (Heath, 1992; West, 1993). Heath (1992) finds that in instances of doctors presenting information, patients tended to remain silent, which consequently enabled the doctor to move on to the next phase. It appears, then, there is an element of consensus in the patient accommodation of power asymmetry.

Recently, there has been continuous effort in the western medical atmosphere to move toward patient-centered medicine in comparison to what was true thirty years ago (Heritage and Maynard, 2006). Involving and informing patients are some of the ways to balance the asymmetries inherent in doctor-patient relations. Physicians have begun to notice the large improvement in patient involvement and adherences to healthcare when following effective communicational strategies (Roter & Hall, 2006). One of the ways to achieve patient satisfaction is to study the intricacies of patient-doctor communication.

Conversation analysis (CA) has served as an important tool to address the structure and organization of medical interaction and patient participation (Heritage & Maynard, 2006). CA studies use microanalysis of doctor-patient communicational patterns to exert a significant influence on the patients' overall satisfaction. For example, Heritage et al. (2007) find that a simple change in the inquiry form from "Is there something else that you would like to address in the visit today?" to "Is there anything else that you want to address in the visit today?" has had a dramatic effect on patient satisfaction. More importantly these studies prove that patients play an important role in their own healthcare (Robinson, 2003; Stivers, 2002). By examining these interactional intricacies, CA studies have the potential to improve medical communication by encouraging physicians to attend carefully to patients' contributions and involve them in the presentation of their problems and in treatment decisions.

A considerable and growing body of conversational analysis research has investigated how doctor-patient interaction unfolds in real time. Part of this research analyzes patient-doctor roles during each specific phases of the medical encounter. Typical medical visits have an overall structured organization (Byrne & Long, 1976) that is divided into five phases: problem presentation, history taking, examination, diagnosis, and decision/treatment (Robinson, 2003). Interaction in each phase is organized within its own structure and as a part of the whole medical consultation structure. Research suggests that patient participation may differ depending on the phase of the medical visit (Halkowski, 2006; Heritage and Robinson, 2006; Heritage and Maynard, 2006; Ten Have, 1992). For example, whereas the opening phase provides space for the disclosure of the patients' agenda and concern (Heritage & Robinson, 2005, 2006), the

history-taking phase is organized to embody the concerns and understanding of the physicians (Boyd & Heritage, 2006). During the diagnosis phase, patients are found to be passive—orienting more toward actions and information that follow in the decision or treatment phases (Robinson, 2003). Patients, however, may be more inclined to negotiate actively with doctors during the treatment phase (Stivers, 2002, 2006). More research is needed to tease apart the factors that contribute to patient participation and satisfaction.

This section has briefly reviewed studies on patient participation and doctor-patient communication in same-language medical consultations. In the next section, I will review research on patient participation in mediated medical visits.

1.2.3 Patient-doctor communication through mediation

With increased diversity in our society has come increased pressure to provide equal treatment to limited-English patients. Title VI of the Civil Rights Act of 1964 was the first legislative act to establish the need for professional interpreters to ensure patients receive meaningful access to healthcare. In August 2000, President Clinton issued Executive Order 13166—*Improving Access to Services for Persons with Limited English Proficiency*, which reiterated the importance of federal agency programs to ensure equal access and benefits for limited-English patients. In response, healthcare institutions have been mandated to provide interpretation services for limited-English speaking patients (Allen, 2000). Additionally, legislation has banned the use of children as interpreters in healthcare and denounced the use of bilingual hospital staff (Angelelli, 2004, Allen, 2000). Government funded agencies have become increasingly interested

in issues of cross-linguistic communication. Medical interpretation services, for example, have issued codes of ethical conduct and pursued the establishment of interpretation certification policy (Angelelli, 2004; California Healthcare Interpreters Association, 2002). As of January 2006, at least 43 states enacted one or more laws addressing language access in healthcare settings, California, where I conducted my research, has more laws (about 70) addressing language access than other states (Chen et al., 2007).

The heightened attention to cross-linguistic contact in health care settings is matched by scholarly attention from diverse scholarly disciplines. A central issue in related research is notion of neutrality and invisibility of the interpreters (Angelelli, 2004; Mason, 2001; Wadebsjö, 2004). Other recent research has begun to study the effect of the interpreter's agency on patient participation in managing their healthcare (Bolden, 2000; Davidson, 2000; Hsieh, 2007). In this section, I will review literature on professional medical interpretation; then I will look into research conducted on medical interaction facilitated by language brokers.

1.2.3.1 Professional medical interpreters

Many studies in translated discourse have challenged the notion of invisibility in the prescribed role of the medical interpreter (Angelelli, 2004; Bolden, 2000; Davidson, 2000, 2006; Metzger, 1999; Roy, 2000, Wadensjö, 1998; Wadensjö et al., 2004). Wadebsjö (1998) problematizes neutrality by addressing the distribution of responsibility among interlocutors. In the same vein, Davidson (2000) observed and recorded 50 visits for the purpose of examining how the interpreter's presence shapes the course and content of medical interviews. The topic of visibility in professional medical

interpretation continues to draw scholarly attention due to its theoretical and empirical implications on the services provided for patients with limited English proficiency. For example, a recent international conference on Non-Professional Interpreting and Translation (NPIT2) in Germany produced several presentations concerned with analyzing micro and macro analyses of the interpreter's role, such as "Some reflections on the translator's repair activity in medical consultations" (Ticca, 2014) and "The ethical habitus of the healthcare interpreter: volunteerism and institutionalization" (Aguilar, 2014).

These studies and others demonstrate the visibility of interpreters as authors of texts (Angelelli, 2004), coordinators of communication (Roy, 2000; Wadensjö, 1998), institutional gatekeepers (Davidson, 2000; Wadensjö, 1998), and historical agents who adhere to social structure of power (Hatim & Mason, 2005). A general consensus has been reached defining professional interpretation as a form of institutional discourse that takes place in state-sponsored institutions (hospitals and clinics) and regulated by a state-run or state-sponsored educational system (Aranguri, Davidson & Ramirez, 2006); therefore, professional interpretation often advocates and maintains a specific form of formal discourse. Institutional discourse is defined by reinforced habits of interaction that includes predetermined rights and obligation with attention to time and behavior of self and others (Atkinson & Heritage, 1984; Cicourel, 1983; van Dijk, 1993; Gupta & Ferguson 1997; Wodak, 1996). Unfortunately, this formal training sometimes leads to restrained patient participation and preserves the asymmetrical pattern of doctor-patient communication.

Several studies demonstrate that professional interpreters take on and support the healthcare provider. Davidson (1998) argues that professional medical interpreters are directly influenced by both medical habits of communication and restrictions of time spent on clinical practice. In so doing, interpreters may act far more as institutional gatekeepers than as patients' ambassadors or advocates (Davidson, 2002). In addition to keeping track of time and the order of consultations (Davidson, 2000), they may also pay more attention to doctors' speech by translating doctors' talk more than that of patients (Amato, 2004; Davidson et al., 2006). Professionally interpreted discourse, thus, may reinforce asymmetries that are already inherent in medical discourse as a form of institutional discourse.

Other studies investigate the interpreter's role from the perspective of the interpreters themselves. These studies suggest that interpreters are restricted by their role descriptions, which limits the parameters provided to work (Greenhalgh & Scambler, 2006). Some interpreters expressed tension between adhering to their role and feeling the need to act as advocates for patients and families (Fatahi et al., 2005; Norris et al., 2005). Some of these studies propose that patients had a preference for family interpreters because they share feelings of concerns and trust (Edwards et al, 2005; Greenhalgh & Scambler, 2006).

Along the same lines, a physician who participated in this current study intimated a preference for family interpreters because they, as he expressed, save time and help patients to communicate information with ease. Families in this study also confirmed that they feel more comfortable with family members. Examples in this dissertation, however, will demonstrate that on some occasions language proficiency and degree of

involvement of the language brokers interfere with the progress of the interaction and patient participation. This study will conclude with suggestions to support language brokers as well as patients and physicians.

In the following section, I will review studies that are focused on medical consultation mediated by language brokers, which is the central focus of this dissertation.

1.2.3.2 Brokered medical interaction

Children of different ages and linguistic abilities continue to serve as the health brokers despite governmental policies and institutional dispreference. They play a sensitive and important role as facilitators of their immigrant parents' medical communication. Besides brokering doctor-patient interaction, immigrant children perform a range of crucial duties that include making phone calls to doctors' offices, searching for and interpreting information on health insurances, filing doctor and health insurances forms, and getting prescriptions filled. Therefore, brokering medical care invokes a number of serious concerns such as the accuracy of exchanged information and the emotional burden on young brokers. Thus far, we know little about the complex domain of brokering in healthcare facilities (Katz, 2014; Martinez & Orellana, 2014).

A small but a growing body of literature has begun to examine children's and teenagers' brokering in healthcare settings and how it affects their families' experiences (Gohen et al., 1999; Katz, 2014; Garcia Santez, 2010, 2012; Martinez & Orellana, 2014; Orellana & Guan, 2014). These researchers are united in acknowledging that medical brokering is a domain fraught with tension. Their concerns relate mainly to two critical issues: the emotional well being of child brokers, and the accuracy of transferred

information. Doctors and medical staff generally oppose the use of children as interpreters for their families on a number of grounds. Rack (1982) describes the act of depending on children as interpreters in medical care as being “unethical” and “unprofessional.” Cohen et al. (1999) have raised the concern that children may learn about matters in the course of interaction that can lead to stress or disturb the normal order of power and authority in the family.

Shifting the attention to accuracy, Flores (2005) identifies five types of errors in medical interpretation: omissions, substitutions, editorialization, additions, and false fluency. Martinez and Orellana (2014) found all these types of errors exist in the data they collected from a multiethnic study with seventeen 9th-12th grades students. Despite finding these errors, the authors advocate for the right of immigrant families to use family brokers as well as interpretive services if available and desired by the families. The authors call for providing institutional support for the children who serve their families while also serving the medical institution in their role as medical brokers.

More studies are needed to further explore critical issues raised in previous research. In this dissertation, I will contribute to the larger debate about using children as brokers in healthcare and add the experiences of adult language brokers.

1.3 Theoretical Background

In this dissertation, I rely on the theoretical positions of conversation analysis and embodied actions. Below, I will briefly review the theoretical background and contribution of conversation analysis and embodied interaction as it relates to this dissertation.

1.3.1 Conversation analysis

From its inception, conversation analysis was developed to examine the forms of opening and closing conversation, the sequential organization of conversational turns, and the relationships between the actions our utterances perform. One of the core concerns of conversation analysis studies is the action performed by the language and the ways by which interlocutors demonstrate their ability to understand and cooperate with this action. The absence of understanding and cooperating is marked as a significant event (Schegloff, 2007).

The style of work that has come to be known as conversation analysis, or CA, is associated with the pioneering research of Harvey Sacks (Schegloff, 1992). The backdrop of conversation analysis is influenced by the work of many scholars in addition to Sacks. Austin, for example, was developing his Speech Act theory at the same time, which distinguishes talk as action (Austin, 1962). More importantly, CA is largely influenced by the work of Erving Goffman on interaction in face-to-face situations (1963, 1964, 1967) and Harold Garfinkel's method of understanding the social order people use to make sense of their day-to-day experiences, what he termed *ethnomethodology* (1964). In the late 1960s and early 1970s, CA emerged from the collaborative work by Sack, Schegloff, and Jefferson—who created the CA system of transcribing— (Heritage, 1984), which was concerned with analyzing ordinary conversation as “the primordial site for human sociality” (Schegloff, 1987:102).

Over the past 40 years, CA developed as a cross-disciplinary international research topic and method for studying talk-in-interaction. It also branched into two fields: basic CA—concerned with everyday mundane conversation, and institutional

CA—concerned with institutional interaction such as interviews, emergency calls, education, medicine, and law (Heritage, 2005). The principle goal of CA is to understand the structure and regular forms present in the social organizations within different settings (Atkinson & Heritage, 1984), and to uncover how participants of conversation publicly attend to doing interactional work (Goodwin, 1979; Sacks et al., 1974; Schelgoff, 1996). This occupancy is investigated in terms of five objects: turn-taking, sequence organization, intersubjectivity and repair, epistemology, and solidarity (Heritage, 2008). These theoretical underpinnings and findings of CA studies inform the analysis and findings of this dissertation.

Over the years, a growing number of studies on medical interaction have employed the methodology and theories of CA to uncover the orderly conduct of medical discourse and doctor-patient interaction (Boyd & Heritage, 2006; Gill, 1998; Heath, 1992; Maynard & Heritage, 2006; Stivers et al, 2005; Robinson, 2003; West, 1984). The CA method has been also used in medical discourse studies with professional interpreters (e.g., Aranguri & Davidson, 2006; Davidson, 2001, 2002) and brokered medical interviews (e.g., Garcia Sanchez, 2010). This current study continues with the same tradition to study the orderly contact of Iraqi patient with limited English abilities.

In the next section, I examine relevant studies on participant and embodied work, and analysis and findings that informed this dissertation.

1.3.2 Semiotic resources of interaction

With the beginning of CA research that focused on analyzing “talk,” another line of research began to develop that combines talk with other semiotic resources in

interaction. Early CA work depended on the use of audio recordings, but the availability of video recordings has made it easier to incorporate the role of embodied action in the organization of meaning-making, such as the work of gaze, gesture, body posture, seating arrangements, and materials in the environment. The work of Charles Goodwin and Marjorie H. Goodwin has greatly influenced the theoretical and empirical research on human communication.

This line of research shows that in building talk-in-interaction, speakers coordinate their utterances by employing different grammatical structures along with a range of embodied actions, such as gaze and prosody. For example, C. Goodwin's (1980) work on gaze shows how gaze, not just names, can be used to select the next speaker. C. Goodwin (2007) also argues for an alternative way of studying reported dialogue. He shows that investigation of reported speech needs to be based on multi-party sequences of talk that show the visible actions of hearers and speaker. In addition, he demonstrates that analysis of reported speech should not exclude utterances that lack syntactic complexity. Additionally, the Goodwins' work further elaborates Goffman's (1981) concept of participation framework. Their research shows that participation is a multicultural activity that involves an array of diverse phenomena of simultaneous actions of talk and other embodied means of communication (C. Goodwin, 2006; C. Goodwin & M. Goodwin, 2004). The analytical framework of participation and embodied interaction informs the analysis in this dissertation.

1.4 Data and Method

Clayman and Gill (2004: 590) explain that “observation is always directed toward conduct as it has been preserved in audio and video recordings, and this facilitates a highly disciplined mode of analysis marked by standards of evidence and analytic precision that are distinctive.” Following this approach, audio and video recordings have been the central method of data collection for this study. The data that informed my analysis is drawn from a larger corpus of twenty video and audio recordings in different language brokering settings. In this dissertation, I focus on ten video recordings and two audio recordings in medical settings. Participants were given the option of audio recording if they are felt uncomfortable with video recording.

Collecting incidents of naturally occurring language-brokering events as the main source of data is very challenging (Garcia-Sanchez, 2010; Katz, 2014; Orellana, 2009). Some difficulties are purely technical: keeping all parties who are involved in the conversation in the same camera frame at all times throughout the duration of recordings proves to be challenging. Often participants move out of the recording zone due to changing their positions and seating arrangements. The main difficulty, however, is due to the nature of the activity itself. It is not easy to anticipate when interpretation will be needed. Additionally, families are sometimes concerned that private family matters may become part of the recording. Such difficulties make certain language brokering settings easier to access than others. Doctor’s visits are relatively more systematic and are accessible sites for collecting language-brokering data as families have already scheduled appointments, but they are potentially more private and sensitive.

I collected data from families in San Diego County from December of 2012 for about six months. Early trips were mostly to initiate contacts with families and the community. I visited and talked to people in Iraqi restaurants, shops, grocery stores, a mosque, and a gas station. I also visited the office of Chaldean-Middle Eastern Social Service (CMSS), a non-profit center that provides a range of services for the Arab and Middle Eastern community in San Diego, with the majority of their clients are Iraqi immigrants. I visited the office four times during which I interviewed the director, staff, and the psychologist of the centre. In two of these visits, I sat in the hallway and observed the dynamics of the office and the types of services provided. Translation is one of the most sought-after services; immigrant families and individuals bring their written documents (immigration letters, medical and bank statements, bills, etc.) and the staff members help them translate and respond if necessary. Another important CMSS service is their Behavioral Health Program. It is an outpatient program that provides mental and psychological assessment and intervention for families and individuals traumatized by war experiences or cultural shock after immigration. I met two of the families in my study through CMSS, and three families I recruited through word of mouth. I visited the families before collecting data to introduce myself and explain my study. After I informed them of the research process, I obtained consent forms from parents and their language brokers. I collected recordings of doctor's visits (including one audio recording) and other brokering settings, such as in the shopping mall, at the pharmacy, and at home. For this dissertation, I analysed the recordings from the medical visits only.

In the fall of 2012, I received UCLA Institutional Review Board approval for this data collection protocol. The collection process included informed consent forms for both adults and minors and was provided in Arabic and English. The study was also approved and funded by UCLA Centre of Brain Culture and Development. In addition, I was awarded the Graduate Division Research Mentorship for 2012-2013 for the proposed study.

1.4.1 Participants

Six families participated in this study; my analyses focus on data obtained from three of these families (recordings from the other families were not medical visits). All participants were given pseudonyms to protect their identities. For families with teenagers, I met the children in the presence of their parents and explained the nature of my study and what would be expected from their participation. The children signed consent forms that were provided in English and parents received those forms in Arabic to ensure they were fully informed of their children's rights. Adult language brokers signed consent forms in English, and language brokerees consent forms were in Arabic. Below, I will briefly describe the characteristics of the families in this study.

1.4.1.1 Family 1

I met Nada in at the hallway of CMSS, where she was busy translating a form for a middle-aged woman. While very engaged in translating and explaining the form, she was at the same time keeping an eye on the passing staff members, whom she interrupted to ask questions. I approached Nada and her relative and introduced myself.

I explained my study briefly and asked if they would be interested in taking part in my research. Nada explained that the woman accompanying her was her aunt, and that she does similar work for her parents and siblings. I asked permission to speak with her family, and we exchanged contact information. Later that day, I received a phone call from Nada's mother, Amal, saying they did not mind participating in my study. I met the family at their home in El Cajon County in San Diego. While sharing tea and traditional Iraqi cookies, I explained my study and obtained consent for their participation.

Amal is a 36-year-old Christian from Mosul, a city to the north of Baghdad. She immigrated with her husband, four children, and father-in-law to the U.S. after spending three years in Turkey waiting for a refugee visa. Although the family is originally from Mosul, they lived for many years in the central area of Baghdad until they left the country because of the wars and the poor economic and security conditions. Amal has four children—three girls and one boy—the youngest of whom is a four-year-old daughter born in Turkey. Amal married her high-school sweetheart right after high school and received no further education. She explained that she understands English very well, but she believes she has no competence in speaking the language. She attended adult English classes provided by the city for immigrant families, but that stopped because, as she explained, classes were crowded and taught unsuccessfully. Amal's oldest daughter, Nada, is the family's designated language broker.

Nada is a 17-year-old high school student. Her siblings, a 16-year-old sister and a 14-year-old brother, speak fluent Arabic and Chaldean Neo-Aramaic (the language of Iraqi Christians in some cities in northern Iraq); they also have high and developing proficiency in English. Nada's mother, however, depends mostly on Nada for translation

purposes, especially for family medical visits. Nada interprets medical visits for her mother, her brother (despite the fact that he speaks English well), her younger sister (four years old), and her grandfather. I recorded samples of her brokering for each of them. Occasionally, Nada interprets for other relatives, neighbours, and friends, but I did not have the chance to record such incidents as they happened randomly. Nada explained that she loves brokering for her family. In fact, she informed me that she convinced her father to rely on her rather than on other relatives or strangers. Her first brokering experience was at the immigration office. She confided that her work for her family bothers her only when it interferes with her school schedule, which makes it hard to catch up on homework. In a recent follow-up phone call, I learned that Nada is in training to be a nurse.

1.4.1.2 Family 2

In November 2012, I participated in the annual meeting of the American Anthropology Association. I presented the findings of a research I had conducted with four Arabic language brokers prior to my dissertation work. During this conference, I met a researcher who also works with Iraqi immigrant families in San Diego. Through this contact, I met my second family at their apartment in El Cajon County. The family consists of an Iraqi Christian couple from Baghdad plus the wife's mother, Salma. At the time this couple were in the process of bringing their adult married children, along with their families, over from Iraq to the U.S.

Salma's son, Hamid, is the designated language broker for his mother. Like his sister, Hamid also lives at the same apartment complex with his own family: a wife and an adult daughter. I met Hamid during my first visit and after explaining the study I

obtained consent forms from the family. In that visit, I recorded Hamid translating an immigration letter for his sister and a medicine label for his mother. Later recordings were obtained from Hamid brokering his mother's medical visits at an eye clinic and a hearing aid specialist.

Salma is 77 years old. She came from Baghdad just few months prior to my meeting with the family. At the time of the first visit, she was very concerned and emotional about leaving her two adult grandchildren because she had raised them following the sudden death of their mother, Salma's oldest daughter. Like her younger daughter, Salma was hoping to bring her grandchildren to the United States. Salma seemed in a very good health and energy, but suffers some common aging symptoms such as moderate blood pressure, high cholesterol, and moderate hearing loss. I recorded five visits to the hearing aids specialist and one visit to an eye doctor.

Hamid is in his early 50s. He is married and has one daughter who was attending college at the time of our meeting. Hamid came to the U.S. five years ago after serving as a translator for the American Coalition during the war. He left the country fearing for his and his family's lives as some strict groups were targeting people who cooperated with the coalition, considering them as traitors. In response to my question about whether or not he is satisfied being in the U.S., Hamid expressed that he gained safety but lost his home, friends, and career. He said immigration for adults is like a "slow death" but he is happy that his daughter has a better chance to live a safe life.

1.4.1.3 Family 3

The third family in this study is a personal relative who lived in San Diego at the time of the data-collecting phase of this study. Karim is a 73-year-old Muslim from

Baghdad who lives with his son Nathan's family. Karim is generally in good health, but suffers a mild condition of diabetes controlled by diet and high blood pressure treated by medicine. I recorded a few at-home translations of mail, medicine labels, news, and immigration letters. I also audio recorded one doctor visit, and observed one pharmacy interaction.

Nathan is 45 years old, married and has three young children (a boy and two girls). As the family mostly depends on services provided by Arabic-speaking people, Nathan does not need to translate for his father outside the house very often. The primary doctor for Nathan's father is an Arabic speaker; however, Nathan still drives his father to all his medical visits as well as other matters outside the house. Translating, thus, is just one of the many things that Nathan does in taking care of his father. Occasionally, the doctor orders certain preventative medical procedures or blood work done at the hospital or medical labs, in which Nathan has to broker his father's interaction with English-speaking medical staff.

1.4.2 The site

According to the United States Census Bureau (2010), the city of El Cajon in San Diego County has a total of 14.4 all-land square miles. Seventy percent of inhabitants are White, followed by African Americans, Asians, Hispanics, and other minority groups, one of which is the growing Iraqi community. In 2010, Iraqis made up about one-quarter of El Cajon's population of 96,000, a quarter of the number of Iraqi refugees in the United States. Most of the Iraqis in El Cajon are Christians, but Muslims also share the city with Iraqis of other religious backgrounds such as Mandeans, Kurds, Turkmen,

Assyrians, and Chaldeans. There is no official number that documents the percentage of these different groups of Iraqi immigrants in the city. Driving around the city, the influence of the Arabic language and culture is visibly evident; many street signs in Arabic advertise grocery stores, restaurants, and various types of social, legal, entertainment, and health services.

1.4.3 Data analysis

I used discourse and conversation analytical methods to analyze my data in the form of video and audio recordings. A key element in such analysis is attention to various features of communication (overlaps, repair, volume, pitch, gaze etc.) as ways by which interlocutors perform action and respond to action. Such analysis take into account the fine-grained subtlety of transference of knowledge that participants treat as relevant (Ochs, 1979). Conversing successfully is possible simply when a recipient understands a prior utterance and responds accordingly. The receiving and delivering of a message is most effective when it is designed in consideration of the recipient's epistemic status. This simple but fundamental concept, known as "recipient design," is defined as the ability to tailor a communicative behavior to a particular addressee (Garfinkel, 1967). The breakdown of understanding occurs when interlocutors fail to employ recipient design. A typical example of communication failure is caused by the use of specialized terms in certain contexts such as medical or legal environments. In addition, language barriers create obvious obstacles to understanding in bilingual situations. How participants display their (mis)understanding of prior talk or other communicative modes can be empirically examined by analyzing the organization of

talk, which includes verbal utterances as well as interactional embodied behaviors such as gaze (Goodwin, 1980), gesture (Goodwin, 1993, 2007), and position of participants relative to another (Hutchins, 1995; Csibra & Gergely, 2006).

In analyzing my analysis of the interaction during language brokering, I will discuss conversational practices of interpretation such as turn taking, questions and answers, and initiation of action within the frame of recipient design, grounding the analysis in participant orientation flows that focus on sequencing, actions and details (Maynard & Heritage, 2005). Through systematic fine-grained speech analysis of participants' talk, this dissertation offers critical understandings of speakership, meaning-making, and negotiating decisions during brokered medical interaction.

Conversation and discourse analytical methods capture the details of what is said and how it is said through a transcription system created by Gail Jefferson in the late 1970s and further developed by Jefferson and colleagues (Sacks et al., 1974; Jefferson, 1984). For the Iraqi language, I transcribe utterances to capture the participants' regional dialects (dialectal variation, however, is not part of this analysis) and personal speech habits including language errors. In other words, I transcribe the speech in Iraqi Arabic as it was actually spoken. The phonological description of the Iraqi consonants and vowels will be presented in an Appendix 2 at the end of this dissertation.

1.5 Overview of the Dissertation

This dissertation is divided into five chapters. Chapter 2 analyzes how patients initiate immediate contact with their physicians and language brokers overriding the brokering process to construct their patienthood. I demonstrate that non-English speaking patients use a range of verbal and non-verbal communicational means to achieve their communicational involvement. Chapter 3 employs quantitative and qualitative analysis to study the distribution of talk during brokered medical interviews. I argue that despite the active role these Iraqi patients play during the medical interactions, they nevertheless speak the least of all participants in the encounters. I also demonstrate that the ways language brokers mediate during these interactions has a significant influence on the patterns of patients' participations. In Chapter 4, I discuss the process of decision-making in brokered medical interviews. I show that the participation of limited-English speaking patients in making medical decisions is structured by both the doctor's authority and the language broker's method of brokering. In Chapter 5, I present the social and linguistic conclusions that can be drawn from this study and provide recommendations on how physicians can better manage their communication with limited-English speaking-patient.

Chapter 2: Constructing Patienthood through Active Participation

2.1 Introduction

Translation is one obvious way to communicate when there is a language barrier. Beyond relying on others, individuals with diverse competencies communicate using linguistic and paralinguistic means to overcome limitations (Goodwin, 2004, 2012; Mondada, 2004; Orellana, Martinez and Lee, 2012). Employing multimodal semiotic practices, interlocutors make use of resources at their disposal to invoke common thoughts and communicate effectively (Clark, 1992; Couper-Kuhlen and Selting, 2001; Goffman, 1981; Goodwin 2000, 2003, 2012; Gumperz, 1995). This theoretical understanding of human competence has been examined empirically in a number of studies on people with linguistically diverse and limited ability, such as infants (Amador & Adams, 2013), aphasia patients (Goodwin, 2000, 2004, 2012), non-native speakers (Seedhouse, 1998; Hosoda, 2003), and child language brokers (Orellana et al., 2012). In this chapter, I extend this line of research to study the interactional competence of non-English speaking patients.

In this study, non-English-speaking Iraqi patients rely on family members to mediate conversations with doctors and medical staff. Close analysis reveals that language brokers are not the only means by which these participants manage their healthcare. As well be seen, on many occasions, language brokereeers override the brokering process to initiate immediate contact with their physicians and language brokers. The analysis of such incidents is the focus of this chapter. This analysis

contributes to a larger debate on the human instinct to interact (Joaquin & Schumann, 2013), cognitive ability to overcome limitations (Goodwin, 2012), and development of competent members in the society (Ochs and Schieffelin, 1986). More specifically, this study addresses non-English speaking patient participation in brokered medical interviews with a view to illuminating the interactional role of the language broker and the patterns of communication in brokered medical interviews.

2.2 Co-existence of Limitations and Competence

Research on interactional competence is ultimately research into social cognition. Traditionally, such inquiry has centered on language and its connection to perception (e.g. Chomsky, 1965; Pinker, 1989). Emerging research on communicative competence and speakership, has challenged the view that language expertise—as an attribute of cognition—is the only omnirelevant property for social interaction. Instead, the new research direction conceptualizes interaction as a process of adaptation between the agent and the local environment conveyed through a number of available semiotic resources (Clark, 1985, 1995; Edwards, 1997; Goodwin, 2000). Such research extends its empirical investigation beyond knowledge of lexicon and grammar to include other communicational modes such as gaze, gesture, and prosody.

In his groundbreaking work, Goodwin demonstrates the ways in which the organization of action, as shown in the analysis of simultaneous and multilayered semiotic resources, elucidates competences and cognitive abilities. Goodwin (2004) argues that only by expanding the analysis “beyond the grammatical abilities of

individuals to encompass multiparty sequences of talk and embodied action” that we can theorize about human ability (p. 151). Such a research paradigm is best tested in a context of linguistic limitation in which other interactional resources manifestly create meaning-making. Goodwin demonstrates his theory by studying the interaction of Chil, an aphasic patient whose stroke left him with no more than three words: *yes*, *no*, and *and*. In addition to the three words, Chil’s linguistic repertoire includes prosody, gesture, gaze, body posture, as well as the ability to operate on talk produced by his interlocutors. This rich linguistic repertoire helps Chil function as an independent speaker who adds, contradicts, evaluates and performs other complicated interactional practices (Goodwin, 1995, 2000, 2002, 2003, 2012; Goodwin and Goodwin, 2002). Context is crucial in rendering programmatic abilities visible (Goodwin, 2000; Goodwin and Goodwin, 2004; Goodwin and Duranti, 1992). Common communicative goals, intact perceptual ability, and close relationships create a contextualized situation that enables Chil to employ the interactional resources available to him. He communicates by building his contributions on his interlocutors’ complex sentences through his simple words, gestures, and rich expressive prosody. For example, using pointing, *yes*, and *no*, Chil chose a specific activity from a list of guesses Chuck, his interlocutor, offered him in a complicated scene that included many other possible options (Goodwin, 2003). These interactional properties are essential in linguistically limited and non-limited conversations (Clark, 1995; Gumperz, 1995; Goodwin 2000, 2012; Goodwin and Goodwin, 2004). Goodwin’s work provides indisputable evidence that language is by no means the only way in which humans enact their communicative competence.

Research on interaction involving non-native speakers is another research

ground that challenges the traditional notion of competence. A growing body of literature investigates the pragmatic norms used to achieve communicational goals among interlocutors from diverse linguistic backgrounds (Firth, 1990; House 2003). For example, Firth and Wagner (1997) show that non-native English speakers often use long pauses to indicate a desire to change the topic or end the conversation. Other investigations of pragmatic competence come from studies on non-native speakers in educational settings. Researchers have shown that the interaction of language novices is enacted through effective orientation to the interactional events and is not limited to language proficiency (Seedhouse, 1998; Hosoda, 2003; Egbert, 2004; Mondada, 2004). Analyzing the ways in which such interactional events are constructed is as important as the content of the message they carry. This study builds on the above-mentioned lines of research to study the communicational norms of patients with diverse language abilities.

2.2.1 Defining limitations through brokering

Languages as well as cultural norms and power structure are some of the challenges that immigrant families face and negotiate during language brokering. Families often develop strategies to deal with such difficulties. Choosing family members over available ad hoc interpreters, such as staff members who speak the immigrant language, is one of the strategies by which parents can exercise their authority and agency (Katz, 2014; Martinez and Orellana, 2014). Katz (2014) notes that parents perceive ad hoc interpreters in healthcare as being rushed and unwilling to help, and therefore prefer to depend on their bilingual children.

Recent research into the organization of interaction in language brokering has begun to reveal some of its intrinsic structure. For example, scholars observe that language brokers mutually employ strategies with parents to decipher communicational tasks (Dorner et al., 2007; Eksner and Orellana, 2012; García Sánchez and Orellana, 2006; Katz, 2014; Orellana, Martinez and Lee, 2012; Orellana, 2009; Valdez, 2003). Orellana (2009) finds children and parents work together “to figure out what is required to respond” (p.55). Constructing meaning making often involves pulling on multimodal practices from both the language broker and the language brokeree’s *linguistic repertoires* (Orellana, Martinez and Lee, 2012). Orellana et al. (2012) shows how a student works with his father cooperatively using gesture, prosody, and their two languages—English and Spanish—to translate and fill a school form. Katz (2004) also finds language brokers rely on parents’ help and support during healthcare visits. Through these collaborations, immigrant families overcome limitations to arrive at shared knowledge and achieve interactional goals. In despite of a focus on the language brokers’ actions, these recent studies provide evidence that meaning-making is mutually achieved by both the language broker and the language broker.

In this study, I divert the attention away from the language broker to focus on the language brokeree’s communicative competence. In doing so, I by no means minimize the role of the language broker. Rather, I intend to contribute to the relevant literature by studying the actions of non-English speaking patients aiming to shed light on their role and interactional capacities, the better to understand the intrinsic structure of language brokering interaction.

2.2.2 Conversational Commitment

Part of the geography of cognition is the visible work of orientation to specific phenomena in the immediate environment (Goodwin, 1981; Goodwin and Goodwin, 2004; M. H. Goodwin, 1980; Rogoff, 1999; Kendon, 1985; Tomasello, 1999; Vygotsky, 1978). Interlocutors position their bodies in away that allows and creates “a public and shared vision and cognitive attention” (Goodwin, 2007:57). This field of attention toward an object in the local environment creates the basis on which multiple actors build their actions as relevant and as central to intersubjectivity (Tomasello, 1995). Accordingly, embodied actions as well as talk are signs of conversational involvement that is best placed within the large sequential organization of the ongoing activity (Goodwin, 1979; Sack et al., 1974; Schegloff, 1968). This is crucial in rendering actions as relevant to the ongoing activity and competence as a visible attribute of cognition. In this vein, the communicative competence of people with limited language is not demonstrable unless examined within the local environment of their interaction. For example, recent innovative work shows the importance of shared attention in soliciting participation from autistic children and rendering their action as relevant to the task at hand (Ochs et al., 2005).

Participation in a context of limited abilities and linguistic diversity underscores important aspects of human interaction such as a willful commitment to interact and careful attention to activities in progress. Contribution to interaction is achieved through a turn-taking system (Sacks et al. 1974; Sacks, Schegloff & Sacks, 1973; Schegloff, 1992). This may be obvious, but managing this system and its implications concerning participants’ contribution is considerably complex.

The question starts with how a turn is constructed. Sacks and colleagues (1974) note that turns regularly have a three-part structure: one shows relation to prior talk, one involves its own contribution, and one addresses the relation of the following turn. These relational orders latch turns to each other. Speakers pack their actions at one or more of these parts. Turns, then, display actions in sequence taken by focused interlocutors. By taking a turn, interlocutors demonstrate the obvious but complex nature of their attention to the development of the conversation. This carries many implications for human beings' imaginative expedients for interaction when a common language is not shared.

Besides shared attention and systematic turn taking, the structure of situated discourse is another crucial element that works as a contextualized clue to render competence as visible attribution of cognition (Goodwin, 2004). Goffman (1981) observes that there is an "interactional order," part of a bigger social order, which governs the dynamics of everyday life. For example we reciprocally exchange greetings and we answer when we receive a questions. These are implicit rituals that members of a society follow in face-to-face situations, or what Goffman calls "co-presence". Situated interaction is structured in a way that allows members to perform and sustain a social identity set by the role they play. In a medical encounter, the discourse is structured to allow for a systematic exchange in which the patient and the physician perform their roles accordingly. The performance of our role is essential to our self, and thus, is aptly assessed and reevaluated.

This chapter is concerned with unfolding the interactional commitment of non-English speaking patients. The task is to look closely at the organization of action

constructed by Iraqi patients to see how they regulate their participation to construct an agency of patienthood. By studying how patients organize their involvement, I seek to uncover the communicational intricacies that define the patient-physician relationship in brokered medical encounters. My findings show that patients' initiated actions and responses occur frequently in brokered medical interaction. By exploiting various sequential spaces, patients present concerns, answer questions, and add information through their own initiative. These findings warrant paying more attention to the conversational role of non-English speaking patients, which in turn may enhance the outcomes of medical visits.

In two major sections of this chapter, I study how language brokereeers exercise their communicational involvement as they interact with their physicians and language brokers. The analyses demonstrate how language brokereeers often override the brokering process to present their own health condition.

2.3 Interaction beyond Brokering

In this study, the patients redefine their role as language brokeree—a person who depends on a language broker—to establish themselves as first-hand speakers beyond depending on an interactional proxy. The setting of the interaction as a medical interview that has a specific structure (describing the medical problem, answering the doctor's questions, voicing concerns, etc.), as well as the social order of interaction (greetings, intonation of questions, etc.) create the environment that facilitates joint attention (Tomasello, 1999) and “common ground” (Clark, 1992) that enables language

brokerees to communicate. In such a rich context, language brokeree employs a host of semiotic practices (e.g., embodied actions and limited English) to overcome limitation and interact independently. The interactional events analyzed in this chapter exemplify how patients use a range of communicational resources to exercise their competence and cognitive abilities.

2.3.1 Monitoring the unfolding of conversation events

Research suggests that eliciting patient accounts and views of their illnesses increases understanding and commitment toward the doctors' advice (Heritage and Maynard, 2006). In brokered medical interviews, patients answer questions through language brokers. Often, however, adult language brokers--as the first receiver of the question--occupy the conversational space that is functionally built for patients to give their account, as exemplified in the encounter below. This encounter starts with a point of reference to a previous visit in which the doctor diagnosed the problem and ordered a hearing aid for Salma, who tried the device for about a month but was not satisfied with it. In the fragment below, Salma (SAL) comes for a second visit to present her hearing experience. Hamid¹ (HAM), the language broker, starts, in line 03, to describe the reason for the second visit.

Excerpt 2.1.a

03: HAM: the sound, it':s not (0.3) very [well].

04: SAL: [abad

¹ Hamid has limited English language proficiency; grammar mistakes in the fragments below are original.

² The Iraqi [r] is pronounced softer than the emphatic trill [r] found in most North African countries. A single

Never

05: HAM: even- even if she adjust [it. aah-

06: SAL: [wrāsi [yūj 'nī min ahh-aḥuṭha
And my head hurts when I put it

07: HAM: [daqīqa
Wait a minute

08: HAM: even she adjust it, with the volume, but it's still the

09: sound not hear it very well. a::nd (.) she s:ay that he h:ad

10: some headache o-on it.

In line 03, rather than translating, Hamid directly informs the doctor about the reason for the visit, explaining that the sound of the device “is not very well.” The agent in his sentence is the device, or one of its properties. Salma, the patient, voices her own account in line 04, describing her condition as “’abad” [never, at all]. She adds her contribution by recognizing the activity going on: the fact they have come to voice a complaint. She describes her concerns: she can’t hear at all. Heritage and Robinson (2006) note that eliciting the medical problem is the main conversational space that is built functionally so patients can give their own account and express their agenda. Hamid in line 03 initiates the description above; Salma may appear to upgrade his description from ‘not very well’ to “abad” never, but upgrading indicates understanding the prior utterance and Salma does not know English. Salma instead is building her own turn to express her account of her hearing experience. Their conflicting agendas are clearly evident from the ways they build their next turns. Salma in line 06 makes use of Hamid’s hesitation in the prior turn (displayed through the token “aah”) and interrupts to continue her complaints. She presents herself as the agent reporting on her condition using first person pronouns: “My head hurts when I put it.” She is arguing that the central problem is the lack of sound, with the headache as an equal and related

complaint. Hamid continues his turn in line 08 from the point where he started line 03: that the sound is not good even if she adjusts it. After Salma's interruption, however, he switches from speaking directly to reporting what she is actually saying through "she say." In so doing he separates her complaint into two different problems. Due to Salma's action, Hamid changes from participation to brokering (from talking directly to brokering her complaints). In many ways, Salma's turn redefines the roles of the participants to its more expected form. Salma's response demonstrates recognition of the structure of the medical interview--the interactional space where patients voice their problem. She builds her utterance as she analyzes the on-going activity observing the gestures of her son. Hamid talks to the doctor using hand gestures to explain the problem, shown below:



Figure 1a: sound not good



Figure 1b: sound not good

03: HAM: the sound, it':s not (0.3) very [well.

04: SAL: [abad
never

Hamid in line 03 shakes his hand repeatedly with palms facing each other as he describes the sound of the hearing aid. Salma observes her son as he speaks. His gestures serve as a contextual cue to inform Salma that the talk underway is already on business. Later in line 06, Salma enacts her own gesture in a similar repetitive manner. In line 06, Salma initiates a gaze toward the doctor, changes it toward her son as she describes her condition, raising her hands up closer to her head while saying that her head hurts.



Figure 2a: My head hurts



Figure 2a: My head hurts

05: HAM: even- even she adjust [it. aah-

06: SAL: [wrāsi [yūj'ni min ahh- aḥuṭha
And my head hurts when I put it

07: HAM: [daqiqah
One minute

In line 06, Salma's words state the problem and her hands describe her headache. Goffman (1963) notes whenever people "co-present", they become the source of information for each other via two different kinds of activity: *give it*—things we say—and *give it off*—things we display in our actions. In that sense, one's expressions, linguistic

or otherwise, have formative power. For instance, in the excerpt below, Salma observes the interaction between her son and the doctor and once again her son's gesture informs her action.

Excerpt 2.1.b



Figure 3a: The right one



Figure 3a: The right one

- 11 DOC: for the right one?
- 12 HAM: (.01) the- th- ((points to Salma's ear))
- 13 Doc: o::h okay
- 14 HAM: =the right one, yes
- 15 SAL: =hāyyah ((points to her right ear))
This one



Figure 4: This one

In line 11, the doctor asks in which ear Salma has more difficulty hearing. Hamid hesitates with words in line 12 but points his finger toward the right ear. The pointing action becomes the source of information for both the doctor and for Salma; thus, they both index their understanding, the doctor with an “okay” and Salma by pointing at the ear with the most problems. The sequential structure of the medical interview—stating the medical problem at the beginning of the visit—and observing how the interaction unfolds as well as embodied actions become the substrate upon which Salma constructs her action.

2.3.2 Using basic knowledge in English

On other occasions language brokerees constitute actions using their basic knowledge of English to respond directly. Through attention to ongoing interaction, patients decompose talk and use their minimum English to practice their speakership. The excerpt below exemplifies this observation. Karim, a 73-year-old Iraqi man, has a modest capacity in English limited to a few greetings and common small words such as “yes,” “no,” “nothing,” and “thank you.” He is visiting a general practitioner to get a medical opinion on the growth on his arm as well as treatment. Prior to meeting with the physician, Karim had an X-ray and a short meeting with a nurse. The nurse filled a form with information about Karim’s general medical history and specific details about his elbow. In Excerpt 2.2.a below, Karim (KAR) and Nathan (NAT), his son who accompanies him as his broker, meet the doctor (DOC). Karim observes the greeting sequence between the doctor and his son and finds the interactional space to take part in the conversation, as explained below:

01 DOC: Hell:o
02 NAT: Hello doctor,
03 DOC: >Hi Hi<
04 NAT: How are you?
05 DOC: good it's Doctor Jenny nice to meet you nice to meet you
(Directing greetings toward Nathan and then Karim)
06 NAT: nice to meet you doctor. how are you?
07 DOC: good excellent let's switch those places so who is the
08 patient?
09 KAR: I am
10 NAT: mm abd[ul
11 DOC: [okay] you sit there you've a [seat here
12 KAR: [my son
13 DOC: and I'll sit here and now we're all comfortable
14 NAT: okay
15 DOC: oka:y
16 NAT: take a position
17 DOC: °that's right.

49

line 01. In line 02 Nathan greets back, adding the word ‘doctor’ that acts as a summons (Clayman, 2012), to which the doctor responds with a second greeting in a repetitive and rushed manner (indicated on the transcription by the “more than” symbol). Nathan and the doctor exchange more greeting turns. The doctor performs a formal greeting by introducing himself and extending a handshake to Karim and his son. In lines 04 and 06, Nathan asks a how-are-you question, which in a medical context is usually initiated by the doctor, offering a social mode of greeting sequence (Sacks, 1992) and a medical mode of presenting complaints (Robinson, 2006). The doctor then finds himself in a position to move the conversation from an exchange of greetings to a more institutional discourse. In this long set of greetings, Nathan is engaged in a sustained episode of interaction with the doctor. In his early work, Simmel (1964) points out that as mediators act between two parties, they either unite or separate. In the greeting sequence above, Nathan is temporarily inhibiting communicative contact with the language brokeree. In Goffman’s terms (1990), the language brokeree has been a *non-person* thus far and therefore enjoys certain unique rights in conversation, including choosing the entry into the conversation. But how do people enter a conversation?

Schegloff (1968) notes that a two-party basic conversation has a simple form of A-B-A-B, referring to people’s participation order in a conversation as “distribution roles.” In mediated interaction, one might expect the distribution of roles as follows: D, LB, LBe, LB, D, LB, LBe, etc. (where D is the doctor, LB is the language broker, LBe is the Language brokeree). However, studies show that such distribution does not always hold true. Wadensjö (1998) observes that mediated interaction usually alternates between triadic and dyadic exchanges. In this opening dominated by the gatekeeper

and the doctor, how does the language brokeree design a turn to enter the conversation? In line 07, the doctor ends the greeting session and returns to business, recognized by the question: "Who is the patient?" From this point on the question-answer sequences are expected to be predominantly about medicine. The question above thus constitutes the real beginning of the medical interview, known as a *switchboard request* (Sidnell, 2010), after some delay. By design, questions project turn completion, which provides the recipient with the interactional opportunity to initiate a turn (Pomerantz, 1984; Schegloff, 1992; Stivers & Robinson, 2006). In this question-answer sequence on lines 08-09, Karim seizes the opportunity offered by the doctor's question and responds with no translation. With an emphasis on the words "I am," he announces his role in the interaction as the patient and the subject of the main concern: his response reconstitutes the re-alignment between him and the physician. Karim constitutes his patienthood by responding directly without receiving interpretation, which gets marked by Nathan who reclaims his role in line 10 by adding the first part of Karim's compound name, Abdul (many male Arabic names are compound nouns consisting of Abdul plus another name, but Abdul is usually dropped in everyday conversation.) Although, he has a novice level of proficiency in English, Karim's response is initiated by his understanding of the doctor's role, the projectivity of question design, and his intuitive desire to be part of the conversation, demonstrated by his attentiveness to business/non-business parts of the conversation (Sidnell, 2010).

We have seen attention to ongoing courses of action enabling language brokerees to engage independently in the interaction. This same technique helps them to initiate unsolicited actions. In the last interaction above, and after the greeting and

Excerpt 2. 2.b

((Directing greetings toward Nathan and then Karim))

08 patient?

(0 . 1)

12 KAR:→ [my son

52

situated knowledge.

The doctor then examines Karim's arms and asks a number of questions related to his medical history and present condition. In line 53, the doctor asks Karim if he feels numbness in his fingers. Despite minimal English competence, Karim again initiates an answer without interpretation. By answering this complicated question, Karim promotes an alignment with the doctor and prompts his son to check his understanding:

Excerpt 2.3

44 DOC: open your fingers

45 NAT: iftaḥ – aṣābī'ak bāba,
Open your fingers dad

46 DOC: try harder hararr harrr,

47 Nat: qawiy qawiy,
Strong strong

48 DOC: very good

49 NAT: kūlliš zēn
Very good

(0.7)

50 DOC: pain?

51 NAT: 'alam,
Pain

52 KAR: lā°
No

(0.3)

53 DOC: °(okay)°good no numbness or anything like [tha-

54 KAR: [no no [no

55 DOC: [oh oh oh

56 NAT: bāba ya'nī šinū numbness, tu'ruf,
Dad what does numbness mean, do you know?

57 KAR: adri yqūlī ēdak da da tlammiš.
I know he tells me your hand is touchy

58 NAT: la-ee e ya'nī - ee-
No, it means, yeah-

59 KAR: ya'nī māko mal [hičī
It means when it is this way

60 NAT: [tnammil [tnammil ee
Numb numb

61 KAR: [tnammil
Numb

62 NAT: mm tnammil okay
Mm numb okay

63 KAR: ee hāda li 'aḡuṣda
Yeah, that's what I mean

From lines 44 to line 53, Karim answers and performs in response to questions about his fingers, with the doctor's turns gradually changing from instructions to questions about Karim's feelings of pain. The doctor holds Karim's hand during the course of administering the exam. Building on prior turns (questions about his fingers) and the embedded activity (pressing to check for pain), Karim can likely anticipate the next question still being about his fingers. The doctor's utterance in line 53 invites a simple response to what is the patient's most likely condition, given Karim's "no pain" answer in the prior turn and in the earlier history-taking questions. Demonstrating understanding of the prior talk, Karim takes the next turn and responds with an overlap, illuminating the sequential space for receiving an interpretation:

Excerpt 2.3.a

53 DOC: °(okay)° good no numbness or anything like [tha-
54 KAR: [no no [no
55 DOC: [oh oh uh

Besides recognition of the embodied activity, Karim responds to the doctor using other interactional resources. Karim is able to build a sequence-responsive turn without translations of prior turns by an interactional process referred to as “performing structural preserving transformation on prior talk” (Goodwin, 2012); a recipient takes apart a prior turn and builds a next turn using different verbal and non-verbal resources, some of which are reserved from the prior talk (C. Goodwin, 2010, 2012; M.H. Goodwin, 1990). In line 53, the doctor utters “Okay” and “good”--both simple words--with a soft voice (shown by the degree marker on the transcript), and marks “no” and “numbness” with stress. Karim, in line 54 initiates a response using these resources: paying attention to prior turns (earlier questions about pain and fingers), feeling the doctor’s touch (as he utters “numbness”), illuminating simple words (“okay,” “good,” “nothing”), and preserving important words (“no numbness”). Also, it might be worth pointing out that the word “numbness” shadows its Iraqi counterpart “tnammil” in some sounds (N and M). Karim’s ability to respond to this complex question gets the attention of both the doctor and son. The doctor’s next turn in line 55 is done in a repetitive manner matching the identical lexical items of Karim’s in line 54, indexing an alignment with the patient. Nathan goes on multiple turns to confirm understanding. In this example, the language brokeree initiates action using different semiotic recourses, allowing him to take an immediate part in the interaction.

2.4 Building Patient-hood through Grammar

This next excerpt exemplifies patient action in a context that differs from the above-mentioned examples in two key ways: the patient is younger and speaks English

well. Despite his fluency, his mother is used to having her daughter, Nada, present at all family medical visits. Nada is the oldest child in the family, a 17-year-old high school student, and the family's designated language broker. The family has been in the U.S. for about two years but the children speak English comfortably and manage their schoolwork well. The purpose of the visit below is to check on Rami's wrist. Rami is 14 years old and the only son in a family of four children. Earlier that month, Rami fell during a soccer game and fractured his right wrist. He was seen in the local emergency room where his wrist was put in a cast and he was instructed to see a doctor after three weeks. Before seeing the doctor in the interaction below, Rami's cast was removed and an X-ray taken. Rami, his mother, and sister then went into another room to see the doctor, who walks in just few minutes later. The whole visit lasted three minutes and 40 seconds. Excerpt 2.4.a below starts with Rami (RAM) explaining the accident to the doctor (DOC). The doctor first directs his question to the mother. The mother looks to Nada (NAD) for interpretation, but Rami answers first with his own account:

Excerpt 2. 4.a

- 01 RAM: ahh I was playing soccer and I fell on it.
- 02 DOC: Okay (0.1) and this wa::s January first?=
03 RAM: =January first ((with a head nod))
 (0.1)
- 04 DOC: Okay ((writing down on his chart))
- 05 RAM: °>first day of NBA game< ((smiling))
- 06 DOC: okay(0.2) th:en wa-was he seen here, or where's he seen=
 ((Shifting his gaze between the mother and the daughter))
- 07 RAM: =Yeah I was seen here. [(0.1) at the emergency room

((Doctor shifts his gaze toward Rami))

08 NAD: [in the emergency room

09 DOC: okay, and what did they do for you?

10 RAM: ahh they got an X-ray.(0.1) and th::ey put me the cast.

11 DOC: the cast [okay

12 RAM: [a::nd they told me co::me January twenty fifth

13 your next appointment

14 DOC: Okay okay you think it's feeling better to[day than when it

15 happened?

16 RAM: [Yeah it's very

17 better=

The main way children are able to participate during medical examinations is when doctors ask them questions. Studies show that physicians direct questions to their child patients as young as the age of two and a half. It is more common, however, for doctors to focus their talk with parents, even around children aged 10 or older who may be old enough to answer for themselves (Stivers, 2001; Stivers and Majid, 2007). Though Rami is 14 years old, the doctor still solicits information from the mother who in turn gazes toward her daughter for translation. Rami redefines his relation with the doctor through initiating immediate action before receiving interpreting in which he insists on giving his own account of his experience. In the above excerpt, Rami is not only redefining the child patient-physician relationship, he also redefines his language brokeree's status in the family by demonstrating his linguistic skills and his right to knowledge of his own experience. In line 01, Rami answers the doctor directly about the cause of the accident, and in line 03 he confirms the doctor's information by a partial repetition of the doctor's prior utterance, indexing an independent state of knowing from

the first speaker (Heritage & Raymond, 2005). In line 05, Rami solicits social rapport with the doctor, conveying his knowledge and love of sports by adding that the accident coincided with the “first day of [an] NBA game” (National Basketball Association). The next question is also directed toward his mother but in line 7 Rami performs a self-selected turn by latching his response to the doctor’s prior utterance, reporting on where he was seen for his injury. The falling intonation of his first transitional constructional units (TCU) and the small pause give his sister, the family language broker, a chance to take the floor to specify that “here” is the emergency room of the same hospital, but Rami continues to confirm his primacy by overlapping with his sister and demonstrating authorship over his experience. In the next turn, the doctor directs his question back to Rami, showing a tacit understanding of Rami’s role in the conversation. In line 16, Rami initiates an unsolicited upgrading of the doctor’s assessment question.

Excerpt 2.4.a

14 DOC: Okay okay you think it’s feeling better to[day than when
15 it happened?
16 RAM: [Yeah it:’s very
17 better

In line 14, the doctor’s question is designed to receive a yes/no answer. Declarative questions are often used to solicit information—from within the recipient’s domain—the recipient of the question is ultimately the one with the right to answer (Heritage, 2012; Heritage and Raymond, 2010). The doctor, however, prefaces his question with the hedging phrase “you think” instead of asking Rami directly how he feels. Hedging

phrases are commonly used when speakers feel they are violating a certain conversational maxim (Grice, 1979) and when referring to an epistemic modality, indicating an unwillingness to make an explicit commitment to the truth of propositions (Halliday, 1994; Hyland, 1998). In this case it serves to make a distinction between what Rami can *know* and what he can *think*. He cannot know that his wrist is better because he is not a doctor, but he can think it is better. One of the achievements of the conversation analytical method is demonstrating our tacit understanding of prior talk through the way we organize our next turn (Schegloff, 1992, Goodwin, 2010). Rami, first, responds to the doctor's yes/no question with a confirming answer: "yeah." Then he upgrades the doctor's evaluation from "better" to "very better", advancing the simpler answer he had given earlier. Studies show that the first speaker's assessment or evaluation becomes a terrain within which the next speaker may position agreement, disagreement, or adjustment toward the assessed item (M.H. Goodwin, 1992, 2010). Heritage and Raymond (2005) also point out that, by performing the repetition or upgrading of an assessment, speakers index primary rights to evaluate their state of affairs. In a "double-barred" action (Schegloff, 2007), Rami uses "yeah" to respond to the question and "very better" to respond to the hedging action, confirming his epistemic right to evaluate how he is feeling. As demonstrated above, Rami takes authorship of his experience and redefines the doctor-patient relationship by performing a number of actions: initiating responses to the doctor's questions, establishing rapport with the doctor, and upgrading medical evaluation.

In the examples above, Iraqi patients exploit various sequential organization and interactional resources to interact immediately with their English-speaking physicians

and construct their patienthood. Although the brokering process is essential to the progression of their medical interview, on many occasions patients answer questions and initiate unsolicited actions prior to receiving any translation. In so doing patients display a desire to maintain an immediate involvement in their healthcare and present themselves as active social and cognitive actors despite their linguistic limitations. They manage their participation by exploiting different sequential spaces such as turn-initiation, turn-responding, and turn-expansion. They are able to take actions by monitoring and analyzing the unfolding course of activities and drawing on interactional resources such as gesture, turn design, and basic English knowledge.

Next, I will explore the ways by which Iraqi patients maintain their independent participation as they receive interpretation from the language brokers. Research has noted that sometimes mediators may act as gatekeepers by withholding and coordinating the language brokeree's participation (Amato, 2004; Bolden, 2010; Davidson, 2002; Del Toro, 2010; Orellana, 2009; Roy, 2000; Simmel, 1964). In the following section, I will look into how patients in brokered medical contexts sustain their participation and present their own medical experience throughout the brokering process.

2.4 Building Patient-hood through Expansion

Just as patients respond to doctors' questions with their own initiations, I have also found them initiating unsolicited expansions to doctors' questions after they receive translation. In so doing, language brokerees confirm an epistemic status—knowledge about their own experience—as well as an epistemic stance—the right to such

knowledge (Heritage, 2012). In the extract below, the doctor asks about the medicine Karim is taking. Nathan plays the role of gatekeeper by responding to the doctor's questions directly. When Nathan translates the doctor's questions, Karim adds more information, thereby sustaining his role in the conversation:

Excerpt 2.5.a

- 82 DOC: any medical problems,
- 83 NAT: 'indak muškila šiḥḥiyya,
Do you have any medical problems
- 84 KAR: ba[ss-
just
- 85 NAT: [ha-high blood pressure. Diabetes=
- 86 DOC: =diabetes?
- 87 NAT: a:nd cholesterol
- 88 KAR: cholesterol. (0.1) ya'nī bass-
Cholesterol I mean only-
- 90 DOC: on on mm insulin or no insulin
- 91 NAT: no insulin just bills. bass taḵuḍ ḥbāyya mataḵ[uḍ insulin
You just take a pill you don't take insulin
- 92 KAR: [no no
- 93 no bass ḥbāyya. wnuṣṣ, mītiyn wḵamsīn
No just a pill, and a half one, two hundred fifty
- 94 NAT: okay okay two hundred fifty
- 95 DOC: okay (.) okay an:d any surgeries before?

On line 83, Nathan translates the doctor's question to his father. The father attempts to answer, but the son overlaps to take the floor instead, displaying his knowledge of his father's health. On line 86, the doctor asks a question about "diabetes" but Nathan continues listing Karim's medical problems. Karim again tries to initiate a turn on line 88

to offer what seems to be more information on his cholesterol level, but in line 90 the doctor chooses instead to expand on his diabetes question from line 86. Again, Nathan responds to the doctor's question and then translates it back to Karim. Finally, Karim in line 93 gets a chance to give his own account: he first confirms Nathan's information but further exercises his speakership through an unsolicited expansion of information: that his pill is only 250 g. and thus half of the usual amount. In the above sequence, requesting and asserting information constructs social action through which a state of epistemic state is displayed (Heritage, 2012). Whereas Nathan is answering the doctor's questions directly, Karim is able to sustain authorship through extending a turn to provide extra unsolicited information.

Sometimes, a patient's expansion on the doctor's questions displays the patient-specific agenda of the visit. In the fragment below, Excerpt 2.6, between Rami (RAM) and the doctor (DOC), whom we met earlier, the doctor examines Rami's fractured wrist and asks him about a bruise on it. The doctor puts pressure, shown in figure below, on Rami's wrist to check for pain as he utters line 53 below:

Excerpt 2.6.

53 DOC: and that doesn't hurt though?

54 RAM: no=



Figure 5: All purple

- 55 DOC: =this (0.1) bruising ha:s been since the injury?
56 RAM: Yeah
57 DOC: okay.
58 RAM: but it's (0.1) a lot more. like it was from he::re to here
59 and it was more darker it was a::ll purple.
60 DOC: Okay okay so it is better now?
61 RAM: Yeah it doesn't hurt.

Rami denies feelings of pain on line 54 despite the bruising on his wrist noted by the doctor in line 55, which Rami confesses in line 56 is related to the accident. Scholars have pointed out that the use of small lexical items such as *okay*, *well*, *so*, and *alright* signal a disjunction between the previous topic and the upcoming one (Beach, 1993; Jefferson, 1978; Sacks, 1966; Schegloff & Sacks, 1973). By using “okay” on line 57, the doctor is ready to transition to another topic. Rami, however, initiates a post-extension turn on line 58, further accounting for his improved condition despite the bruise. Throughout the visit Rami tries to convince the doctor that his injury has healed and he is ready to resume playing sports. The doctor makes Rami’s agenda and its questionable truth visible by the way he designs his questions. Heritage (2012) shows

that negative interrogatives are often designed to solicit agreement rather than request information. The “that doesn’t hurt” question offers Rami a turn for confirmation; tailing the question with “though”, however, hedges the projected confirmation. Rami therefore initiates an unsolicited post-expansion turn on line 58 to account for the doctor’s hesitation. The purpose of Rami’s action is to connect the faded bruise with improvement, whereas the doctor’s is to connect the bruise with a persistent condition. The doctor acknowledges Rami’s efforts at giving this long explanation and emphasizing key words to maximize their effect. On line 60, the doctor’s question “Okay okay so it is better now?” is an action-based and designed-based preference for confirmation (Heritage and Sefi, 1992; Schegloff, 2007), giving Rami a chance to confirm his initial answer to the question from line 54 by stating: “Yeah it doesn't hurt.”

Sometimes a patient’s expansion reveals a misunderstanding or misinterpretation of prior talk. Excerpt 2.7 below is from Salma’s first visit to the doctor. Recall that Salma is a 77-year-old recent immigrant with a hearing problem. Her son, who immigrated to the U.S. about five years ago, accompanies her to all of her medical visits. He has limited English proficiency, evident in his many errors and visible struggles while communicating. Some of these mistakes affect the accuracy of delivered information:

Excerpt 2.7

165 DOC: [have she ever had a loud noise exposure?

166 HAM: loud noise?

167 DOC: has she ever been around like in a job where there’s real

168 loud, a lot or there ahh-

169 HAM: tasma'īna fad aṣwāt qawiyyah fad šī min min-ahh
Do you hear loud strong sounds something from from-

170 SAL: l:a
No

171 HAM: no, she doesn't

172 DOC: okay
(0.2)

173 SAL: bass ma maf- ma asma' tilfizyūn ((hands extended forward))
Just I don't under- I don't hear the TV

In the above fragment, the doctor's question in line 165 is part of the history-taking process, but it is interpreted to the patient as a part of the diagnosis phase when the son uses the wrong verb tense in his translation. On line 166, the son (HAM) repeats "loud noise", indicating a trouble source in understanding (Drew, 1997) and a need for explanation. The doctor (DOC) treats this repetition as a problem of understanding and repeats the question with more details. The son mediates the question using the present tense, making the question sound like an inquiry about a present condition. His repetition of "min min-" following by the breathing sound *ahh*' indicates a continued difficulty in finishing translating the question. Salma denies hearing any weird noises. On line 173, taking advantage of the silent period after the doctor's turn, Salma (SAL) expands on the question by further explaining her hearing condition in the temporal state that she received the question: a present state. The answer on line 170 merely negates the question, the post-expansion turn makes it obvious that the received information is not the desired information.

In the first section of this paper, we found that language brokerees actively involve themselves in the conversation by working around the brokering process. The examples in this second section demonstrate that language brokerees are also actively

engaged in the interaction after receiving translation. They participate by expanding on the same turn or next turn to add more information. Next, I will explore examples of the patients' actions with the language brokers using their native language.

2.5 Unsolicited Responses to Language Brokers' Talk

Brokered medical interaction is marked with various levels of asymmetries: knowledge (expert-novice), linguistic (English-Arabic), and social structure (native-immigrant). Language brokers are tasked with mediating these encounters. The language brokers, however, are also limited by elements such as the realm of knowledge, social structure, and varied English abilities. In that sense, the language brokeree has to manoeuvre some of these asymmetries on their own initiative. The non-English-speaking patients interact with their physicians through the help of a mediator. Besides actions toward the doctor's talk, language brokerees contribute to the interaction by initiating actions directed toward the language broker's talk. Examples of these actions include reminding language brokers to ask important questions, insuring accuracy of given information, and supplying information when talk is delayed.

In Excerpt 2.8 below, Salma and Hamid are answering questions about the history of her health and her current condition. Repeatedly, and probably expectedly, we see adult language brokers act as caregivers with their elderly parents rather than assuming just the role of interpreters. In so doing, they may temporarily impair language brokeree participation. This point is important to consider, as this dissertation shows, the roles during language brokering are often overlapped, intersected, and distributed differently. Hamid asks and answers questions, explains, and adds information, often

before translating or confirming with his mother. On line 184, Hamid (HAM) performs a few false starts before completing his sentence. On line 187, Salma (SAL) initiates a turn in Arabic through which she performs a number of actions as will be explained below:

Excerpt 2.8

- 181 DOC: all the med she is taking right now? ((Extending a form to
the son))
- 182 HAM: Yes, this one for for thi:s time-
- 183 DOC: Okay
- 184 HAM: because she has some some p-pro-problem with ahh with amm
- 185 blood pressure.
- 186 DOC: Okay
- 187 SAL: hāy māl-ḡaḡaṭ,
This is for blood pressure
- 188 HAM: eyy huwwa da-yqullī -
Yeah, that is what he is telling me

A new immigrant, Salma arrived from Iraq just a few months prior and lives with her daughter and the daughter's husband. She suffers from what seems to be common aging illnesses. She has been seeing physicians for hearing loss, high blood pressure, and cataracts in her eyes. Despite these conditions, she appears to be in good health and good spirits. In this visit, the son and the doctor have mostly dominated the interaction, both often referring to Salma using third person singular pronouns. On line 181, the doctor (DOC) asks about the list of medicines Salma is currently taking. He performs his question by extending his arm to show the list of medicines on a form filled earlier. On lines 184 and 185, Hamid utters many false starts and repairs before

finishing his sentence. Hamid likely is performing a word search, trying to come up with the right medical term "blood pressure". Goodwin and Goodwin (1986) show that if a participant has difficulty finding a word, other participants often provide candidate words to help the talk progress. Attentively observing the event, Salma recognizes Hamid's efforts to finish his turn but is unable to come to his aid as she has limited proficiency in English. As Salma sits between the doctor and Hamid, she is able to look at the paper as the doctor pulls it back toward him. On line 187, Salma performs many actions through her self-initiated turn. Noticing her son's earlier efforts in line 184, she asks in her native language, using a low, soft voice: "hay mal ɖaɣaɭ" [that is for blood pressure]; the language broker confirms her guess. Salma's question is organized in a slight high-raising tone, to confirm rather than ask for new information (Heritage, 2010). The question is also performed in a soft voice as a face-saving act (Brown and Levinson, 1978), preventing any vulnerability her son may feel from her questioning his performance (Goffman, 1967). Selma's question confirms her knowledge that the chart she saw is the medicine list she filled out with her son prior to seeing the doctor. It is also a way of recognizing her son's hesitation and making sure to supply him with the right information. Her question additionally serves to inform her about which stage the medical visit has reached, since this question as well as others receives no translation. Through turn-initiation in Arabic and mentoring the ongoing activity Salma performs an action of clarification, indexing a stance of knowledge and involvement.

Salma continues initiating more actions, demonstrating the active role she plays during her medical visits and presenting her patienthood independently from her son's actions. In Excerpt 2.9 below, Salma and her son are visiting an eye doctor for a post-

surgery checkup. Salma had cataract surgery on her right eye a week before the meeting of the fragment below. In this visit the nurse (NUR) checks on her progress:

Excerpt 2.9

28 HAM: .hh because we have some ahhh mm- un-.hh understood I
29 between the pharm:acy and between the doctor about what
30 they said.
31 NUR: okay
32 HAM: ahhh that way we [need to be-
33 SAL: [šūf akū waraqa min at-tabīb
Look for a paper from the doctor

34 HAM: >yeah yeah< ((to his mother))
35 we need to be clear on it
36 NUR: Sure no problem
(0.3) ((Hamid unfolds a paper))
37 HAM: this what the pharmacy write. and this what the doctor-
38 (0.1) he give us a description about the drops so we just
39 need to be sure of ahh-aa this kind which one
40 NUR: Okay=
41 HAM: okay?
42 NUR: ah-umm
43 HAM: about this one is four drops we don't have any problem,
44 but about this one it's two drops, I think this one-
45 NUR: once a [day=
46 HAM: =ahh
47 SAL: [bass hāy hāy qah-taḡtalif
Just that one that one is different

In line 28, Hamid tries to explain that there is a discrepancy between the instructions they have received from the doctor and the pharmacist. On lines 28-30, he initiates many false starts and repairs in an effort to finish the sentence. As he holds the medicine bottles up, he points out labels to the nurse. Salma notices his arduous effort and points out that there is a paper from the doctor, probably the prescription, which may better explain the situation. Another way in which Salma demonstrates attentiveness and involvement during the medical encounter is asking for interpretation when it is delayed or not received. In Excerpt 2.10 below, the doctor and son join in laughter without first explaining why to Salma:

Excerpt 2.10

194 DOC: and you don't know of any family history of hearing loss?
 195 HAM: I'm her son. [(.) so haha we don't have any [hahahah
 196 DOC: [hah hhaa [no family
 197 history of hearing loss ((writing on his paper))
 198 only onl[y-ha-
 199 SAL: [šino
 What
 1200 HAM: yqūl 'iddkum aḥad bil'ā'ila ma-yasma',
 He said do you have somebody in the family who does not hear

The doctor's question about family history is formed to invite a confirmation; the question, however, is confusing to answer: is the doctor asking if the son has knowledge of their family medical history, or if any hearing condition exists in the family? Both doctor and son join in laughter, recognizing the potential double meaning of the question. The son then confirms that as a son he knows the family history, and that they do not have any hearing loss in the family. Salma is excluded from this exchange until

she asks. The son is ready to move on so he can expand more on the topic, but Salma notices the change in discourse and, in an overlap, initiates a request for an explanation, thus demonstrating her desire to be included not only in the business but also the social part of the interaction.

2.6. Conclusion

The findings of this chapter lead to a conclusion that patients with low English competencies construct their patienthood actively through monitoring interaction and deploying different kind of semiotic resources. They exploit various interactional resources and different sequential organizations of the turn-taking system. They constitute their participation by monitoring the unfolding course of action and analyzing the activity in progress. When interacting with the doctor in a context of linguistic diversity and limitation, they make use of different resources such as projectivity of question-design, composing and decomposing of prior talk, activity embodiment, and basic competence in English. During interactions with the language brokers, language brokereeers initiate actions and responses based on their knowledge of their own medical condition, and display an epistemic right to such knowledge. Using these various sequential places and interactional resources, patients practice attentiveness to talk-in-progress and analysis of the unfolding course of action whether in its medical or social mode. Most importantly, they explicitly solicit immediate contact, expressing their right to their patienthood and speakership.

This chapter, then, presents the ways patients act in order to promote their own immediate and active role in brokered medical interviews. I invite more attention to the

patient interactional contribution. On the one hand, these findings speak to human instinct and the need to communicate despite limitation; on the other, they provide valuable information on the non-English-speaking patients' role. Language brokering research puts great emphasis on the role of the language brokers. This study confirms previous findings in mediated interaction that show mediators' involvement may sometimes inhibit language brokeree's participation. Language brokerees, however, are found not to be just passively interacting through the brokering process. Instead, they sustain immediate involvement in their health care by actively providing important information about their health. Studies show that soliciting patients' accounts of their illness increases the patients' recall of information, understanding, and commitment to their doctor's advice. My findings, then, promote revisiting the roles of non-English-speaking patients and encourage more attention and consideration of patients' interactional contributions.

CHAPTER 3. DISTRIBUTION OF TALK: WHO TALK AND WHO TALK NEXT?

3.1 Introduction

In this chapter, I provide qualitative and quantitative analyses of distribution of turns-at-talk so as to elucidate understanding of patients' participation in brokered medical interviews. The background to this inquiry relates to an apprehension expressed repeatedly in the medical research that patients' participation is structured around doctors' initiatives. Brokered medical discourse differs from general medical interaction in that it combines formal and informal registers. On the one hand, brokered medical discourse is an informal conversation between two family members, and on the other, it is an institutional discourse between a patient and a physician. These two discrete modes of discourse, brokered and institutional, determine patients' opportunities to speak. With regard to participation rights, my analysis in this chapter relies on three questions concerning brokered medical discourse. First, to what extent are patients' voices being heard within these two discursive frameworks? Second, what variables affect the organization of participation? Third, what correspondence can be found between the frequency of participation, the way of brokering, and the length of the medical interviews?

3.2 Distribution of Turns

Who talks and who talks next is a simple if fundamental determination of conversational organization. Interaction, whether formal or informal, is organized by a system of turn-taking (Sack et al., 1974; Schegloff, 1996): one speaker takes a turn while the other(s) waits for its completion before beginning her/his turn. If the next speaker's turn does not take place, often the original speaker will self-select to initiate another turn (Goodwin, 1987; Sack et al., 1974). In this simple form of conversation, the dynamic of "one party talking at-a-time is organizationally primary" (Sacks, 1992: 34).

In a medical framework the physician projects an action (e.g., question/comment) and the patient acknowledges that he/she is the addressee of the doctor's talk through his/her own re-action (e.g., answer/question). This communicational norm preserves the distribution of participation among interlocutors and found to be prevalent in many cultures (Sidnell, 2010). When a third party enters the conversation, turn-taking must be reconfigured. A mediator is expected to take a turn after each of the aforementioned actions, translating sentences from language 1 to language 2. Despite this expectation, research shows that this is not always the case. Studies find mediators, whether professionals or language brokers, commonly initiate actions and pass over some turns of talk without offering translation (Amato, 2004; Angelelli, 2001, 2004; Bolden, 2000; Davidson, 1998, 2000; Garcia-Sanchez & Orellana, 2006; Mason, 2001; Orellana, 2003, 2009; Wadensjo, 1998; Wadensjo et al., 2004). This is especially true with language brokers who have a relationship with and feelings toward the language brokerees (Garcia-Sanchez, 2010; Orellana, 2009; Reynolds and Orellana, 2009). There remains

the question, then, of how much of the language broker's intervention facilitates or impedes the patient's turn-taking.

In institutional encounters, participants orient more toward their institutional identity and formal training. Doctor-patient communication is a formal discourse characterized by purposeful and predetermined goal-oriented forms of conversation (Atkinson and Drew, 1979). Studies find doctors to be the most talkative parties at consultations. Time is another relevant factor in institutional context; medical training pays attention to how much time is spent during patient-doctor consultations (Dugdale et al., 1999). Therefore, with the above-mentioned constraints in mind, how (and how much) is a non-English-speaking patient able to maintain involvement in a conversation?

3.2.1 Distribution of talk in professionally interpreted encounters

At issue in this inquiry are the divergence and similarity between professional and untrained forms of mediated discourse. Amato (2004) analyzes three doctor visits and finds that the sum of turns produced by physicians and patients is slightly smaller than the total number of turns produced by interpreters. Although Amato's findings may suggest that most turns are translated and knowledge is transferred between the two monolingual parties, analysis of zero renditions and self-initiated turns reveal otherwise. Amato observes that professional interpreters in her study privilege physicians as primary interlocutors by translating more doctors' turns than patients'. Davidson (2000) similarly asserts that interpreters do in fact convey much of what is said but they do so selectively. More profoundly, Davidson observes that interpreters are occupied with

keeping the medical interviews on track and physicians on schedule more than they are with bringing forth patients' agendas. Following a similar line of research, I have studied patterns of participation in brokered medical encounters. The analysis imparts knowledge of the ways in which language brokering diverges from professional interpretation in regard to patterns of participation. My findings suggest that although language brokers and professional interpreters similarly communicate information between the two monolingual parties, their behavior differs in substantial ways. Whereas professional interpreters share knowledge with physicians based on discipline training, the language brokers share knowledge with family members based on family ties. The source of mediators' knowledge influences their translating style. Statistical analysis and discourse-analytical examples in this chapter will illuminate these differences further.

3.3 Quantifying Interaction

Conversation analysts begin their endeavors from the point of observing a single moment of interaction; as Schegloff (1993) reminds us, "one is a number" at which any interactional phenomenon becomes a describable point of analysis (Heritage, 1984). It is important, however, to go beyond the analysis of individual moments to understand the prevalence of the observed phenomena *in situ* (Heritage and Maynard, 2006). Conversation analysts have long been quantifying interactional features informally using descriptive words such as "massively," "regularly," and "commonly" (Schegloff, 1993; Heritage and Maynard, 2006). As a means of identify the frequency of certain communicational patterns, conversation analysts increasingly have been using more

systematic coding analysis (e.g., Heritage and Maynard, 2006; Stivers, 2005; Stivers et al., 2009).

Schegloff specifies three essential components that determine the relevance of statistical analysis; 1) a defensible notion of denominator—“environment of possible occurrence,” 2) a defensible notion of numerator—“set of occurrences whose presence should count as events and whose non-occurrence should count as absences”, and 3) a named domain for the interactional event concerned (Schegloff, 1993: 103). The selection of an applicable denominator requires careful consideration, for an ill-chosen one invites flawed conclusions. The main condition is to choose an analytically relevant denominator for the interaction in question. For example, as Schegloff explains, choosing minutes to measure the frequency of laughter to examine the sociality of a specific age group is not a valid denominator as people do not laugh per minute. Quantifying analysis, then, should be used to specify a claim on an interactional event as it is relevant to the phenomena in question; it should not be understood as an alternative to qualitative analysis but “rather it builds on its back” (Schegloff, 1993 p: 102).

Medical research has employed both qualitative (Mishler, 1984; West, 1984; Atkinson, 1995) and quantitative analysis (Korsch et al., 1971; Cohen-Cole, 1991; Roter and Larson, 2002) to study physician-patient relationships. These two analytical frameworks have been kept separate, but researchers have begun to combine both methods to reach more robust outcome-based conclusions (Roter and McNeilis, 2003; Heritage and Maynard, 2006; Heritage and Stivers, 1999; Stiver, 2005, 2010). Heritage and Maynard (2006) draw attention to the importance of broadening the level of analysis

in order to generate findings at a statistically evidential standard. This chapter is a modest step in that direction. Although the amount of data I was able to collect for this dissertation does not admit of a broad statistical analysis of brokered encounters in general, adding a layer of quantitative methodology to my analysis nevertheless serves to identify patterns of communication among the participants in my study.

In this chapter, I present quantifying analyses of participants' talk-in-interaction in the course of three selected medical visits. In this analysis, I aim to generate a broad understanding of participation dominance and frequency. I also study turns of zero renditions—that is, turns left untranslated (Wadensjö, 1998)—to illustrate privileging patterns. Quantifying turns is intended to measure issues of frequency, dominance, and orientation in a dialogue (Amato, 2004; Drew, 1991; Markova and Foppa, 1991). This analysis engages with patterns of participation asymmetries. Asymmetries become salient only insofar as they restrict participation. In fact, without a certain level of asymmetry in knowledge and individuals' roles, communication might be needed less (Linell, 1990). Asymmetries in the turns taken by conversation participants underscore the distribution of opportunities relevant to participants' roles and the context of their conversations (Drew, 1991). By quantifying turns, I am not suggesting that counting the number of turns is significant in and of itself. Rather, as far participation rights are concerned quantification serves to further our understanding of conventions of dominance in brokered discourse. The main concern here, then, is the distribution of participation in a context of linguistic diversity. Also of concern is the turn-taking sequence of brokered medical interaction around which participation is organized.

To determine the extent of these concerns, I began by counting the total number of turns taken by each participant in comparison with the total number of turns per visit. Then, to quantify the patients' participation relative to their interlocutors in the course of each visit, I compared the percentage of each participant's turns within each visit and counted the number of turns with no translation. Results of such analyses offer a blueprint of the distribution of participation in brokered medical encounters and inspires investigating to why such patterns appear dominant.

In the following, I first describe the data material upon which this investigation relies, before providing quantifying followed by qualitative discourse- analytical discussions and findings. I then summarize contributions and provide a critical review concerning the possibilities of such analyses. The analysis reveals a symmetrical pattern of participation among interactants with the same role; yet, a wide asymmetrical range of participation among those interactants with different roles across examined encounters. These findings will be explored below preceded by description of data.

3.4 Data: Three Brokered Medical Interviews

Data presented in this chapter come from three first-time medical visits held at different medical facilities around San Diego County. Choosing first-time visits is intended to eliminate the possible influence of familiarity, such as doctor's familiarity with the people and cases, on the course of the interaction. These encounters nevertheless differ in ways that help chart the various profiles of language brokering among immigrant families. Two of the language brokereeers, one male and one female, are in their 70s, while the third patient is a young mother in her mid-30s. The age and

gender of the language brokers vary as well. The two older patients are accompanied by their adult sons, and the young mother by her teenage daughter. Further varying is the length of each encounter, which generally depends on the purpose of the visit. I argue that differences found in mediating style relate to the range of these variables, while similarities stem from the inherent features of the language-brokering discourse. Before proceeding to an analysis of this dataset, I will describe each encounter and specify the dominant communicational features found of each visit.

3.4.1 Encounter 1: General description

Encounter 1, the shortest in the dataset selected for this chapter, lasts a little over six minutes. As I set up the camera the doctor enters the room, gives one general greeting, and inquires further about the study. At the doctor's instigation, the patient and the language broker register their verbal consent, whereupon the researcher leaves the room to encourage authentic interaction.

In this encounter, Amal, a 36-year-old Christian immigrant from the north of Iraq, visits a neurologist to discuss the results of an fMRI that was ordered by her general practitioner. Her daughter, Nada, a 17-year-old high school student, brokers the interaction. Amal has been suffering from a severe headache that has prompted her primary physician to order the neurologist visit recorded here. The visit starts with a review of her fMRI results, followed by diagnosis, then suggested follow-up steps, and closing. The doctor assures Amal that the fMRI results show no serious problems in the brain. There is, however, some abnormality found with the nerves connected to her

eyes that suggests “high pressure in the brain.” The doctor orders a visit to an eye specialist and some blood tests.

Throughout the encounter, the doctor directs Nada to communicate the information to her mother by prefacing his utterances with “tell her.” Nada does so by quoting his utterances with “yqūl” [he says]. Nada, however, reports her mother words directly as saying, “she has an appointment.” In so doing, Nada aligns herself with her mother and becomes part of what she is reporting. As we will be seen in due course, the older language brokers in this study exhibit different patterns when managing information transfer. The level of involvement and responsibility each language broker assume influences her brokering approach, which in turn shapes the patient’s participation.

3.4.1.2 Quantifying Encounter 1

Number analysis in Table 1 shows that the participant with the most turns is the language broker, at 48 percent of all turns, followed by the doctor and then the patient. The sum of turns taken by the doctor and the patient differs by a small amount from the total number of turns taken by the language broker. This does not mean equal participation by the doctor and the patient. In fact, Amal’s turns are half the amount of the doctor’s turns. The proportion of broker’s turns to patient’s and doctor’s turns does suggest a close approximation between translated turns and all turns taken during the encounter.

After a brief greeting, the interaction starts with the diagnostic phase in which the specialist explains the problem based on the test results. This visit does not include some of the medical interview phases such as problem soliciting and history taking,

which depend heavily on the patient's knowledge and participation. Hence the patient's interaction is defined accordingly.

Participants	Number of turns	Percent of turns	Zero rendition
Doctor	30	35	0
Language broker	41	48	2 Mother's turns 5 Doctor's turns
Language brokeree	15	17	0
Total	86	100	7

Table 1: *Amal and Nada's Visit*

Seven turns of zero renditions are counted in this visit: two questions from the patient and five doctor's turns. Quantitative analysis of zero renditions does not support the privileging patterns found in previous studies with professional interpreters, as the patient's contributions are transferred the most. Qualitative analysis shown in a later section reveals that untranslated turns reflect the limits of Nada's linguistic ability, rather than privileging issues. Additionally, some of the untranslated turns are doctor's comments directed specifically to Nada to explain medical terms and avert misunderstandings.

Summarizing Encounter 1, the patient is the one who has spoken the least but is also the most translated participant in this encounter. Quantifying zero renditions shows

more untranslated doctor's turns than patient's turns, suggesting that the patient's contributions are treated as relevant and passed on to the doctor.

3.4.2 Encounter 2: General description

The second encounter lasts approximately twenty-four minutes. Before seeing the doctor, the patient meets first with a nurse who takes preliminary information, and then with a medical technician who administers an x-ray. Accompanied by his adult son, the patient is then moved to a different room where he meets with the doctor after a short period of waiting. This short waiting time is noteworthy, as it is a common feature in all of the medical visits recorded in this project. By contrast, one of the drawbacks of using professional interpretation in medical visits is the long period of waiting for an available interpreter (Davidson, 2001).

The patient is Karim, a 73-year-old man who is visiting the doctor for the first time with his 45-year-old son, Nathan. A month before this visit, Karim fell to the ground unconscious and was taken to the emergency room. The incident was treated as a heatstroke and Karim was released the same day. Afterward, a fluid began collecting on the top of his right elbow; Karim came to check on this condition in this visit. The physician-patient interaction lasts about fourteen minutes and includes all of the common medical interview phases: greeting, introduction, solicitation of problem, history-taking, examination, diagnosis, treatment, and closing. The visit ends with the doctor dispensing treatment and instructing the nurse to clean and wrap the affected area.

The prominent interactional feature in this encounter is delayed translation; Nathan often answers the doctor's questions first before translating back to his father. His brokering approach shapes the turn-taking sequence and reveals a discrepancy in the source and right of knowledge between Karim and Nathan. Nathan answers questions by drawing on second-hand information known as a B-event, whereas Karim speaks from a position of primary access to his own illness and personal experiences, an A-event type of knowledge (Heritage, 2005; Labov and Fashnel, 1977). Nathan also seeks a social rapport with the doctor and directly answers questions about his father's lifestyle—for example, about his father's living habits and work history (these interactional patterns will be exemplified in later sections). These specific features determine the amount and pattern of talk during this encounter.

3.4.2.1 Quantifying Encounter 2

In this second encounter, the language broker is once again the participant with the most turns—turns which occupy nearly half of the interaction—followed by the doctor, then the patient. The sum of the doctor's and patient's turns is higher than the language broker's, and the patient's turns are much less frequent than the doctor's. These numbers indicate that more turns are exchanged between the doctor and the language broker than turns translated to the patient. For part of the visit, Nathan sometime interacts only with the doctor, particularly during the greeting, introductory, and small talk. Whereas in the first encounter the language broker avoids unfamiliar terms or translates them incorrectly, in this encounter, Nathan ensures an accurate

translation by requesting clarifications. These patterns of interaction amounted to only twenty percent of the patient's participation in this encounter.

Participants	Number of turns	Percent of turn	Zero renditions
Doctor	104	35	0
Language broker	137	45	12 Doctor's turns 5 Father's turns
Language brokeree	61	20	
Total	302	100	17

Table 2: *Karim and Nathan's visit*

Zero renditions analysis shows that the patient is the most translated participant in this encounter. The untranslated turns indicate the percentage of dyadic turns exchanged between participants. For example, Karim sometimes answers questions autonomously, prompting Nathan to exchange multiple turns with his father to check for understanding; these turns are not translated. On many occasions, Nathan answers the doctor's questions directly without engaging his father. In sum, the brokering approach accounts for the amount of participation: Karim speaks the least, but is translated the most, similar to Encounter 1.

3.4.3 Encounter 3: General description

The patient in this third encounter is Salma, a 77-year-old Christian Iraqi immigrant from Baghdad who suffers from hearing loss. Her son, Hamid, in his early

50s, has been in the United States for five years and is the broker for his mother's medical visits. This visit is the longest encounter in this dataset, lasting close to thirty minutes; it included all the regular phases of medical interviews. The treatment phase lasts four minutes and involves a procedure to take impressions of Salma's ear canals. (Since Salma is physically unable to participate during this phase, these four minutes are not included in the analysis).

It is important to mention that despite Salma's hearing loss she appears to follow the conversation without difficulty. Seated proximate to her interlocutors, Salma responds promptly to questions throughout the encounter. The main feature that shapes the pattern and amount of participation is the son's level of involvement and his English proficiency. Even though Salma is in good health and good spirits, she is elderly patient, and Hamid accordingly assumes a high level of responsibility for her, acting more as a caregiver than an interpreter. Whereas Nathan in the previous encounter offers delayed interpretation that enables his father to continue participating, Hamid often answers the doctor's questions directly without translating back to his mother. The doctor also treats Hamid as the main interlocutor by asking him questions directly while addressing his patient using a third-person pronoun (e.g., "Do you know how long she has been suffering from a hearing loss?"). In fact, on three occasions the doctor takes multiple consecutive turns prompting Hamid to ask for time to translate. Hamid's English proficiency is another factor that shapes this interaction. For example, by using the wrong tense, Hamid translates a doctor's question about current condition as if it were a history-taking question, thus, the doctor receives a wrong answer. On other occasions,

the doctor engages in explaining medical and non-medical terms, which adds to the time spent between the two in a dyadic conversation.

Reaching decisions as to the best type of hearing aid for Salma is one of the most significant phases in this encounter. The doctor pushes for the type he believes to be the most suitable for Salma's degree of hearing loss. Salma, however, prefers a different type on account of its small size, which she finds more aesthetically pleasing. Despite this lengthy interaction, the patient's participation comes to no more than 15% of the total turns taken during the encounter.

In sum, the language broker's linguistic ability and assumed responsibility drive the ways in which participants manage the encounter. These characteristics portioned the patient's participation to no more than fifteen percent despite the lengthy visit.

3.4.3 .1 Quantifying Encounter 3

The previous pattern likewise prevails in this encounter, with the language broker producing half of the talk, followed by the doctor, and then the patient. The doctor's turns double the patient's, and the sum of the doctor's and patient's turns is much higher than are the language broker's turns. This suggests a higher level of participatory asymmetries amongst the three interlocutors. In fact, the percentage of the patient's participation in this encounter is less than that in the second encounter (which was twenty percent) even though this interaction lasts for almost double the time of the second encounter. It also suggests a long period of physician- language broker interaction without the involvement of the patient.

Participants	Number of turns	Percent of turns	Zero renditions
Doctor	164	37	0
Language broker	209	48	30 Doctor's turns 11 Patient's turns
Language brokeree	67	15	0
Total	440	100	44

Table 3: *Hamid and Salma's visit*

In table 3, the number analysis of zero-rendition reinforces the participation patterns uncovered by quantifying turn-taking: the doctor's untranslated turns are much higher than the patient's. This indeed indicates that more of the patient's turns are translated than doctor's, but it also reveals that more dyadic turns are exchanged between the language broker and the physician. Additionally, two of the patient's turns are translated but not answered by the doctor, and a few of the patient's turns that disfavored the doctor's choice receive no translation. Finally, this encounter is, of the three, the one most shaped by institutional voice, a circumstance that the doctor's agenda, the language broker's level of involvement and limited English proficiency combine to produce.

3. 4 Discussion: distribution of turn-taking sums

The length and reason for each visit should offer different opportunities to speak; surprisingly, however, the dataset analyzed in this chapter proves otherwise. In all three

encounters, participants who share the same role occupied approximately the same percentage of turns.

Medical Visits	Time (minutes)	Doctor's turns	Patient's turns	Broker's turns
Encounter 1	6	30 (35%)	15 (17%)	41 (48%)
Encounter 2	14	104 (35%)	61 (20%)	137 (45%)
Encounter 3	26	164 (37%)	67 (15%)	209 (48%)

Table 4: *Comparing Turn-taking*

Table 4 shows that the number of turns varies in each encounter but the percentage of these turns are within a close approximation. The ratio value relates the number of each individual's turns to the number of total turns within the duration of the medical visit. This close approximation of percentages reveals that participants with the same role have the same opportunities to interact despite the differences in time and structure of each visit—the first visit is short and focuses entirely on the diagnosis and decision phases while the other two encounters are longer and incorporate all phases of the medical interviews. This outcome indicates that some aspects of brokered medical interactions maybe pre-determined and institutional: contributions are taken when they are due and they are organized by interlocutors' role. The distribution of sums also reveals a dominant asymmetry—patients spoke the least, followed by the doctors, while the language brokers spoke the most. The percentage of talk between the patients and the physicians indicates that language brokers exchange more dyadic conversation with the doctors than the patients. These findings illuminate that brokered medical

encounters share some features with same-language medical encounters and professionally interpreted medical encounters. Similar to same-language medical interaction, the doctor is the most dominant participant, and consistently speaks more than the patient. And similar to the professional interpreters, the language broker exchanges more dyadic conversations with the doctor than the patient.

Within this general conformity, I found slight differences in the ratio of patients' participation that is worth further investigation. Patients' talk occupied approximately the same proportion (17%, 20%, and 15%), in encounters that varied in time (6, 14, and 26 minutes). In the next section, microanalysis will elicit an explanation for these differences.

3.5 Qualifying Turn Taking

In this section, conversation-analytical investigation of turn-taking reveals a number of important findings. First, it describes the turn-taking sequences of brokered interaction. Second, it helps to explain the differences found in patients' participation. Patients in this dataset try to actively ensure their participation despite the delimiting factors that shape each encounter. For example, in the encounter below, the doctors ask about the medicines the patients are taking. Each language broker treats the question differently, which in turn defines the language broker's turn—Nada relays to her mother to answer the doctor's question, while Hamid, the adult language broker, answers the question directly, as explained below:

Excerpt 3.1: AMA (Amal, patient), NAD (Nada, language broker), DOC (doctor)

89 DOC: what about the medication, she- is she still tak:ing-
 90 NAD: taḵdīn dawa?
 Are you taking medicine?
 91 AMA: n::o.

Excerpt 3.2: SAL (Salma, patient), HAM, (Hamid, language broker), DOC (doctor)

185 DOC: these're all the medicines she's taking right now?
 ((Showing his paper to Hamid))
 186 HAM: Yes, this one for for thi:s time,
 187 DOC: Okay.
 188 HAM: because she has s:ome p-pro-problem. withahh with ahh
 189 blood pressure.
 190 DOC: Okay.
 191 SAL: hāy māl-ḍaḡṭ?
 This is for blood pressure
 192 HAM: ayy huwwa dā yqūllī -hūa yqūllī hāy l-adwiyya [taḵuḍha kulha
 193 qatlū ayy.
 Yeah, he is telling me he is telling me, these are all the
 medicines she is taking I said yeah.
 194 SAL: [ayy ayy
 yeah yeah

In Excerpt 1, Nada (line 89) translates the question readily, giving her mother the floor to take a turn immediately. In Excerpt 2, Hamid answers the question directly, and thus withholds an opportunity from Salma to answer herself. This obstruction of patient participation comes about coordinately: the doctor presents the list of medicine to Hamid, and Hamid responds without consulting his mother. Salma recognizes the form being something they filled before meeting the doctor, and requests in line 191 a conformation that this is about her blood pressure medicine. Her action prompts Hamid

to explain in line 192 what he had not translated earlier. In these examples, we can see how methods of brokering offer unique patterns of participation: Amal's turn is immediate and taken as the answer for the question; Salma's participation is delayed and possibly not counted as the doctor has already received his answer from the language broker. The slight differences in patients' participation across three encounters underscore the distinct approaches by which the language brokers mediate interaction. Studying turn-taking patterns in brokered discourse clarifies these differences further.

3.5.1 Brokered turn-taking sequence

All encounters open with the doctor's turn, followed by the language broker's, and then the patient's. This sequence, although prominent at the beginning of each visit, becomes less so as the interaction progresses. For example, Encounter 1 begins with the doctor giving information in language 1; the language broker transfers it into language 2; and then the language brokeree indexes receiving information, as in the example below:

Excerpt 3.3:

03 DOC: okay tell her, her ex:am looks f::ine. (.) okay?

04NAD: yqūl il-faḥṣ maltič okay. mābī šī hassa rāḥ yaḥčī 'al-MRI.
 He says your exam is okay. nothing there, now he is going to talk
 about the MRI

05 AMA: ah-mm

After the sequence above, the doctor takes a turn to give more details about her exam results. This pattern, however, is not the common sequence for this visit. A more

dominant turn-taking pattern is constructed by the doctor exchanges multiple turns with the language broker who then summarizes the exchange in one extended turn (Sacks, Schegloff, and Jefferson, 1974):

Excerpt 3.4

52 HAN: dā-yqūl il-muškila māma mubrāsič il-muškila b'uyūnič. ahh
 53 (.)'indič ḥassāsiyya. Wda-yšūfūn 'uyūnič dā-ti'tīr 'ala 'ala
 54 rāšč. dā-twuja'. y'ammā rāḥ yḥwlič 'ala m-ahh muḫtašš māl
 55 'uyūn, ḥatta yafḥaṣ 'uyūnič waiḏā maqidar yu'ruf šinū huwwa
 56 as-sabbab rāḥ yḥawlič 'al-mustašfa. ḥatta yḏarbūnič 'ubra
 57 ḥatta ysaw – yqīsūn ḏaḡaṭ māltič ḥatta yšūfūn 'ālī lū lā.
 58 iḏ-ḏaḡaṭ (.) °māl (.) °'yūnič, (0.1) °so yqūl al-kūlla mu-
 59 šūč mo- min alras, (0.1) b'uyūnič.

He says the problem, mom, is not with your head, the problem is with your eyes. Ahh, you have allergies and they see that your eyes affect your head and it hurts. Either they'll send you to an eye specialist to examine your eyes, if he doesn't find the cause, he will send you to the hospital so they can give you a needle so they can measure your blood pressure, to see if it is high or not. Pressure of your eyes, so he say the reason, the cause is not from not from the head, in your eyes.

Nada summarizes the many turns she exchanged earlier with the doctor in one extended translated turn seen above (lines 52-59), informing her mother about both the diagnosis and the treatment decision. In such a long turn some of the information may be lost or filtered; it also limits or delays patient uptake on the information received. This shift in the turn-taking sequence is also found in encounter 2 with Salma and Hamid. The doctor opens the interaction, Hamid translates, Salma gives an answer, Hamid translates, and the doctor gives a common response “okay” (Heritage, 2006) to index receiving the answer as shown below:

Excerpt 3.5

- 01 DOC: do you know about (.) how many years that she has (0.1) had
problems with hearing loss? ((Writing on a chart, using
his desk as support))
- 02 HAM: min šgad fatrah (.) anti 'indki muškilah bissami'?
Since when you have had problems with hearing?
- 03 SAL: šārli ya'nī (.) tlat arba' snīn, (.) bass ya'nī hassa da-zīd.
I've been like that for three four years, but it's increasing
- 04 HAM: It's about three four years ag:o but now (0.2) it's (0.1)
- 05 mo[re.
- 06 DOC: [okay (0.9) getting worse ((writing on his paper))

The initial sequence in this visit, as demonstrated in Excerpt 3.5, shows the following turn-taking sequence: doctor, language broker, patient, language broker, and doctor. This pattern soon changes to a more common one: doctor (multiple turns), language broker (one extended translated turn), and patient (one short turn). In the excerpt below, the doctor takes many consecutive turns (not all shown here), which nudges Hamid in line 46 to ask for time to translate. Because of this delay, some of the information is lost and Hamid starts repeating himself:

Excerpt 3.6:

- 461 DOC: ye-hh-ah so- we'll have you back in three weeks[for-
- 462 HAM: [Okay
- 463 DOC: Ok::ay?=-
- 464 HAM: =let me translate for her

465 ya'nī ygul rāḥ tarja'in wara tlat asābī' 'alamud ḥatta
 466 yaḳḍūn il-qiyasāt māl haḍa l-tube 'ala aḍānki eeh ḥatta
 467 ysāwūn order yqīysūn haḍa lqiyās māl tube malki 'ala danki
 468 ḥatta yḳalūha fit, hassa huwwa rāḥ ysawwī faḥṣ li-aḍānki.

So he says you'll come back after three weeks so they can take measure for this tube on your ears, yeah. so they put an order they measure the size of the tube on your ear so they can fit. Now he'll check your ears.

This extended translated turn in lines 465-468 limits the ways in which the patient receives and responds to information. Indeed, the broker's approach does coordinate turn taking, which in turn dictates patient's participation.

Another brokering approach found in this dataset is delayed translation. Nathan often presents himself as his father's knowledgeable caregiver by answering the doctor's questions first. However, he is also aware of his interactional role as a broker, thus, he relays the doctor's utterance back to his father afterward. Nathan's delayed translation halts his father's participation temporally, as in the examples below:

Excerpt 3.7:

84 DOC: okay okay a::nd amm (.) any surg↓eries before?
 85 NAT: y-yeah he got one e::ye surg[ery.(°sadly) yeah=
 86 DOC: [one eye surgery,
 87 NAT: =>'indak ako-'amaliyya bil'uyūn < mu? sawwit qabil?
 >You have there-an eye surgery<, didn't you? you had before?
 88 KAR: bass bil'uyūn hičī,
 Just in the eye nothing major
 89 NAT: ayy a long °time
 (0.2)
 90 KAR: la liš wallah bass mal-'uyūn, °Nathan, 'andi hay mal-ḥaṣwah.
 91 switlha taštīt.
 No by God why just the eye one, °Nathan, I had that kidney stone

one. I had lithotripsy.

In line 85 above, Nathan volunteers to answer a question about his father's past medical record, recalling only one surgery. Karim first confirms his son's answer in line 88, but then in line 90 he adds that he has undergone more than one surgery in the past. Thus, Nathan's brokering approach leads the patient to take a post-expansion turn to clarify a statement of a B-event type—knowledge by observation or transfer rather than first-hand personal experience (Labov and Fanshel, 1977).

The microanalysis of turn-taking further clarifies norms of patient participation found in the quantifying analysis. It shows the ways in which the brokering sequence differentiates opportunities to speak. For example, Amal's participation is immediate due to her daughter's immediate translation; Karem's participation is often delayed since his son answers first and then translates; and Salma's participation is limited because her son often answers on her behalf. These patterns are not neatly exclusively found in each visit; rather, they are distributed with different emphasis. For example, immediate translation is found in all three visits, but used more by Nada, the teenage language broker, than the older language brokers. Generally, brokering approaches may be related to the language broker's age and language proficiency. Nada, as a young teen, relies on her mother to answer the doctor's questions despite the fact that she brokers all of her mother's medical visits. Hamid and Nathan are both older language brokers who regularly act as caregiver of their parents during medical visits as well as other situations. This chapter points out differences in brokering approaches that may stem from the language brokers' age and assumed responsibility; this finding should be further tested in future studies with bigger study samples.

3.6 Quantifying Zero Renditions

Amato (2004) found that professional interpreters privilege physicians as participants by translating more doctors' turns than patients'. This study corroborates that in brokered interviews patients' contributions are treated as primary, regardless of their overall participation percentages, and are translated more than the physicians'.

Encounters	Doctors' turns	Patients' turns
Encounter 1	5	2
Encounter 2	12	5
Encounter 3	30	11

Table 5: *Comparing Turns of Zero Renditions*

The high number of zero renditions during the encounters mediated by the adult language brokers indicates more dyadic turns exchanged between the doctors and language brokers. Some of the untranslated turns are social rapport initiated by the language brokers, as Excerpt 3.9 shows below:

Excerpt 3.9:

295 NAT: medic::ine yeah my dad goes to school to learn English now.
(0.3) he speaks Turkish and little Farsi=
296 DOC: =::oh good good y:eah I speak a little Farsi °yeah
(0.7)
297 NAT: almost like a second language in Iraq.
298 DOC: real-↑really?

299 NAT: yeah specially in Karbala and al-Najaf, all this-you know-
 300 DOC: oh ↑wow

During this exchange, Karim recognizes and repeats the word “medicine” (not shown above); that influences Nathan to speak of his father’s multilingual ability in line 295. The exchange continues for a few more turns before the patient is included. Other untranslated patient turns are intended to recap information already received. Karim uses the time in which the doctor gets ready to perform the treatment and in the course of that silence he initiates talk with his son. Nathan explains from what already has been conveyed by the doctor instead of translating his father’s question and receiving a new statement from the doctor. Other untranslated turns seem to be due to difficulty with language as in the example below; Amal’s turns in line 83 and 86 do not receive translation:

Excerpt 3.10:

83 AMA: gullīla ya‘nī mū il-muščila min il-mafasil mal-ruqubah
 84 maltī? da-taḍrib ‘la rasī?
 Tell him isn’t the problem with my neck joints, affecting my head?
 (0.4) ((Nada gazes toward her mother throughout))
 85 NAD: °wait ((Nada looks down))
 (0.2)
 86 AMA: anī hāy aš-aš-šuhūr ‘uyūni tḡawš tḡawš hwāiya
 These months my eyes have been blurry very blurry
 (0.2)
 87 NAD: huwwa da yqūl il-muščila mubir-rās
 He is saying the problem is not from the head

As noted by Heritage and Robinson (2006), patients often offer their own hypotheses for their illnesses, as Amal does so in line 83 suggesting that her headache may be due to a problem with her neck joints. She requests that her hypothesis be translated to the doctor by saying “gullīla” [tell him]. Her request is met with considerable silence before Nada, in English, asks Amal to “wait”(line 85). Amal’s utterances, however, never receive translation. During the course of this silence, Nada fixes an extended gaze on her mother that shifts to the ground as she asks her to delay the question (line 85). Nada displays her difficulty translating not only through paralinguistic cues but also through her words. Noteworthy, Nada asks her mother to “wait” using English, the language of translation, not the language in which they converse. Nada once again avoids translation during this encounter. In line 86 Amal gives another description of her condition—that her eyes have been very blurry—which coincides with the doctor’s decision to visit an eye specialist. Amal’s turn faces another period of silence before Nada (line 87) offers an unrelated comment instead of a translation. It is important to note that these two turns by Amal are her only ones that receive no translation. Nada does not ignore these turns, but responds to them with actions other than translation, which may indicate a difficulty with translation rather than any privileging issue. Analysis of zero renditions shows that patients’ turns are translated more than doctors’. These results are different from what Amato found in her study with professional interpreters, who were thought to privilege physicians by translating their turns more. In this study, the issue is not privileging; most of the patients’ conversational contributions are translated. The brokers’ language proficiency as well as their roles beyond being translators shape patients’ interaction significantly.

3.7 Conclusion

In all three encounters examined here, the language brokers speak more than the other interlocutors. This is an expected outcome, as the language broker transfers utterances between two monolinguals. Not all language brokers' turns, however, are used for rendering doctors' and patients' talk. Some of the language brokers' turns are self-initiated conversational rapport with the doctor or the patient. The doctors produce more turns than the patients in all the encounters. The patients occupy a small percentage of turns in proportion to their interlocutors. Amato (2004) notes that all interpreters in her study adopted the same approach, resulting in more orientation toward the doctors' talk rather than the patients'. The brokered medical interviews examined in this chapter show that the language brokers use different brokering approaches depending on their age and linguistic ability, which in turn produce different turn taking patterns that result on unique participatory experiences.

Quantitative analysis of turn taking shows a close approximation of the turns taken by all participants in all encounters despite differences in time, reasons for the visits, and brokering approaches. This is an important as well as surprising outcome emphasizing two key points in brokered medical discourse: 1) patients' participation is accounted for when it is due and, 2) and most patients' turns are translated. Qualitative analysis also reveals important aspects of brokered discourse: 1) turn-taking sequences accounted for the patients' participations patterns, and 2) patients ensure their involvement by creating opportunities that bypass delimiting factors. Both frameworks, quantitative and qualitative, show that brokered medical discourse is not a

homogeneous discourse, but it has the ingredients of institutional and conversational discursive norms. Three types of brokered turn-taking sequences are identified: 1) immediate (doctor> broker>patient>broker>doctor); 2) delayed (doctor,> broker> broker), and extended (multiple doctor turns>one extended language broker turn> on sort patient's turn). Studies that consider patterns of involvement in medical interviews often look at these issues from the perspective of visibility and power. This study shows relationships between brokers' responsibilities, knowledge, and linguistic ability. More importantly, patients, consistent with previous findings in this dissertation, continue to show active involvement in their healthcare despite various factors that delimit their participation.

Lastly, this approach of providing codified data flanked with discourse analytic investigation gives us the opportunity to form a comprehensive overview of communicational patterns in brokered medical interaction. According to the hypothesis outlined at the beginning of this chapter, variables derive from the characteristics of both the language brokers (i.e., age, linguistic ability, level of involvement) and communication (i.e., duration of interview, purpose of the visit, institutional predetermined discourse). Despite these variables, this study does provide a few particularly solid results: doctors speak more than patients, non-English-speaking patients seize and create opportunities to speak, and language brokers methods and personal characteristics shape the progress of brokered interactions.

CHAPTER 4. DECISION-MAKING IN BROKERED MEDICAL INTERVIEWS

4.1 Introduction

Patients' participation in personal healthcare decision-making has been encouraged over the years internationally (World Health Organization-WHO 1978) and locally (The Institute of Medicine-IOM, 2003). Health policymakers assert that, whenever possible, patients should be empowered to choose their treatments (Brody, 1980; Emanuel and Emanuel, 1992). The involvement of patients in this way is now used a qualitative index of healthcare (IOM, 2003). The rationale behind this advocacy is, on the one hand, ethical—patients have the right to choose their healthcare (Brody et al., 1989; Hewett et al., 2009; Kaplan, 1999), and, on the other, practical—it increases patients' commitment to treatment, enhances their knowledge of their illness, and favors successful clinical outcomes (Brown et al. 2003; Greenfield et al., 1985; Hall et al., 1994; Street, 1991; Street et al., 1993).

Reaching a medical decision is a complex and highly sensitive matter for all parties involved; thus, scholars have proposed different models for medical decision-making. Liss (1990) notes that there is a difference between needs and wants and argues that healthcare should eliminate this difference when medical decisions are reached. Other scholars conceptualize the decision-making process as a joint activity between patients and physicians in which each party states and discusses treatment preferences before reaching final decisions. This model is known as *shared decision-making* (SDM) (Charles et al., 1999; Kaplan, 1999, 2004). SDM, however, has not met

with universal acceptance among adepts. Whitney (2012), for example, argues that SDM is neither suitable for every patient nor applicable in every situation. As a corrective to SDM, an alternative model has been developed with a view to initiating patients into the details of their illnesses. This approach has been termed *informed decision-making* (Sheridan et al., 2004). Their differences notwithstanding, both models, shared and informed medical decision-making, have been endorsed by healthcare organizations. For example, the American Cancer Society and the National Institute of Health (NIH) recommend both informed and shared decision-making in cancer screening (Frosch and Kaplan, 1999). The Patient Protection and Affordable Care Act (2010) likewise promotes patient-centered healthcare in which patient participation is strongly emphasized. In short, research continues to emphasize the importance of involving patients when reaching decisions (Bekker, 2009; Elwyn et al., 2013; Elwyn et al., 2012).

Despite such advocacy by researchers and policymakers, studies show a spectrum of patient-participation patterns ranging from passive detachment to active involvement. Some studies assert that patients have authority and influence. For example, patients sometimes demand specific medicine for their children, such as antibiotics, leading doctors to push back and negotiate (Stivers, 2005). Street (1991) also draws a positive picture of patients' participation in decision-making: he affirms that patients influence doctors' decisions by offering opinions on diagnosis and treatment, by disagreeing with doctors, and by making explicit recommendations concerning their healthcare. Heath (1992) and Have (1995) report the opposite, claiming respectively that patients exhibit a marked passivity when receiving decisions of diagnosis and

treatment. Other studies, these observing physician's roles, claim that physicians are often reluctant to involve patients in decisions (Braddock et al., 1999; Elwyn et al., 1999). For instance, Briss (2004), for instance, reports that only fifteen percent of cancer-screening patients are given the opportunity to engage in shared decision-making. In sum, there is no single dominant pattern of participation in decision-making; nonetheless it is evident that reaching a medical decision is a complex process in which both doctors and patients contribute to its outcome.

In brokered medical interviews, the process of decision-making assumes an added layer of complexity for an obvious reason: various voices and perspectives are involved and have to be reconciled. Besides patients' and physicians' voices, the language broker's voice complicates the process further. The language broker's agency, language ability, brokering method, and desired care for a family member may intervene when decisions are made. Despite this complex context, treatment management and decisions in brokered medical interaction are still unmapped research ground that deserves attention. Nevertheless, studies have looked at decision-making in non-medical settings of language brokering. In the next section, I will review the findings of previous studies with a view to elucidating participants' roles in reaching decisions.

4.2 Decision-Making in Language Brokering

With the exception of a few studies, research on decision-making in language-brokering literature is surprisingly limited, and especially in the medical context. The relevant literature looks at decision-making as a part of language brokering rather than

as a discursive phenomenon in and of itself. These studies mainly focus on children's experiences by soliciting their views on mediating decisions for their parents.

Much language brokering research has suggested that children often act as primary decision-makers for their families (Harris and Sherwood, 1978; Tse, 1995; McQuillan and Tse, 1995). Tse (1995), for example, examines the experiences of 35 high school language brokers and finds that these students "influence the contents and messages they convey, and ultimately affect the perception and decision of the agents for whom they act" (Tse, 1995, p.180). More profoundly, McQuillan and Tse (1995) note that students generally determine the meaning of oral and written communication between school and parents and make decisions for themselves and their siblings that normally would be made by parents. In contrast, Orellana et al. show the process as a distributed one in which different participants exchange and pull information: children are familiar with the language and culture of the host society, and parents are experienced in the affairs of their families. Studies accordingly suggest that immigrant parents negotiate important matters with their linguistically and culturally practiced children (Fuligni, 1998) and even permit and encourage them to make decisions (Valdez, 2003).

In medical settings, some studies explore the hardships children endure when brokering medical visits for parents and siblings. Valenzuela (1999) notes that children's experiences during such visits are often fraught with embarrassment, difficulty, and even dehumanization. Other studies show that in some medical encounters children and parents share and negotiate information the leads to reach decisions about medicine and future treatments (Garcia-Sanchez, 2010; Orellana, 2009). Katz'

ethnographic account (2004, 2014) of Mexican families' experiences shows how children and parents influence each other's life trajectories through language brokering in medical and other settings.

Thus far, scholarship has mostly centered on young children and teenagers. Building on this research, I will investigate decision-making mediated by adults and teenagers. This study takes the view that decision-making is an interactional event constructed by all participants involved in which all conversational contributions are potentially significant and describable phenomena (Heritage, 1984). Such a research paradigm offers a careful dissection of the decision-making process by training a lens on understanding the participants' roles.

My investigation is mainly informed by studies of healthcare decisions that employ a conversation-analytical research method (e.g. Ten Have, 1995; Heath, 1992; Hernández-López, 2011; Stivers, 2005, 2006). It is further informed by studies on negotiations in other contexts, particularly a study by Maynard (1984) on negotiations in plea-bargaining. Maynard discusses decision-making as an interactional phenomenon constructed through a specific sequential organization of talk in which (1) a speaker presents a position and (2) a recipient expresses alignment or non-alignment with this position (Maynard, 1984). Between the unveiling of a proposal and its acceptance or rejection a number of discursive responses can intervene.

4.3 Decision in Brokered Interviews

In the current study, I follow the same line of investigation with a focus on the format of doctors' decisions, the ways in which patients receive and react to decisions,

and the means by which language brokers influence the process. The findings of this study demonstrate that doctors use a specific format when explaining treatment decisions. Also, the unfolding of the interaction reveals that doctors plan a specific course of treatment for their patients that depends more on the former's professional expertise rather than the patient's choice. Patients, on the other hand, do not treat doctors' decisions as a closing phase of the process. Contrary to some findings that apportion decision-making to language brokers, this chapter shows that language brokers try to convey both family and medical sides. However, in the event of conflict, they seem to be more influenced by the expert authority. In the following inquiry, I present these findings with examples from three consultations: (1) Salma—a patient with a hearing problem, (2) Karim—a patient with fluid on his elbow, and (3) Amal—a patient with a severe headache. The analysis starts from the onset of decision statements and follows the negotiation process until reaching closing of the decision phase.

4.3.1 Decision formats

In the medical fraternity there prevails a broad consensus that doctors ought to respect their patients' autonomy by presenting their decisions with due consideration for the patients' right to manage their own medical care. This study, however, demonstrates that although physicians may list a number of possible treatments, they use linguistic strategies to pursue a specific preferred choice or treatment protocol. Examples from this dataset show that doctors state their decisions using the linguistic strategies below:

1. Using the first person plural collective *we*

2. Affirming the existence of alternative possibilities
3. Pursuing agreement on a specific treatment decision

These strategies are exemplified in the excerpts below:

1- Hearing aids

211 Doc: and these are the hearing aids we can pick from.

212 HAM: uh-mm

2- Fluid on elbow

235 DOC: th::ere're >couple of things we can do.<

236 NAT: akū šağltiyn nigdar [insawīha
There are two things we can do

237 KAR: [eyy
yeah

3- A case of headache

20 DOC: couple of things we can do, I think we need to send her to the

21 e:ye specialist. and h:ave him take a look at her.

22 HAN: Awkay

In all three examples above, the doctors start the treatment decision phase in a very similar fashion. The usage of the pronoun “we” sets a double affiliation stance: it refers to interaction participants and/or an authoritative voice of medicine. It also provides a chance for the doctor to change his stance between the two positions. The use of certain words and phrases such as choices to “pick from” and “couple of things we can do” may indicate possible options. Patients’ immediate responses, as can be noted in the examples above, are short and influenced by the brokering method to a certain degree. In example 2, there is a prompt translation of the doctor’s decision, thereby

revealing a patient's immediate response. In examples 1 and 3, the patients' responses are not seen due to delayed translation. Notably, patients as well as language brokers receive decisions with minimal response tokens (Elizabeth Couper Kuhlen, 1996), such as "yeah", "uh-mm", and "okay" in all three cases. Analyzing decision episodes as a whole, and not just the onset of stating a decision, reveals that these modest tokens of agreement are not by any means indicative of a small role in the process. To understand these conversational expressions, I will examine the doctors' decision statements introduced above within the local contexts in which they occur. These cases are examples of: (1) an instance of disagreement with the doctor's decision, and (2) two instances of agreement with the doctor's decisions in brokered medical encounters.

4.3.2 A case of a conflict: Decision-disagreement

Reaching a consensus on a treatment is certainly the preferred result and goal for both doctors and patients. In this chapter, I begin exploring decision-making with a case of disagreement that carries important implications. First, as stated earlier, research emphasizes, as well as medical ethics requires, that patients should be given a choice whenever possible. The medical visit analyzed here is an example of a case in which options are available for the patient, yet the doctor insists on a specific choice. Second, research also shows that patients commit to treatment more confidently when their consent is solicited. This case profiles the other side of the story: when the patient's preferred choice is not fully considered.

Fisher (1984) notes that physicians have the potential to control patients' access to knowledge and understanding of information, which in turn affects their choices. The

case of Salma, a hearing-impaired patient, substantiates Fisher's observation. In selecting appropriate hearing aids for Salma, there is a clear discrepancy between the doctor's medical opinion and the patient's preferred choice of hearing aids. The doctor believes that a behind-the-ear (BTE) type of hearing aid is the most suitable for Salma's range of hearing loss. Salma, in contrast, is concerned mostly with the look of the hearing aid, preferring the smaller, inconspicuous in-the-ear (ITE) aid that lodges inside the ear. Hamid, the son acting as a language broker, is clearly aware of his mother's choice, it being something they probably discussed prior to meeting with the doctor. Hamid tries to accommodate both views, but displays an early inclination toward the doctor's decision.

The doctor opens the decision phase in line 213-214 projecting possible options available for "we," the participants in this interaction. But in line 216 he proceeds to show his preference for a specific type: BTE device. Moreover, in lines 217 and 218, he intimates a possible disagreement:

Except 4.1

209 DOC: Okay, so I went ahead and (treated) her test results
210 HAM: Yes-ahh you got here ohh-okay
211 DOC: and these are the hearing aids we can pick from.
212 HAM: uh-mm
213 DOC: now this will show us what hearing aids in that (.) potential
214 range to work for this (.) hearing loss.
215 HAM: uh-aa
(0.2)
216 DOC: and if we can use (0.1) if we use behind the ear hearing aids

217 we can fit this without any problem. some people don't want

218 (.) [behind the ear hearing aids.

219 HAM: [no

220 HAM: ygūl aḍa raḥ yšadulki simmā'ah tḵallayna haky warra 'aḍankī

221 ya:: 'nī (.) 'adī

He says if they'll make you hearing aid to put like that behind
your ears I mean (.) normal

222 SAL: ya'nī ma-yṣīr - (..)
So it can't be- (..)

223 HAM: she prefer the the small one. i:ns:ide. >you c:an't do<, o:r

224 DOC: ((Sniffing sound))

225 HAM: hassa huwwa raḥ ywarrīna il-aškāl illi illi illi ya'nī,
He is going to show us the shapes that that that I mean

226 SAL: hāy il-wara, 'aḍani kulha tbayin
That is the one behind, my whole ear is shown

227 DOC: well this's about the smallest one=

228 HAM: =this is a small one

229 DOC: this is probably the smallest we can get

230 HAM: ahha

231 DOC: it's gonna look [like this one here ((points to a photo on
the computer screen))

232 HAM: [hāḍi aṣḡar wiḥda.
This is the smallest one.

233 SAL: eee ((smiling))

234 HAM: tḵaliyha bnuṣṣ il-iḍān
It is inserted in the middle of the ear

235 DOC: it looks like- this is in the ear.

236 HAM: ye:s inside inside the ear yes

237 DOC: right.

238 HAM: that that what she prefer not-not behind the ear
((Doctor clearing his throat))

239 HAM: that what she told me now hhh.ahah

240 DOC: is that because she is afraid of what it'll look like?

241 HAM: ehh.hahaha ygūl hāy li'n tkāfyn la taṭla'yn ma-ḥilwa hhhaha
hahah he said is that because you are afraid you won't look pretty
hahaha

242 SAL: yeah hahah [hhhahahah hahah

243 HAM: [haha hahahhah .hhh

In the exchange above, the doctor sits facing a computer on his desk, Hamid sits in the same direction, and Salma sits in front of the doctor and next to Hamid. The doctor finishes the history-taking phase and proceeds to introduce his decision on the hearing aids options. As the doctor utters the word “these” in line 211, he points at the computer screen, which displays two graphs representing Salma’s hearing loss, as shown in the figures below



Figure 6a : Hearing aid



Figure 6b : Hearing aid

In pointing at the graphs and saying “these are the hearing aids we can pick from,” the doctor presumes that his interlocutors are able to convert the graph to a form of practical knowledge on possible options available to them. Consequently, his utterance is met with an affirmative “uh-mm” in line 215, followed by a considerable interval of

silence. Also notable is that Hamid does not translate the doctor's turn here. These interactional accompaniments (the "uh-mm", the silence, and the absence of translation) intimate a potential problem with understanding. Although the doctor suggests possible options at the beginning, he reduces the range of choices in lines 216-217 by not describing any of these possibilities and instead only naming only one type of hearing aid, "behind the ear hearing aids" (Figure 5b):

Excerpt 4.1.a

216 DOC: and if we can use (0.1) if we use behind the ear hearing aids
217 we can fit this without any problem. some people don't want
218 (.) [behind the ear hearing aids.

I argue that the doctor shifts his footing in line 216 by eliminating "can"; he changes his utterance from "if we can use" to "if we use." Through self-initiated same-turn repair (Schegloff, 1979, 2004), he frames making a decision not as a matter of ability, but a matter of a choice: the first "we" may refer to the medical voice (as a collective opinion of medical experts in general), he knows "we" can use it; and the second "we" refers to interlocutors (if we, as participants in this interaction, agree to use this type). Therefore, although he reduces the choice by naming only the type he prefers, he presents the choice anew as if it resulted from consensus. He frames his decision as the most "fit" for Salma's hearing loss but acknowledges that his choice may not be a popular one. Hamid relays the decision to his mother in a manner that shows an early subordination to the expert voice:

Excerpt 4.1.b

219 HAM: no

220 ygūl aḍa raḥ yšadulki simmā‘ah tḵallayna haky warra ‘aḍanki

221 ya:: ‘nī (.) ‘adī.

He says if they’ll make you hearing aid to put like that behind
your ears I mean (.) normal

By saying “no” in line 219, Hamid disaffiliates with the doctor’s last statement that his choice may not receive an approval, and thereby aligns with the doctor’s stance on the appropriate choice. He also does not translate the doctor’s anticipation of possible disagreement. And in line 220, he is already *selling* the doctor’s choice by adding “‘adī” (normal), implying that there should be no problem if “they” choose the BTE device for her. Salma, however, expresses a different agenda for her medical care. She is clear on what type she prefers. Instead of stating her opinion directly, she enacts her disagreement in a question that challenges the doctor’s preference. Her question is interrupted and reformulated by her son:

Excerpt 4.1.c

222 SAL: ya‘nī ma-yṣīr - (..)
So it can’t be- (..)

223 HAM: She prefer the the small one. i:ns:ide. >you c:an’t d:o<, o:r

224 DOC: ((sniffing sound))

225 HAM: hassa huwwa raḥ ywarrīna il-aškāl illi illi illi ya‘nī,
He is going to show us the shapes that that that I mean

226 SAL: hāy alwara, ‘aḍani kulha tbayin.
That is the one behind, my whole ear is shown

In line 222, Salma starts to express her preference in the form of a question. The end of her turn is unclear as Hamid interrupts her and translates her utterance into a statement that clearly expresses her preference, saying, “She prefer the the small one,” demonstrating his knowledge of his mother’s choice despite her incomplete sentence. He proceeds to ask the doctor about the possibility of granting his mother her preference. Notably, Hamid performs his question with discernible effort: slowing, hesitation, prolonged vowels, and unfinished utterances. Posing a question is a “face-threatening” act (Brown & Levinson, 1978) for both speakers and hearers: it obligates the hearer to give an answer and obligates the speaker to accept various possible outcomes. Hamid slows his speech (line 223), as when he states his mother’s preference, probably in anticipating the doctor’s rejection. The doctor withholds his response in line 224 and merely makes a sniffing noise instead. Schegloff (1992) notes that the absence of an action is as significant as its occurrence. Not providing an answer to or a comment on a patient’s choice is uncommon in medical consultations. By withholding an answer, the doctor implicitly shows his disapproval of the patient’s choice. In this instance, the disagreement among the participants clearly asserts itself. The doctor’s sniffing sound in line 224 and Hamid’s improvised answer in line 225, which he is unable to complete coherently, mark this irregular absence of the doctor’s response to patient’s question. Hamid does not translate his mother’s disapproval of the doctor’s choice in line 226, treating it not as a valid assessment of the issue at hand, but rather as a side comment. Through certain actions, Hamid promotes the doctor’s choice, but he also clearly represents his mother’s choice. This change in footing reveals the delicate position the language broker occupies when negotiating medical

decisions—the position of attempting to navigate the dialectic of power between the patient’s right and the doctor’s expert opinion.

Withholding a response occurs again in line 239, after Hamid clearly reiterates his mother’s preference for ITE, the small hearing aid that fits inside the ear. Ironically, in line 229, the doctor shows a rather enlarged picture on his computer that displays “the smallest” possible ITE hearing aids, trying to demonstrate that the smallest device is still clearly visible, but Hamid and his mother confirm that this is in fact what she prefers. The doctor then uses another strategy, this time using humor to lessen the seriousness of her choice. He offers that the reason behind her choice is that she worries about her looks, implying that a 77-year-old patient ought to subordinate aesthetic considerations to her medical needs. Salma, however, shares in the humor and confirms that, “yeah,” that is indeed her concern:

Excerpt 4.1.d.

- 240 DOC: is that because she is afraid of what it’ll look like.
- 241 HAM: ehh.hahaha ygūl hāy li’n tkāfyn la taṭla’yn ma-ḥilwa hhhaha
hahah he said is that because you are afraid you will not look
pretty hhahaha
- 242 SAL yeah. hahah [hahah
- 243 HAM: [haha hahahhah .hhh
- 344 DOC: that’s okay because I wanna show her something

The doctor goes on to use another strategy, to fish for Salma’s agreement. He demonstrates both types of hearing aids, starting by wearing the ITE aid (line 248). As he puts this device in his ear, Hamid and Salma clearly show their preference for this type (in line 250 and 251):

Excerpt 4.2

245 DOC: okay, this hearing aid [is g]onna be about this si[:ze
246 HAM: [yes] [size yes
247 hāḍi il-ḥāj̣m malita
This is its size
248 DOC: so it is gonna look about-like this
(He puts the device in his ear)
249 HAM: yes
248 HAM: šofi šoon rāḥ tbayin
Look how it is going to look
249 SAL: eyy
250 HAM: raḥ tbayin kulliš šḡayra
It will look very small
251 SAL: eeh eeh eeh, ḥilwa
Yeah yeah yeah, pretty
252 HAM: seem like like-se- it look like (.) there is nothing.
(0.1)
253 DOC: w-w::e[ll-
254 HAM: [tbayin 'bālak māku [māku
It looks like nothing nothing
255 SAL: [eyy māku šī
Yeah nothing there
256 HAM: yes it look [like nothing
257 DOC: [you can still see it pretty good, right?
258 HAM: yes

As the doctor demonstrates the small hearing aid (line 248), Salma and Hamid go on multiple turns confirming their preference for this type. In line 250 Hamid judges the device as being very small, an appraisal with which Salma agrees, even upgrading her

son's assessment to *ḥilwah* (beautiful). Her assessment is again treated as a side comment and is not translated to the doctor. But in line 252, Hamid communicates their agreement to the doctor. The delayed response and the elongated "well," often used as a token to show a problem with a prior turn, shows in line 253 that the doctor does not achieve what he intended with his demonstration. In line 254 and 255, Hamid and his mother, with an overlap almost completing each other's turn, show an emotional alignment--both were smiling while uttering these lines, knowing that the device in the picture is what she prefers. Hamid again communicates his assessment to the doctor that it looks like "there is nothing there." The doctor contradicts Hamid's assessment and solicits his confirmation in a tag question stating that, although small, it is still very much visible. Hamid yields to the doctor's authoritative voice and succinctly with a "yes" he registers his agreement in line 258.

The doctor next demonstrates behind-the-ear hearing aid. He solicits their approval through many strategies: 1) He reiterates that this style is the most suitable for her hearing loss, giving greater flexibility to deal with the range of her condition; 2) he expresses that it does not look as bad as people think; 3) he emphasizes that the visible part outside the ear could be made in grey to match Salma's hair; and 4) he notes that her ample hair will hide the device. The fragment below shows the participants' reaction to the doctor's second demonstration:

Except 4.2

261 HAM: hādy [illi tʃɪr [baʻad ((gesturing behind the hair))
 This one is the one behind-

262 SAL: [hādy ali-eeh eeh-hāy ma-ḥilwa hāy
 This is the- yeah yeah- it's not pretty

263 DOC: [if you use this stuff watch- when I put this on

264 SAL: °lā hāy maḥilwa
No this is not pretty

265 DOC: you only see this and little tube ((showing his ear))

266 HAM: yes hāḍa bass al-tyūb ibayin, whaḍa yanḏamm wara
Only this tube shows and this is hidden behind

267 DOC: but with her hair you won't even see this

268 HAM: yqūl miṭl ahh ahh ((passing his hand on his hair))
He is saying like ahh ahh

269 SAL: zēn līš, ḍiyka mu-°zēnna?
But why, that one is not good?

270 HAM: which-she asks me which is prefer. This one or this one

271 DOC: hh.ahha well [I just want you to be sure because people when

272 HAM: [she ask me now

273 they think about s:ize and the way it's gonna look.

274 HAM: ah-uh?

275 DOC: I think these don't look as b:ad. specially with people with a lot
of hair.

As the doctor demonstrates the device, Salma comments in lines 262 and 264 that it is not pretty. This comment is not translated, leaving the doctor unaware of her strong opinion. The doctor describes the device favorably but an unmoved Salma asks what is wrong with the one that she prefers:

Excerpt 4.2.a

269 SAL: zēn līš, ḍiyka mu-°zēnna?
But why, that one is not good?

Hamid, for his part, instead of relaying his mother's question, softens it into a mild expression of preference (270). In doing so, he denies Salma a specific answer to her

question. The doctor thereupon advances his preference further, explaining that the difference between the two hearing aids is a matter of style but BTE is more suitable to match Salma's hearing loss and is his personal preference. More importantly, the doctor for the first time gives Salma a choice to pick the one she thinks she will wear more:

Excerpt 4.3

295 DOC: it is up to her. [either one will [work
296 HAM: [Yes [yeah but but which one is better? that
297 what what she asked me. She asked me about about which one is
298 (.) better.
299 DOC: the:re there's really no difference (.) in [terms of-
300 HAM: [the same-the
301 DOC: yes, these are different styles
(Few lines deleted)
334 DOC: >there' is no better hearing aid< than the one they gonna
335 wear. (0.1) [hahhahhahkhaahhah=
336 HAM: [ygūl antī ta-hhhahha-ygūl-
He says you li-hhahha-says
337 DOC: =if she's not gonna wear [this, we might as well do the
338 HAM: [yes
339 DOC: other one=
340 HAM: =yes
341 ygūl aḍa antī tridīn ḍika- tfaḍḍaliha [bkifkī. ya'nī antī antī
he says if you want that one prefer it as you want. so you you

((double wording to mirror the original text in Arabic))
342 SAL: [zēn miḳalīnī da-šufha-ah,
Okay can he let me see it-ah
343 HAM: okay she (.) she want to try which one is better

344 DOC: I think this is better personally=
 345 HAM: yes but she [want to hear better
 346 SAL: [huwwa šifaḍḍal?
 What does he prefer?
 347 HAM: ygūl hāḍi afḍḍal=
 He said this one is better
 348 SAL: =o:kay [okay
 349 DOC: [I think this would be better ((holding the device))

In the fragment above, the doctor finally empowers Salma by giving her a choice in line 295 “it is up to her”; his utterances, however, are not translated. Instead, Hamid insists on posing a question in order to solicit the doctor’s preference and he frames the question in line 297 as if it comes from Salma, even though she has not yet posed this question. In doing so, he is conveying that the best choice is the expert’s recommendation.

Excerpt 4.3.a

295 DOC: it is up to her. [either one will [work
 296 HAM: [Yes [yeah but but which one is
 297 better? That what what she asked me. She asked me about about
 298 which one is better

Noteworthy is the extended interaction, from line 295 to line 341, between the doctor and Hamid with no translation for or involvement of Salma. In line 332, the doctor once again repeats that it is her choice. In line 334, he acknowledges the importance of the patient’s choice for committing to treatment, yet he decreases the importance of the matter by a long laugh on line 335 and by the use of the auxiliary verb in “might as well

do the other one” in line 337, positing her choice not as one equal to his, but as a trivial remedy that is better than nothing. Notice here that the doctor does not really explain the disadvantages of Salma’s choice, but merely emphasizes the advantages of the hearing aids he prefers. In line 341, Hamid translates the doctor’s offer to make a decision, but Salma cuts him off and asks if she can see them, which again demonstrates her concern with the look. (Later, not shown, the doctor does let her try on the BTE device but by emphasizing that her hair can cover the out-of-the ear part). Hamid translates her question differently to show that it is a matter of which device is better. The doctor takes this chance to enforce his opinion in lines 344 and 349. Hamid does not translate either, but Salma finally asks what the doctor prefers and upon receiving the answer from Hamid, she gives her consent.

The case presented here shows a clear conflict between the patient’s choice and the medical choice. The doctor first empowers the patient by stating that possible options are available. Throughout the interaction, however, he uses many strategies to push for one specific choice of hearing aids—one such strategy being the denial of an answer and withholding information about the patient’s desired hearing aids. The doctor’s preference is clear from the opening of the decision statement, but the patient continues to challenge the doctor’s choice by asking questions, by demanding to see and try the devices, and by clearly stating her dislike of the doctor’s choice. Some of her actions, as well as some of her doctor’s, were not translated. The language broker evidently treads on a very sensitive ground as he mediates this case of conflict, but he clearly influences the interaction greatly by not translating his mother’s strong comments. Nevertheless, there is enough evidence of the patient’s stance toward the

doctor's choice that it should have been treated openly. Whereas the patient signals her acceptance with a small token of agreement, she registers her disagreement more vigorously.

This case affords a clear example of a medical decision that ostensibly started as optional but ended as a de facto prescription. Despite the patient's active role, the medical voice as well as the language broker's way of translation influenced the process of the decision-making. After the first encounter analyzed here, the patient revisited the doctor four times with different complaints, including discomfort, pain, headaches, and the hearing aid's bad sound quality. Not giving a full consideration of the patient's preference and available options appears to have affected the patient's commitment to the treatment.

4.3.3 Cases of doctor-patient agreement

Shared decision-making is not always the favored approach of patients (Whitney, 2012). Patients, sometimes, have no specific preference of treatment and are ready to depend on the physician's expert opinion. In that sense, asymmetries of knowledge and participation figure as the norm (Markova and Klaus Foppa, 1991). Also, shared decision-making not only involves the doctor's and patient's preferences, but also has to incorporate a treatment protocol that ministers to the specific medical problem (Kaplan, Ganiats and Frosch, 2004). I present here two cases that demonstrate patients' willingness to seek and accept their doctor's decisions. In this section, doctors'

decisions are met with their patients' agreement, and patients manifest their agreement by actively working with the method of brokering in each visit.

In these visits, the doctors deliver their decisions using the phrase "a couple of things we can do" (e.g., line 235) and proceed to propose a number of remedies designed for their patients. Patients display immediate or delayed reactions to decisions depending on the method of brokering. They register agreement and involvement through assessment, questions, and suggestions of causes of illness or treatment actions.

In the first example, Karim, a 73-year-old patient accompanied by his son Nathan, is about to hear the doctor's decision about his injury. The doctor opens this phase by saying there are "a couple of things" to do about the fluid on Karim's elbow. The specific course of action pursued is governed by the treatment development; there is no patient choice, only alternative directions that the treatment may go depending on a patient's medical progress:

Excerpt 4.4

- 235 DOC: th:ere're >couple of things we can do.<
- 236 NAT: āku šaġltiyyin nigdar [insawwiya
 There are two things we can do
- 237 KAR: [eyy
 yeah
- 238 DOC: >first thing we can do< is (.) i:s to try to take some fluid
 aaa-and take some of the fluid out (.) to make it go d:own,
- 239NAT: aa n-niṣḥab as-sā'il haḡa [niṣḥaba wa-°galil.=
 aa tr-pull the that fluid pull it out and- little
- 240 KAR: [a::h eyy eyy

241 NAT: yeah?

242 DOC: and then (.) w:e'll wrap the a:rm so you've to keep it

243 wrapped to keep it tied so the fluid doesn't come back.

244 NAT: wnūrbuṭ ēdak 'alamud as-sa'il ma-yrja' marra ṭāniya.=
And we wrap your hand so the fluid does not come back again

245 KAR: ay hāy ʔkafy
Yeah that's enough

246 DOC: a lot of time the fluid comes back.

247KAR: w ḡaliban as-sa'il yrja' (.) marra ṭaniya=
Mostly the fluid comes back again

248 KAR: =h:mm.

249 DOC: but that's the first step, if we can get it to not come back

250 then we're done.

251NAT: aḡa gidarna ma-nḡalli yrja' marra ta-ḡalaṣna min al-mūškila.
If we can prevent it from coming back then we have solved the problem

252KAR: ḡūš
Good

252 DOC: if (.) the fluid comes b:ack,

253 NAT: aḡa as-sa'il riḡa' marra ṭaniya?
If the fluid comes back again

254 DOC: then we'll talk about it. (.) [either [do-

255 KAR: [yrādilha 'maliyyah.
It'll need a surgery.
(0.1)

256 DOC: then we'll do either cortisone injection into the area, (.)

257 to keep the inflammation down.

258 NAT: okay what's the cortisone, [g:as?

259 DOC: [it's a steroid medicine,

260 NAT: okay. o::h (.) fa fad-ynṭiyk fed dawa yisamu mal mal b-

261 hāyyah 'alamud yḡalli al-manṭaḡa hāy dā'iman nāzla (.) hāy
Okay ohh (.) some mm some-he give you some medicine aa it is called
for for-on that area in in order to keep the area down

262 KAR: h::aa

263 NAT: aaa ada ma-nijḥat al'maliyya °il-ūla
 Yeah if the first method does not work

264 DOC: and if th:at doesn't work then then we go in th:ere and we do

265 a surgery to take it out.

266 NAT: okay wada ma-nijḥat hāy al'maliyya il-ṭalta, insawwiy mitl

267 al'maliyya wnishabha.
 Okay and if the third method doesn't work we do a surgery to take
 it out

In the example above, the doctor presents a contingent order for the treatment protocol:

1) at the end of the visit he will remove fluid from the patient's elbow and wrap the affected area; 2) if the fluid comes back, he will try medicine; and finally (3) if the medicine does not take care of the problem, they will resort to surgery (line 264). The doctor states his decision of treatments as announcements, and not options, whose occurrence depends on the success of the previous action. Information is introduced gradually and advanced by the condition “if the fluid comes back.” Karim displays token agreement after each proposed step (e.g., lines 240, 245, 248, 252). His agreement is not manifested passively, as shown in previous literature (e.g., ten Have, 1995; Heath, 1992). Instead, he appears attentive and engaged. In line 240, Karim shows his deference in double tokens “a::h yeah yeah,” confirming that the proposed treatment is appropriate for his condition, an affirmation further emphasized by “ay hay °kafy” [yeah that is enough] in line 245 and “kūš” [good] in line 248. These verbal agreements receive no translation; thus the doctor is unaware of their expression. Nevertheless, the doctor attentively addresses Karim, observing the patient's verbal and non-verbal behavior. His gaze fixed on the patient, the doctor sits facing Karim as he explains possible treatments, monitoring his patient's head nods and facial expressions

throughout. His attentiveness to the patient's reaction is further evident as the doctor holds his turn, clearing the floor for the patient's turn:

Excerpt 4.4.a

- 252 DOC: if (.) the fluid comes b:ack,
- 253 NAT: aḍa as-sa'il riǰa' marra ṭaniya?
If the fluid comes back again
- 254 DOC: then we'll talk about it. (.) [either [do-
- 255 KAR: [yrādilha 'maliyyah.
It needs a surgery.
(0.1)
- 256 DOC: then we'll do either cortisone injection into the area, (.)
- 257 to keep the inflammation down.

In line 253 Nathan translates the doctor's utterance from line 252. Karim promptly finishes his son's utterance in line 254, overlapping with the doctor and predicting the course of action if the treatment fails--"needs a surgery"--which interestingly is the doctor's last resort, as the doctor states later. The doctor pauses upon hearing Karim's utterance, waiting for translation. When the translation does not come, he continues to explain the next step. This attentiveness to the patient's actions is demonstrated in different parts of the interaction. Earlier in the encounter, the doctor solicited the patient's decision to seek help and validated his concern:

Excerpt 4.4.b

- 225 DOC: u-usua:lly this's not a problem,=
- 226 NAT: bšikil 'āmm hāy mu-muškila,=
In general this is not a problem

227 DOC: =but >it depends on how much< this b:others him.

228 NAT: bass ta'timd šgad mḍawwičtak. ^hwaiyya?
But it depends on how much it bothers you. a lot?

229 KAR: la ka-manzar mḍawwčatnī hāy [šwayya
No as a look it bothers me a little

230 NAT: [he don't like the look of ahh=

231 DOC: =Yeah.

232 NAT: °he doesn't like it

233 DOC: so that's okay.

234 NAT: māku mūškila
No problem

In the fragment above, after giving the diagnosis (not shown here), the doctor evaluates the seriousness of the condition in line 225, that it is “not a problem,” thus preceding with treatment depends on how much the condition bothers Karim (line 227). In line 228, Nathan translates and adds an interrogative through “a lot,” displaying a concern about the validation of using the medical time and resources in a case that does not seem very serious. Karim, in line 229, emphasizes that the look, more than the pain, of the fluid collected on his elbow bothers him “šwayya” (a little). With an emphasis on “okay,” in line 233 the doctor validates Karim’s concerns that it is a good enough reason to seek help, and moves on to state treatment decisions.

In this case, besides attentiveness to the patient’s concerns and reaction, there is a general attention to the brokering process. The doctor and the language broker coordinate turn-taking, enabling Karim to receive the information at a prompt and comfortable pace. In a few instances, the language broker even matches the doctor’s manner of articulating his turn (e.g., notice line 225 and 226 above). After receiving the

doctor's decisions about treatments, Karim confirms his agreement (line 267), and then actively inquires further for more information (lines 268, 273):

Excerpt 4.5

- 267 KAR: °kūš ḥačī. (.) hassa il-maṭlūb šino?
Good talk. (.) what is requested now?
- 268 NAT: that is good- w-what is needed now?
- 269 DOC: we take some fluid out.
- 270 NAT: niṣḥab as-sa'il hassa.
We pull the fluid out now
(0.1)
- 271DOC: okay?
- 272 NAT: okay.
- 273 KAR: baniḡ yrādilha šī?
Anesthetization is needed or something?
- 274 NAT: are you gonna numb the area? Or
- 275 DOC: we gonna put some c::ooling solutions,
- 276NAT: raḥ nḡālī fad šī šī yibarid il-manṭaqa,=
We are going to put something cold on the area
- 277 DOC: =to make the area ahh mm much less painful. I [(mean ..)
- 278 NAT: [mišir biha-
- 279 'alam, kūlliš qalīl 'alam.
There is no pain, very little pain
- 280 KAR: haa, (0.1) whāy tubqa hīčy lu raḥ yšidha?
Haa, and it stays like that or he's going to wrap it?
- 281 NAT: yšidha mu'aqattan (.) wb'dīn yšūf šinū an-natīja.
He wraps it for now and then we will see the results

In line 267, Karim accepts the doctor's plan. This time the doctor hears Karim's approval, whereupon Karim asks specific questions regarding the next step--the numbing of the injured area--and the procedure's details; all questions are relayed to

the doctor and answered. As the doctor prepares to perform the treatment, Karim has engaged with a conversation with his son:

Excerpt 4.5

- 282 KAR: balkī tinjaḥ hāy
Hopefully this works
(0.1)
- 283 NAT: tinjaḥ
It'll work
- 284 KAR: huwwa ygūl (.) māku muškila bīha,
He said there is no problem with it,
- 285 NAT: huwwa ygūl wiḥda wara wiḥda [(.) ya'nī aḍa maṣārit hāy ṣīr
He said one after the other, so if this does not work
- 286 KAR: [eyy hhh
Yeah hhh
- 287 NAT: =il-waraha waḍa ma-ṣārit hāy, tṣīr il-tālta.
The other one will, and if that doesn't work the third will
- 288 KAR: eyy kūš
Yeah good

During the doctor's silence, Karim reviews with his son what he has just learned about his condition. In line 282 Karim reiterates his approval of the procedure by hoping that this simple in-clinic treatment will take care of the problem. In line 284 he asks his son to confirm that there is no serious problem with the fluid collected on his elbow. He receives a recapitulation of the diagnosis and recommended treatments from his son, to which he gives his consent. Before leaving the office, Karim asks more questions, inquiring if he can use his hand to write and if he needs an appointment for subsequent visits.

In this case, the doctor presented three actions (in-clinic treatment, medicine, and surgery) as available treatments for the patient's condition. Notably, these actions

could have been presented as optional treatments with the advantages and disadvantages of each explained. Instead, these possible actions depend on the way the injured area responds to treatment. The patient agrees with both the doctor's treatment and his program for possible future actions. The patient in this case receives a prompt translation during as the doctor delivers the decisions. He expresses his agreement actively through small tokens of agreement as well as requests for further information. The language broker did not translate some of these agreements. Nevertheless, the doctor displayed attentiveness to the brokering process and the patient's verbal and non-verbal communication cues such as the patient's head nods. He also addressed the patient directly and validated his concerns.

In a second example of a decision-agreement case, Amal has been suffering from a severe headache and has undergone fMRI as ordered by her primary doctor. In the visit analyzed here, Amal, accompanied by her 17-year-old daughter, Nada, visits a neurologist who explains the fMRI results and designs treatment accordingly. He explains that tests show nothing serious in the brain except for the nerves behind the eyes, which seem stressed. The neurologist thus orders a visit to an eye specialist, among other steps. The doctor opens his decision statement, much like in Karim's case, offering that there are a "couple of things we can do." It is important to mention that this is not the only way in which doctors deliver decisions; it is, however, what is found in this dataset and thus warrants consideration. The doctor then uses the evidential verb "I think," by which he mitigates the authoritative institutional voice. Then he proceeds with a specific treatment protocol he has designed for his patient:

20 couple of things we can do, I think we need to send her to
21 the e:ye specialist. and h:ave him take a look at her.
22 NAD: A::wkey.
23 DOC: °okay and the other thing that we may have to do i:s ah-send
24 her like to (...)? to get a lumbar puncture. (.) and
25 that's where they put a needle in-you know, like when
26 you have a ba:by they they do an epidural?=
27 NAD: =Yes.
28 DOC: well it goes a little bit further, and they measure the
29 pressure to see if it's too high.
30 NAD: o:kay.
31 DOC: and if it i:s then we may have to give her pills [(.) to
32 NAD: [okay
33 DOC: bring it [down.
34 NAD: [okay
35 gonna b:e (0.1) a variant(.) beCause everything looks
36 f:ine. and she's getting better.=
37 NAD: =doctor mm she have allergies in her eyes.
38 DOC: she has what?
39 NAD: allergies.
40 DOC: oh °y[eah
41 NAD: [yes [she have
42 DOC: [but this-we're talking about d:eeep in the
43 eye.[(0.1) where you see the ne:rve that goes to the brain?
44 NAD: [oh okay
46 DOC: that's like when I lo-that's what I'm looking at that
47 neRve. (0.1)to see if there's any evidence of Pressure. and
48 I don't see it. but (.) the eye doctor he puts dr:ops he

49 dilates he can see (.) everything [in the eye.

50 NAD: Okay=

In the fragment above, the doctor plans certain actions to investigate further the reason behind Amal's headache. He announces his decision in line 20 as a "couple of things we can do," which are specific steps he arranged for the case: visiting an eye specialist, undergoing a lumbar puncture at the hospital, potentially taking pills, and (as shown later in the excerpt) doing some blood tests. Because there is no immediate translation, we don't see the patient respond yet. Instead, Nada, the language broker, responds with small tokens to index receiving and following the information. These "verbal gestures" are not irrelevant or ancillary to the overall analysis of the conversation. Researchers demonstrate strongly how these small forms of talk can accomplish important interactional goals such as evaluation, interpersonal involvement, and the creation of social meanings (Goodwin, 1991; Gumperz, 1982; Schiffrin, 1984). Notable is the variation in the ways in which Nada verbalizes these tokens. For example, the first "okay" in line 22 as "Aw::kay" expressed with extra effort could be linked to Nada's later turn in line 37, the doctor's recommendation for her mother to see an eye specialist and that thought may be what leads Nada to explain her mother's eye condition in line 37. In line 27 Nada performs her "yes" strongly and latches it to the doctor's prior turn to index understanding and acknowledges the doctor's effort in explaining the medical lumbar puncture from line 25. In other turns, Nada utters a simple "okay" to index receiving information, but in line 44 she prefaces the affirmation with "oh", a particle that signals a transition from confusion or ignorance to understanding or familiarity (Heritage, 1989). Similarly, we saw Karim perform a range of social actions through minimal respond

token. Thus it deserves mentioning that although prior studies report that minimal token of patient passiveness, this study shows that language brokereeas as well as language brokers actively use these small tokens for linguistic effect and communicational functions

Throughout the above excerpt, Amal shifts her gaze between Nada and the doctor, a sign that she is trying to make sense of the interaction between the doctor and Nada as it unfolds. In an extended turn, Nada summarizes the doctor's diagnosis and treatment decisions:

Excerpt 4.7

- 52 NAD: yqūl il-muščila māma mubrāsič il-muščila b'uyūnič. ahh
53 (.)'indič ḥassāsiyya. wda-yšūfūn 'uyūnič dā-ti'tīr 'ala 'ala
54 rāsč. dā-twuja'. y'ammā rāḥ yḥwlič 'ala m-ahh muḳtaṣṣ māl
55 'uyūn, ḥatta yafḥaṣ 'uyūnič waiḍā maqidar yu'ruf šinū huwwa
56 as-sabbab rāḥ yḥawlič 'al-mustašfa. ḥatta yḍarbūnič 'ubra
57 ḥatta ysaw – yqisūn ḍaḡaṭ māltič ḥatta yšūfūn 'ālī lū lā.
58 iḍ-ḍaḡaṭ (.) °māl (.) °'yūnič, (0.1) °so yqūl al-kūlla mu-
59 ṣūč mo- min alras, (0.1) b'uyūnič.

He says the problem, mom, is not with your head, the problem is with your eyes. Ahh, you have allergies and they see that your eyes affect your head and it hurts. Either they'll send you to an eye specialist to examine your eyes, if he doesn't find the cause, he will send you to the hospital so they can give you a needle so they can measure your blood pressure, to see if it is high or not. Pressure of your eyes, so he say the reason, the cause is not from not form the head, in your eyes.

- 60 AMA: bes gūlliyyla qūlliyyla ani rāyḥa 'ind um l-'yūn, qālatlī

- 61 'indič ḥassāsiyya wa'indič šwwiyya bu'd.
But tell him, tell him I have gone to the eye doctor and she told me I have allergies and a little far sighted.

62 NAD: ahh she went to [her doctor-(0.1) she went to her doctor=
 63 AMA: [wanṭṭatnī naḍārāt]
 and she gave me glasses
 64 HAN: =l:ike amm eye specialist, and she told her that(.) she
 65 has allergies and she ga:ve her glasses.
 66 DOC: yeah that's but this this's [something completely
 different.]

Starting in line 52 and ending in line 59, Nada conveys the doctor's diagnosis and treatment decisions, but some of the information and explanation have been lost. Nada relays the crux of the doctor's report, stating that no problem was found in the brain (translated as "head") but that there might be a problem with the eyes. Nada replaces the doctor's explanation about the nerve behind the eyes with allergies in her eyes. She does so, possibly due to insufficient language proficiency, despite the doctor's explanation in a prior turn that allergies and neuro-ocular disorders are separate issues. Amal, in line 60, also asks Nada to inform the doctor about her earlier visit with the eye doctor who diagnosed her eye allergies. The doctor again confirms that Amal's present condition is different from her earlier diagnosed eye allergies. This exchange should have informed the doctor that Amal did not receive clear information on her condition, but he does not demand nor offer further explanation. Nevertheless, this example offers evidence that Amal is actively reacting to the doctor's diagnostic decision.

As Karim did in his case, below Amal asks to confirm that there is no serious problem (line 70), but the confirmation once again comes from the language broker who generates a confirmation based on information previously stated by the doctor, rather

than relying the question to the doctor then translating a new, real-time statement of confirmation from the doctor:

Excerpt 4. 8

70 AMA: la‘ad huwwa ṭāli‘ ya‘nī šī yamhum [hassa?
So is there something shown up with them now?

71 NAD: [la ma-ṭāli‘ šī. (.) d::aygūl
72 bil-‘yūn il-muščila ygūl ‘andič šwwiyya ḍaḡuṭ bass huwwa
73 ygūl ani hassa šifat wmākū šī. (0.1) fa-da- ygūl ḥatta
74 inḥaūlič ‘la doctor māl ‘yūn wanšūf. (0.1) ygūl bass ar-rās
75 ma-bī kūlšī

No, nothing shows. He’s saying the problem in the eyes, he says you have a little pressure, but he says I saw nothing so he says we will send you to a doctor for eyes and we’ll see. He says but there is nothing with the head.

76 DOC: does she unders::tand o::r-

77 NAD: yes

Throughout the above exchange between Amal and Nada, the doctor writes on his paper. Amid his silence, Amal (similar to Karim in the case presented earlier) uses the time to ask for a confirmation of the diagnosis of her condition. Nada in lines 71-75 recapitulates the information to her mother. The doctor observes the dyadic conversation between the mother and daughter; receiving no translation, he checks for the patient’s understanding in line 76, showing his attentiveness to the sequence of the brokering process. The doctor next suggests another step (line 78), to which Amal again adds information she finds necessary to share:

Excerpt 4.9

- 78 DOC: and I'm gonna a:sk for some special blood tests too, to
79 check [the hormone levels
80 NAD: [okay (0.1)
81 raḥ ysawwilič ahh-aḳtibar mal damm (.) da-yaktib hassa
He is going to do blood test. He is writing it now
82 AMA: °faḥiṣ da::m- lu bāčir lu 'ugbah 'andi (0.1) taḥliyl hnāk
Blood test-either tomorrow or after I have blood test there
(Hannah looks at her mom and then the doctor then puts her
head down))
(0.8)
83 AMA: gullīla ya'nī mū il-muščila min il-mafāsil māl-ruqubah
84 da-tuḍrub 'ala rāsi?
Tell him I mean the problem is not from my neck joints? Is affecting
my head?
(0.4)
85 NAD: °wait
(0.4)
86 AMA: anī hāy aš-aš-šuhūr 'uyūni tḡawš tḡawš hwāiya
My eyes these months are blurry very blurry
(0.2)
87 NAD: huwwa da yqūl il-muščila mūbir-rās
He is saying the problem is not from the head

In line 78, the doctor decides to check Amal's hormone level. Amal informs her interlocutors that she has scheduled a blood test appointment with her primary doctor (by "there," she refers to the clinic that ordered the neurologist's visit). Her utterance is not translated immediately, but later Nada conveys this information to the doctor, who decides to communicate with Amal's primary physician to avoid ordering similar tests. Amal's involvement thus alters the course of her future treatment. In line 83, Amal

proposes a reason for her headache and asks Nada to relay her attempt at a self diagnosis to the doctor. Nada in line 85 asks her mother to wait but the proposal never gets translated. In line 86, Amal adds information that may confirm or justify the doctor's diagnosis: the doctor orders Amal to see an eye specialist, whereupon Amal remarks that her eyes have indeed been very blurry. Neither of these turns are translated. This information, had it been transferred, could have affected the patient-physician interaction in this phase; nevertheless, as the doctor finishes explaining the steps proposed for Amal's treatment, Amal again shows her attentiveness and active engagement:

Excerpt 4.10

- 118 AMA: hassa šrāḥ ysawwī,
Now what is he going to do?
- 119 NAD: hh yeah rāḥ ydiz fax lil-doctor malt-doctor Nasr. ḥatta
120 ysawwūliċ ḥaḍa a:l-taḥlīl.
Yeah he is sending a fax to yo-doctor Nasr, so they do hat test.
- 121 AMA: haa? w::mal-‘yūn, šwwakit inrūḥ?
Haa? and the one for eyes, when you are going to him?
- 122 NAD: what about the eyes, like [the eye °specialist
- 123 DOC [oh I'm gonna ask the girls to
124 set up an [appointment=
- 125 NAD: =o:kay=
- 126 AMA: =whāy il-doctor-aa- wīn ḥikūn? ḥaḍa al-ṭabīb.
And this doctor-where is he going to be? That physician.
- 127 NAD: yā ṭabīb?
What physician?
- 128 AMA: māl abū l-‘yūn?
The one for the eyes?
- 129 NAD: and the eye specialist like it'll be far away from here or-

130 DOC: I ha-hh-it depends up:oon what the insurance says.

131 NAD: okay

132 DOC: th-they're the ones who have contracts with different

133 doctors.

134 NAD: ygūl y'timid 'al il-insurance māltič
He said it depends on your insurance

135 AMA: okay

In the excerpt above, Amal takes the initiative in asking many detailed questions about her treatment process, beginning with a question about the next immediate step (line 118) before proceeding to questions about the modalities of future doctor's visit (e.g., appointment times and office locations). In this exchange, Amal registers her tacit agreement at the beginning with the doctor's diagnosis and treatment decisions, but she clearly and actively enacts her involvement later through asking questions and providing information that influences the future course of actions. Some of her turns and questions are left untranslated, possibly due to Nada's linguistic inability. Had they been translated, they might have triggered more interaction and information transfer between the doctor and the patient.

In the two above cases, there are many similarities, as well as some differences, in patterns of interaction. In both cases the doctors open their decision statements with similar phrasing: announcing that there are "a couple of things we can do." These "couple of things" are determined courses of action that the doctors have designed for their patients. The medical practitioners in both examples stay attentive to their patients' actions and to the brokering process. In both cases, the method of broking has had an impact on the interaction. The prompt translation of the doctor's

words allowing Karim to respond more immediately whereas in Amal's case, Nada's delayed translation prevents the doctor from hearing Amal's assessment; nevertheless, in both cases the patients stay actively involved during the decision process. Similar to each other, both patients request a recapitulation of information exchanged at their appointments, including greater detail about their course of treatment and the proposed next steps. Additionally, although the mass of literature concerned with medical interactions dismisses small forms of talk as signs of inactive involvement, this study contends otherwise. Karim's and Nada's small tokens of agreement are far more indicative of their concern and involvement than they may originally appear. First, these minimal response tokens merit reconsideration in and of themselves, as they show acute attentiveness to the interaction under way. Second, they deserve analysis within the larger set of the interactional phase where they occur. The two cases above demonstrate that patients do not always have opinions different from those of the medical expert they consult. Patient agreement should not be interpreted as a form of passivity.

4.4. Conclusion

The current chapter highlights important aspects of decision-making in brokered medical interviews: it defines a common format of decision delivery, it describes the ways patients enact their involvement whether in agreement or disagreement with the decision, and it imparts knowledge of the ways in which the brokering process may shape the encounter.

Doctors seem inclined to provide some form of sharing practice during the decision-making phase. Examining decision episodes as a complete activity, however, reveals that doctors' greater receptivity to "sharing practice" has resulted from this proliferation of related literature. In fact, medical decisions are not only designed by the doctors, but interaction and knowledge are advanced and controlled according to the doctors' initiatives and are dependent upon their expert knowledge. Doctors empower patients temporarily by offering possible choices and using linguistic strategies that delineate a collective action. For example, through the use of "we" and words such as "pick," "choose," and "a couple," doctors cast their decisions as if reached through collective action, the result of a collaboration in which all possible choices and alternative treatments are presented and considered. They may also empower patients by extending an offer to make a choice and/or soliciting their concerns. Through the use of different interactional strategies, however, the doctors manage these offerings. Language-brokering literature has proposed that language brokers are the decision makers; this study shows that decisions made during brokered medical interaction, similar to same-language medical interaction, are in fact mainly the doctor's domain.

This chapter additionally demonstrates that the language brokeree performs their agreement as well as disagreement actively. In the hearing aid case, the doctor opens the decision phase by stating that there are different options for hearing aids, although he pointedly supports only one type. The doctor's bias is challenged and temporarily retarded by the patient. The way in which the patient insists on her preference affects how the doctor presents his information: since the patient is concerned about the appearance of the hearing aid, the doctor presents his choice in such a fashion as to

assuage her aesthetic concerns (e.g., the size of the hearing aid is overstated; the behind-the-ear part could be ordered in a color that matches her hair; her hair could cover the obtrusive part). The patient's preference, however, is never fully discussed. The doctor neither offers a comparison between the two hearing aids nor weighs the advantages and disadvantages of each device. When the doctor does finally present his patient with a choice, it is conveyed with a laugh and in pointed language that suggests the offer is both perfunctory and disingenuous.

In the two cases of agreement, the patients do not seem to have a specific preference at the outset. They are ready to seek their doctors' expert opinions. In both cases, the proposed treatments are contingent on their cases' development. In all three cases the patients play an active role in the process of decision-making. They agree or disagree, ask questions, and offer hypotheses about their illnesses and treatments. On many occasions, the patients as well as the language brokers use many forms of small talk to index different actions. These small tokens are traditionally considered signs of patients' passivity during medical decisions. This chapter offers a re-conceptualization of the role these tokens play in the medical encounters, arguing that such tokens are important interactional resources that show attentiveness to the details of the interaction and whether or not the patient is in agreement.

Another shared feature of the three encounters is that all three patients use the interval during which the doctor is silent to ask for reassurance about their condition. In all three cases, that reassurance and information summary come from the language broker. The method of brokering influences the interaction in this phase to a great deal. When receiving translation promptly, patients have the chance to respond and ask

questions about their treatment, while delayed translations or non-translation limits patient-physician negotiation. This chapter certifies that language brokers are not intrinsically the decision makers in a medical domain, however their actions do affect the process a great deal, and consequently influence the outcome. Whereas aligning with the expert's decision may result in a patient's dissatisfaction and a case of disagreement, staying neutral and conveying the patient's inquiries lead to more patient involvement and greater acceptance of proposed treatments.

Chapter 5: Conclusion

While it is true that research on mediated discourse, including language-brokering and professional interpretation, has been growing steadily in the last three decades, little has been said about the language brokeree—the person who needs mediating. Relevant studies generally center on analyzing the mediator's role in facilitating interaction more than the actions of the novice speaker. While the number of non-English-speaking patients is fast increasing in our healthcare clinics and hospitals, accumulating evidence from medical research is showing that successful medical experiences are achieved through effective communication. It is therefore vital to understand the language brokerees' interaction with their medical caregivers. This dissertation fills such a gap by documenting the organization of talk and the embodied practices of individuals with limited English-speaking ability. The verbal and non-verbal communicational means of Iraqi language brokerees in medical encounters form the basic unit of analysis in this study.

Excluding the first chapter, which introduced the study, each chapter has focused on a particular aspect of the language brokerees' interactional role and the ways in which their roles were considered, facilitated, or hindered. Chapter 2 gave a descriptive analysis of the ways in which language brokerees constructed agency and speakership, using various semiotic resources to override the brokering process and thus presenting themselves as competent members. Chapter 3 examined asymmetries of participation by studying turn-taking systems qualitatively and quantitatively. Quantitative analysis looked at distribution of talk, pointing out that patients were consistently provided with fewer opportunities to participate. Microanalysis looked at the patterns of turn-taking

systems and the factors that influenced patient participation. Chapter 4 gave a detailed analysis of reaching medical decisions and the patients' role in this phase. The principle findings of each chapter will be briefly reviewed below, followed by a discussion that includes limitations and implications for future research.

5.1 Chapter 2

In chapter two, I examined the language brokeree's communicative competence. Relevant research presents the language brokeree as a speaker who solely interacts via a proxy using the language of origin. Analysis in this chapter challenged this traditional view and presented the language brokeree as an active social actor who interacts with the local environment to build agency and speakership independently. The interactional events analyzed in this chapter demonstrate the ways in which the non-English-speaking patients exercise their communicative competence and interactional involvement.

Findings revealed that the language brokerees made use of the structure of questions (the tone of stating a question enables the hearer to predict the end of the turn), the composing and decomposing of prior talk, action embodiment, and a basic competence in English. Through the use of these resources and by monitoring the interaction, language brokerees presented themselves as competent members despite their limitations. Language brokerees also constructed their agency by displaying knowledge of personal experiences and asserting their right to present such knowledge. Sometimes the language brokers answered the doctors' questions directly and, in doing so, they occupied the interactional spaces designed for the patient. The language

brokerees, however, redefined the roles of participation by correcting or adding to the information given by the language broker. Using such a rich host of interactional resources in various sequential places, the language brokerees built their patienthood and speakership.

My findings provide valuable information on the non-English-speaking patients' communicative competence. Through active participation and keen observation, language brokerees sustained involvement in a context rooted in diversity and limitation. Studies show that soliciting patient involvement increases the patients' recall of information, understanding, and commitment to their doctors' advice (Heritage and Maynard, 2006; Stivers, 2005). My findings in this chapter, then, encourage physicians and medical staff to consider their patients' contributions attentively and to involve them more in the conversation.

Future studies on patients' communicative competence could give more focused analysis on patients' action in each phase of the medical visit. Studies evidence that patients appear more active in certain parts of the medical interview than others (Heritage and Maynard, 2006; Stivers, 2005). Chapter 4 in this dissertation examined the decision-making phase and other chapters took note of patient contributions during the opening and history-taking phases. More detailed analysis focusing on each phase may illuminate further the factors that encourage or discourage patient participation.

To unpack how the Arab patient constructs actions through grammar, further research endeavors might focus on analyzing how patient contributions are organized through the structure of the Arabic language. This issue was not taken up in full detail in this study and remains to be examined. Additionally, this chapter shows a number of

diverse ways in which novice English-speaking patients constitute interactional commitment in medical settings; future research could expand further on language brokers' actions in other language brokering settings.

5.2 Chapter 3

In Chapter 3, I provided qualitative and quantitative analyses of the distribution of turns-at-talk in three brokered medical encounters. The aim was to elucidate understanding of the amount non-English speaking patients participated in comparison to their interlocutors. I employed two frameworks: number analysis to study frequency of participation and microanalysis to study patterns of participation. These analyses considered the impact of the dual discursive forms that governed the interaction: the institutional discourse between patient and physician and the informal familial discourse between two family members. My goal for this chapter was to answer three questions: 1) What is the amount of patients' talk in comparison to their doctors' and language brokers'; 2) what is the form(s) of turn-taking system that structures participation; and 3) what are the factors that influence frequency and forms of participation.

Findings confirmed that the language brokers took more turns than the two monolingual participants; not all turns, however, were renditions of the doctors' and patients' talk. In all examined encounters, the patients produced a smaller percentage of turns in proportion to the doctors and the language brokers. The main finding in this chapter was that same-role participants (e.g. patients, language brokers, and doctors) exhibited proportionately similar numbers of turns in each of the examined encounters. This result occurred despite the fact that each encounter had its own unique set of

variables including length of and reasons for the visits. Qualitative analysis suggested that turn-taking sequences are shaped to a great deal by the ways the language broker mediates the interaction. More specifically, analysis showed that the language brokers mediated interaction in ways that reflected their linguistic ability and the ways they exercise responsibility toward their parents, which in turn influenced their parents' participation. Despite this mediation and other constraints, however, the patients ensured active involvement by creating and seizing opportunities to install themselves as competent members. Both analytical frameworks, quantitative and qualitative, showed that brokered medical discourse is not a homogeneous discourse, but it has the ingredients of institutional and conversational discursive norms.

Studies often look at participation patterns from the perspective of visibility and power. This study confirmed a relationship between the language brokeree's participation and the brokers' knowledge, linguistic ability, and exhibited responsibilities toward the language brokeree. Depending on this relationship, three types of brokering sequences were identified: 1) immediate brokering, 2) delayed brokering, and 3) extended (multiple turns) brokering. Chapter 3 also confirmed, similar to Chapter 2, that the language brokerees kept an active role despite delimiting factors.

The main limitation of this chapter lies in the number of encounters examined: three medical visits. For a more robust application of this type of research, a much larger study covering a wider range of subjects, regions, and different types of medical consultation would be necessary. Chapter 3 also suggested that the small differences in patient participation found across the three encounters relates to the age of the language brokers. The older language brokers seemed to take on a bigger role than just

interpreting, whereas the younger language broker depended more on her parent to answer the doctor's questions and provide information. This finding should be further investigated with a large number of participants from different age groups.

4.3 Chapter 4

Chapter 4 centered on studying patient participation in a specific part of the medical encounter: the decision-making phase. In this chapter, I highlighted important aspects of medical decisions, one of which was decision formats. As physicians stated their treatment decisions, they seemed to follow a specific format that seemed to show possible options and shared practice. Examining decision-making as a complete activity, however, revealed that treatments were not only designed by the doctors based on their expert knowledge, but interaction and information were advanced and controlled according to the doctors' initiatives. Doctors empowered patients temporarily through linguistic strategies that delineate a collective action and possible options. For example, through the use of "we" and words such as "pick," "choose," and "couple," doctors cast their decisions as if reached by consensus after presenting all possible choices and alternative treatments and considering them together. They also empowered patients by occasionally extending an offer to make a choice and/or soliciting their concerns. The doctors nevertheless used a variety of interactional strategies to manage these offerings and thus controlled the processing of treatments.

Language brokering research has suggested that language brokers, because of their positioning as the experts of the language and culture of the dominant society, often become the decision makers for their families. In this study, I demonstrated that

decision-making in brokered encounters is a complicated process in which many factors intertwine and affect its progress. It is true that the language broker is an integral part of the decision-making process; he is not, however, the decision-maker. Nevertheless, the way language brokers mediated the process--which was found to be dependent on their English proficiency, their level of responsibility for family members, and possibly their age (as found in the previous chapters)--did indeed influence the decision-making process. These characteristics affected how and what brokers translated, which in turn influenced the process of reaching decisions; thus, the method of brokering had a significant impact on the process of decision-making. On some occasions the language brokers did not translate the patients' comments and questions, which not only affected the doctor-patient interaction but also prevented the doctor from knowing the patients' concerns and opinions. Generally, Chapter 4 acknowledged that language brokers were not intrinsically the decision makers in a medical domain, however their actions did affect the process a great deal, and consequently influenced the outcome. In all three cases the decision-making processes were strongly controlled by the physicians. Even so, the patients continued to play an active role by asking questions, offering hypotheses about their illnesses, and suggesting proper treatments.

Although these findings are limited by the scope of medical consultations and medical problems, this study is the first to give microanalysis on language brokers' participation during decision-making episodes. Extensive research is needed in medical as well as other brokering settings to shed more light on the complicated process of negotiation and reaching decisions in triadic interaction.

5.4 Significance of Findings and Future Research

Due to the increasing number of limited-English-speaking individuals in our society, this dissertation aimed to study their participation in healthcare settings, an important and sensitive venue of everyday life. The goal for this dissertation is to contribute to three fields of research: language brokering, medical interaction, and communicative competence in a context of linguistic diversity and limited ability. In terms of language brokering research, this study demonstrated the language brokerees' ability and contributions to facilitating meaning-making through the use of verbal and non-verbal communication. The study documented the cooperative nature of the language brokerees' action as they build their contributions on the utterances provided by other interlocutors. To build actions cooperatively participants must reach a common knowledge of the participants' roles and the actions they are pursuing by enabling the development and progress of their common interactional goal. This complicated, yet common, feature of interaction is the dynamic in which new competent members are continuously created (Ochs & Schieffelin, 1983). This study demonstrated the ability of the language brokerees to build relevant actions despite their limited English proficiency. These findings should encourage representatives of the dominant society to give more focused attention to the actions of novice individuals, recognizing them as being a relevant and integral part of interaction.

Consistent with previous scholarship, this study delineates the sensitive and multilayered position of the language broker, and further imparts knowledge on the elements that contribute to the language broker's roles. As they facilitated interaction, language brokers often changed positions between immediate participation and

translation. Wadensjo (1998) made note of the different roles played by the interpreters, which includes mediators, intermediates, gatekeepers, caregivers, and interaction coordinators. This study hints at a possible connection between the roles language brokers play when taking care of their parents and the way they mediate brokered interactions. Older language brokers are used to taking care of their parents in everyday situations, therefore they assume the same role at the doctor's office. They answer questions, add information, and intervene in ways that may hinder language brokerees' participation. In a similar vein, Bolden (2012) showed that the interpreters often use their language expertise to gain the right to speak on the behalf of the novice speaker. The language brokerees' participation, however, has the potential to redefine the language brokers' role to its more expected form. For example, by performing actions such as adding and correcting information, evaluating statements, and asking and extending on questions, patients display their right to be firsthand representatives of their own personal experiences, thus, giving language brokers their cue to retreat back into the more conventional role of mediator.

The analysis in this study noted a different pattern of mediation by the young language broker. The teenage language broker seemed less inclined to interfere as a participant and adhered more to her role as the broker. Although participants' roles changed and intersected in a consistent and complicated manner regardless of whether the interaction was mediated by an older or younger language broker, age nevertheless seemed to be a factor in the distribution of these roles. More studies with larger numbers of participants would help further unpack the relationship between age, possibly gender, and participants' roles..

The physicians in this study were generally found to manage the interaction in similar ways to what has been reported on same-language doctor-patient interaction (Frankel, 1995; Mishler, 1984; West, 1984; West & Frankel, 1991). The doctor's role constantly reflected a paternalistic model of medicine in which he controlled the progressivity of the interaction and the providence of information and treatment. Research evidence increasingly supports that effective physician-patient communication leads to better healthcare decisions and patient and physician satisfaction (Roter and Hall, 2006). For this reason, research has been directing its attention to how physicians can change communication approaches with their patients in order to achieve more effective outcomes (Anderson & Sharpe, 1991). Other research directions emphasize the patients' responsibilities for communicating effectively (Harrington et al 2007). In brokered medical interviews, more research should direct its attention to finding models and suggesting strategies that support the language brokers' work and at the same time ensure effective patient participation.

Despite limitations and constraints, this study has effectively documented the patients' active involvement as they interact and accept or resist their doctors' input. These findings provide a contrast to the passive patient role found in many medical studies. For example, Heath (1992), Perakyla (1998) and Stivers (2005) have reported patients accepting diagnoses with minimal response. This study, however, showed patients actively asking questions, requesting confirmation, and offering hypotheses of their illnesses when they received their doctors' diagnoses and treatment decisions. Their actions altered the interaction and participants' roles in many ways. Such findings are possibly culturally and situationally bound. Further studies that take deeper

consideration of the Iraqi language and culture may illustrate these findings to a greater degree. In addition, future studies should look at the organization of interactional practices in the Arabic language such as repair, repeats, overlaps, and questions design, in order to understand better the ways in which Iraqi, or Arab, patients organize their contributions.

This study highlighted three styles of brokering, which are also patterns of turn-taking in brokered encounters: 1) delayed brokering, 2) immediate brokering, and 3) extended turns of broking. These patterns seemed related to the language broker's proficiency and roles of engagement; they also shaped patient participation significantly. Whereas receiving prompt translation gave patients the chance to voice concerns in a timely manner, delayed translations or non-translation limited the patients' ability to act upon the received information. Educating physicians and medical caregivers on such patterns and how they can be recognized could effectively change patient participation. For example, doctors can be trained to pay more attention to their patients' non-verbal communication, particularly the use of gaze or gesture to initiate action and take a turn. In addition, doctors can easily notice when language brokers answer questions directly without referring back to the patient, and instead insist on receiving the patient's direct input.

Another factor that was found to influence the structure of participation is the physicians' attention to the brokering process. Some of the analyzed segments of interaction in this study exemplified the doctors' attentiveness to patients' talk, language broker-language brokeree interaction, and the time needed for translation. In one example, the doctor paused upon hearing the patient's interruption and waited for

translation of her utterance. In another example, the doctor stopped and asked the language broker to translate what had been said thus far. Sometimes the doctor even parsed his utterances in a way that allowed for time for translation. There were other examples, however, where the doctor extended his turns and thus compelled the language broker to ask for more time to translate. These practices can be brought to the medical personnel's attention in order to reach a more effective model of communication in such situations.

As noted above, the goal of this dissertation was to contribute to existing sociolinguistic research concerning brokered discourse, novice speakers' competence and medical interaction. First, the study determined the interactional role of non-English-speaking patients in brokered medical encounters, in particular to provide a first step to the emerging medical communication research on brokered medical encounters. The study also encourages medical training to pay more attention to non-English-speaking patient communication. Second, the novice speakers' organization of social, linguistic, and paralinguistic abilities was explicated. Third, the study demonstrated the asymmetrical participation in brokering encounters and the factors that influenced such participation. Fourth, the study pointed out some of the inherent features of brokered medical discourse. Fifth, the study also highlighted doctors' practices that lead to more successful language brokeree-physician communication. Hopefully more research efforts such as this study will accumulate and bring about changes in medical training and lead to the development of more patient-centered care.

Several areas of future research are suggested by this study. Whereas this study was based on a small number of consultations collected in San Diego, California, a wider region incorporating diverse practitioners and geographical areas would be able to strengthen the claims made here.

In addition, the study documented some incidents of interaction between the patients and the nurses. These incidents, however, were not the focus of this study; future research may broaden the scope of inquiry to include medical interaction with nurses and other medical staff. Patients usually fill forms, take X-rays, and receive instructions before and after meeting with their physicians. These forms of medical communication affect patient healthcare experiences, but they have not been explored in literature yet. To understand the interaction occurring in medical settings, a wider range of discourse should be examined, including communication that takes place prior to and after doctor consultations.

Finally, I want to re-emphasize that my study findings are based on a limited number of families, medical consultations, and geographical area. These findings, therefore, are not generalizable or permanent features of brokered medical discourse. They are, however, important indicative features of brokered encounters and represent a first attempt to focus explicitly on the non-English speaking patient's participation. My findings also suggest future directions for change, which it is the value of doing this kind of work.

APPENDIX 1: TRANSCRIPTION CONVENTIONS

The following set of conversation analytic transcript symbols used in this dissertation, and in conversation analytic research in general, was developed by Gail Jefferson (1978, 1996) to capture the details of everyday talk, as it occurs actually.

[	beginning of an overlap/simultaneous talk between turns
]	ending of an overlap/simultaneous talk between turns
=	latching—two utterances without any perceptible pause.
(0.2)	length of silence in tenths of seconds
(•)	micro-pause
.	falling intonation
?	rising intonation
,	continuing intonation
::	lengthening of the last sound
-	cut-off of current sound, self repair
↑	raise in pitch
< >	slow speech
> <	rushed speech
hh	hearable aspiration
.hh	hearable inbreath
°word	quieter than the surrounding talk
<u>word</u>	stress or emphasize
(word)	indicates transcriber's uncertainty on the utterance
((word))	transcriber's commentary, description of events

APPENDIX 2: TRANSLITERATION CONVENTIONS OF ARABIC

Arabic letter	IPA	Symbol	Phonological description
أ	<u>ʔ</u>	ʔ	Voiced glottal plosive
ب	b	b	Voiced bilabial plosive
ت	t	t	Voiceless alveolar-dental plosive
ث	θ	θ	Voiceless dental fricative
ج	dʒ	j	Voiceless Approximant palatal
چ	tʃ	č	Voiced dento-alveolar affricative
ح	ħ	ħ	Voiceless pharyngeal/epiglottal fricative
خ	x	k	Voiceless uvular fricative
د	d	d	Voiced alveolar-dental plosive
ذ	ð	ɖ	Voiced dental fricative
ر	r	r	Voiceless trill alveolar ²
ز	z	z	Voiced dento-alveolar fricative
س	s	s	Voiceless dento-alveolar fricative
ش	ʃ	š	Voiceless palate-alveolar fricative
ص	s ^ʕ	ʂ	Voiced emphatic alveolar fricative
ض	d ^ʕ	ɖ	Voiced dental emphatic fricative
ط	t ^ʕ	ɗ	Voiced dento-aveolar emphatic fricative
ظ	ð ^ʕ	ʐ	Voiceless dento-aveolar empathic fricative
ع	ʕ	ʕ	Voiced pharyngeal fricative
غ	ɣ	ḡ	Voiced uvular fricative
ف	f	f	Voiceless labio-dental fricative
ق	q	q	Voiced velar plosive
ك	k	k	Voiceless velar plosive
ل	l	l	Voiceless dento-alveolar lateral
م	m	m	Voiceless bilabial nasal
ن	n	n	Voiced denot-alveolar nasal
ه	h	h	Voiceless glottal fricative
و	w	w	Approximant labial
ي	y	y	Voiced Semi-vowel

² The Iraqi [r] is pronounced softer than the emphatic trill [r] found in most North African countries. A single “r” is pronounced between trill [r] and flap [r].

APPENDIX 2: TRANSLITERATION CONVENTIONS OF ARABIC

Long vowels:

Short vowels	Long vowels	Transliteration symbol
a	ā	Low central unrounded
i	ī	High front unrounded
u	ū	High back rounded
e	ee	Mid front unrounded
o	oo	Mid back rounded

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