

**Interpreting and Translating in  
Public Service Settings**  
*Policy, Practice, Pedagogy*

**Edited by**

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# Interpreters in Emergency Wards

## *An Empirical Study of Doctor-Interpreter-Patient Interaction*

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**Abstract.** *This paper explores interpreting practice in the field of emergency medicine. The analysis is conducted on a corpus of tape-recorded interpreter-mediated encounters between the medical staff of an Italian hospital and English-speaking tourists. The specificity of the setting – an Accident & Emergency Ward – where patients are not members of a minority community, but feel nonetheless vulnerable because the emergency has occurred away from home, as well as the unusual profile of the interpreters who are employed on a seasonal basis as “administrative assistants”, make this study an atypical investigation into public service interpreting. Through the use of different theoretical approaches – from Fairclough’s distinction between powerful and non-powerful participants, to ten Have’s notion of phase-specific conversational patterns, to Hall’s theory of contexting – it is demonstrated that asymmetry in medical encounters is the product of a complex set of factors. More specifically, it is a shifting variable which is locally and interactionally determined through successive turns at talk by all interlocutors, doctor, patient and interpreter alike. The latter, in particular, is seen to behave as a fully-fledged social actor who makes independent choices on the basis of his or her assessment of the goals and requirements of the ongoing activity.<sup>1</sup>*

### 1. Introduction

This study is part of a wider research project designed to build a corpus of audio-recorded dialogue interpreting sessions taking place in a variety of professional fields – from healthcare to immigration services and business negotiations – which can serve as an empirical basis for investigation of real-life interpreting practices. Given the confidential nature of most of these face-to-face encounters and the consequent difficulty in obtaining authorization to record them, to date, relatively few analyses have been conducted

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<sup>1</sup> I am indebted to Diana Unfer for the time and energy she spent in collecting the data. Without her enthusiastic commitment, this study would not have been possible.

on transcribed interpreted interactions.<sup>2</sup> In an attempt to contribute to this area of research, the present discussion explores the behaviour of participants in medical encounters from the point of view of their contribution to and control over the ongoing activity. Taking as a starting point the by now largely accepted and documented view of the dialogue interpreter as an active participant in the interaction,<sup>3</sup> the following analysis will show how the interlocutors' moment-by-moment decisions concur to shape the structure of discourse at the various stages of the communicative event.

## 2. The setting and the data

The data for this study were collected over a one-month period – July 2004 – by a student interpreter who worked under my supervision, Ms. Diana Unfer.<sup>4</sup> Since ensuring the anonymity of both the facility and the staff involved in the encounters was a *sine qua non* condition to obtain the authorization to record, it will only be said here that the setting is a National Health Service hospital, located in a popular tourist destination, a seaside resort in Northern Italy, which, every summer, attracts large numbers of holidaymakers from the United Kingdom, as well as from other countries of northern, central and eastern Europe. Given this seasonal inflow of foreign visitors, the local health authorities operate every year, from May to September, an additional Accident & Emergency Ward specifically reserved for tourists (*Ambulatorio di Medicina Turistica*) within the Casualty Department of the general hospital.

Posts for “Administrative Assistants-Interpreters” are usually advertised every two years, following an assessment of the previous years' needs in terms of number of staff and languages required.<sup>5</sup> The job title is deliberately

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<sup>2</sup> For a review of past studies on recorded interaction in the field of medical interpreting, see Bolden (2000). More recently, three full-length monographs have appeared – namely Angelelli (2004); Meyer (2004) and Bot (2005) – which draw on extensive corpora of recorded data.

<sup>3</sup> See Wadensjö's (1998) seminal work on the multi-faceted nature of interpreters' conduct in face-to-face interaction.

<sup>4</sup> Her unpublished dissertation (Unfer 2003-2004) offers a detailed, first-hand description of both the professional setting and the recorded data.

<sup>5</sup> The hospital in question has been operating the interpreting service for more than 15 years and is currently participating in an EU-wide research programme, which focuses on enhancing communication between medical staff and foreign patients. At the end of each consultation, the latter are routinely asked to fill in a questionnaire to evaluate

chosen to indicate that successful applicants will be asked to perform a series of administrative tasks alongside the interpreting one, such as hospital reception work, filing patients' details, providing information on services, procedures and payments, etc. Requirements for the post make no specific mention of academic qualifications in either translation or interpreting. The selection is carried out through an interview which is designed to test the applicants' knowledge of the foreign language(s). The successful candidates are then recruited on a seasonal basis for a period of 5 months. On-the-job training is provided, but only in the administrative field.

From a practical point of view, it is interesting to note that interpreters wear the same white uniform as the medical staff and could easily be mistaken for bilingual nurses by foreign patients, and all the more so because they prepare the patients' case notes, inquiring about the nature of the complaint, and sometimes even about the symptoms, before ushering them into the doctor's room. At the end of the consultation with the doctor, interpreters are once again left to deal on their own with the patients, to give them technical instructions, or simply direct them to another hospital facility or to the closest chemist. We will see that this perception of the interpreter as a member of the medical staff has an impact on the interaction.

The recorded sessions involved the following participants. The interpreters were two young women with a degree in foreign languages; they have been renamed here Tina and Teresa (i.e. names beginning with T for tourism). Out of the 9 encounters, Tina interpreted 6 (T.1, T.2, T.3, T.6, T.7, T.8) and Teresa 3 (T.4, T.5 and T.9). The doctors were all male. The patients, or at least one of the parents in the case of children, spoke English, although only in 4 cases were they British nationals and native speakers of the language. The remaining patients came from Poland (2), Denmark (2) and the Netherlands (1).

Table 1 offers a schematic illustration of the encounters. Sessions 1 to 5, highlighted by means of shaded cells in the table, will provide the exemplification for the present discussion. All the complaints reported by the patients were either minor injuries or minor ailments. Aside from the requirement of anonymity, this was the only limitation imposed on the observer, who was not allowed in the room when more serious cases were being dealt with.

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the quality of the information they received through the interpreter. The results of the survey will be used to critically assess and improve the interpreting service.

Place	A&E Ward for Tourists, Italian NHS Hospital		
	Transcript 1 (T. 1)	Transcript 2 (T. 2)	Transcript 3 (T. 3)
Date	14 July 2004	14 July 2004	22 July 2004
Duration	10' 49"	6' 31"	14' 27"
Interpreter	Tina	Tina	Tina
Patient	Polish baby girl with her parents	English woman	English woman
Complaint	High temperature and red dots	Eye problems	Swollen ankles
	Transcript 4 (T. 4)	Transcript 5 (T. 5)	Recording 6
Date	27 July 2004	27 July 2004	19 July 2004
Duration	6'	11'	6' 22"
Interpreter	Teresa	Teresa	Tina
Patient	English girl with her parents	Polish baby boy with his parents	Young Dutch woman accompanied by her employer
Complaint	Ear pain	High temperature	Sore knee
	Recording 7	Recording 8	Recording 9
Date	22 July 2004	22 July 2004	27 July 2004
Duration	9' 10"	14'	4' 35"
Interpreter	Tina	Tina	Teresa
Patient	Danish boy with his parents	Young Danish wom- an	Young English man
Complaint	Nasal herpes	Stiff neck	Sore throat

Table 1: The recorded sessions

### 3. The medical encounter in an Accident & Emergency (A&E) Ward

Following the literature on doctor-patient interaction (see, e.g., Byrne and Long 1976; Heath 1986; Waitzkin 1991) the typical phase-by-phase structure of a medical encounter can be represented as follows:

1. opening
2. complaint presentation
3. verbal and physical examination
4. delivery of diagnosis

5. prescription of treatment and/or advice
6. closing

Within this conventional framework, ten Have (1991:151) suggests classifying sequences of talk, which he calls “episodes”, according to their higher vs. lower “conversational quality”, i.e.:

- type 1 episodes, in which non-medical topics are discussed;
- type 2 episodes, which have to do with medical topics that are relatively marginal to the main agenda of the consultation;
- type 3 episodes, in which the main medical agenda is explicitly developed.

In the opening phase of an encounter, parties usually engage in small talk (type 1 episodes) to establish a relationship. Type 1 and type 2 sequences may also occur whilst a predominantly non-verbal activity is being performed, such as the physical examination. Type 2 episodes tend to concentrate mainly towards the closing of the encounter (stages 5 and 6 above), as the patients may want to “clarify any residual matters” following the physician’s “exposition” of the diagnosis (Tebble 1999:185), or “elicit some minor medical advice or submit some medical idea of their own, even if it is not related to the major agenda” (ten Have 1991:151). Type 3 sequences, on the other hand, are usually characteristic not only of the announcement of the diagnosis, but, prior to this, of the verbal stage of the data-gathering activity, otherwise known as history taking (or, in medical jargon, differential diagnosis).<sup>6</sup> This phase, which is the least “conversational” in nature, normally entails a question-answer pattern tightly controlled by the doctor, where patient-initiated topics are largely dispreferred.

Before discussing the notion of asymmetry in the questioning format, let us briefly consider the features which differentiate consultations concerning minor injuries and ailments in an A&E Ward, in particular those involving foreign patients, from similar events occurring in other healthcare settings. Unlike in the case of the “informing interview” (see Maynard 1991, 1992), when doctors meet again with patients, after the latter have gone through a series of examinations, to present the findings and deliver a final diagnosis, the doctor-patient encounter in an A&E Ward is by definition an emergency consultation. When the complaint is a minor one and the condition of the

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<sup>6</sup> For extensive bibliographical references on the process of differential diagnosis, see Bolden (2000:393).

patient enables him<sup>7</sup> to interact with the medical staff, the encounter will typically proceed from stage 2 through to stage 6, unless the physician requires specific tests – for instance, an x-ray – and refers the patient to the relevant department, thus stopping at stage 3. In either case, the core activity being performed in this context, prior to the emergency treatment (which may be either prescribed or delivered), is the gathering of information through questioning and physical examination.

The emphasis on this phase of the interaction is further reinforced by the fact that patients and doctors are unknown to each other. This means that there is no medical history on which the doctor can base his assessment of the patient's problem, and that the production of a focused historical account becomes fundamental to the forming of an accurate diagnosis.

The urgent nature of the medical condition on the one hand, and on the other the large number of requests which must be handled especially in the summer season impose a fast pace on the encounter, where the occasion for small talk is drastically reduced, introductions are brisk and rapport-building is considered non essential. To go back to ten Have's classification, this means that type 1 episodes are either totally absent or, much less frequently, confined to the physical examination.

If we now consider the case of foreign tourists who do not speak the language of the country they are in, who, whilst on holiday, are faced with a health problem affecting either themselves or their children, who are far away from home and are unable to consult the family doctor, we can easily understand how much more vulnerable these patients must feel in a situation which is naturally stressful. Although this interactional scenario is hardly comparable to the conventional image of a community interpreting framework, where the hierarchical configuration of the participants' roles, naturally stemming from their unequal knowledge, is heightened by a marked status differential (the service users are in this case immigrants and refugees), the psychological dependence on the interpreter can be assumed as a typical trait of this kind of interaction too.

#### **4. Asymmetry vs. symmetry in medical interviews**

As ten Have observes (1991:140), when set against the benchmark of ordinary conversation among peers, doctor-patient communication exhibits

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<sup>7</sup> In the remaining discussion, doctors and patients will be conventionally referred to as 'he' and interpreters as 'she'.



at least two kinds of asymmetries. First, there is an asymmetry of topic, given that it is the patient's condition that is under examination and not the doctor's. Second, there is an asymmetry of knowledge and therefore of tasks, whereby the patient reports the complaint, answers questions and accepts the doctor's decisions, while the doctor listens to complaints, elicits specific information, makes a diagnosis, and prescribes treatment. This means that, apart from the initial decision to consult a physician and request treatment, the patient loses the initiative early on in the encounter, and the doctor takes over as the dominant party, by controlling the question-answer format.

Investigating interactional behaviour in terms of turn-taking and topic development, researchers have found that moves such as questions, which establish a conditional relevance for specific kinds of actions (i.e. answers), are mostly taken by doctors and seem to be dispreferred when taken by patients. Fairclough (1992:153) argues that this interactional dominance by the doctor results from an asymmetrical and institutionally determined distribution of "talking rights and obligations"<sup>8</sup> between "powerful" (P) and "non-powerful" (N-P) participants, whereby: "(i) P may select N-P, but not vice-versa; (ii) P may self-select, but N-P may not; [...] (iii) P's turn may be extended across any number of points of possible completion". What this means in practice is that the patient usually takes the floor when the doctor offers it by asking him a question. The doctor, on the other hand, is not given the floor but takes it when the patient has finished answering the question, or when he decides that the patient's response has become "irrelevant" to a strictly medical assessment of his problem. In the latter case, overlaps may be used by the doctor as a device to cut short the patient's turn. A corollary of this organization is to do with topic control. It is the doctor who introduces new topics through his questions, "polices the agenda" – the expression is again Fairclough's (*ibid.*:155) – by simply acknowledging the patient's answer without commenting on or assessing it, changes topic abruptly, or else stays on topic by reformulating a question which he thinks has not been satisfactorily answered.

This asymmetrical model is contrasted by Mishler (1984) with a more

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<sup>8</sup> Drew and Heritage (1992:22) clarify that, in institutional interaction, acceptance of, or rather, adherence to "special and particular constraints on what one or both of the participants will treat as allowable contributions to the business at hand" depends on their orientation to the goals, tasks and identity of the institution in question.

symmetrical interactional format – which the author sees as morally superior and professionally more effective – where the doctor swaps the normative “Voice of Medicine”, with its assertiveness, scientific objectivity and affective neutrality, for the “Voice of the Lifeworld”, thus displaying a high degree of attentiveness to the patient’s understanding of his problem and to his communicative needs. The effect of this alternative conversational style is that turn-taking is more collaboratively managed and topic development more extensively negotiated by the two participants. Although both Mishler and Fairclough explore the possibility of analyzing the same interaction in terms of conflict and struggle between the two voices, with the VoL intruding on the doctor’s agenda, they nonetheless seem to imply that the shift in conversational models is made possible primarily by the doctor’s willingness to make the floor available to the patient. Fairclough’s words (1992:146) are unequivocal:

Notice that the initiative for yielding a measure of control to the patient in medical interviews of this sort invariably comes from the doctor, which suggests that doctors do still exercise control at some level, even if in the paradoxical form of ceding control.

Looking at doctor-patient interaction from a different angle and explicitly rejecting the notion that asymmetry is simply an effect of institutionalized power relationships, ten Have (1991) suggests considering interactional control as a variable of the specific phase in the interaction. Whereas the patient has limited possibilities for requesting information during the questioning sequences of history taking, his interventions appear to be more acceptable in other phases, for instance during or after the discussion of treatment (see section 3 above).

Whilst accepting both perspectives as promising analytical tools, we would contend that equal attention needs to be devoted to the patient’s conduct as a crucial factor in deciding the extent of the doctor’s domination on the interaction. Building on the above-mentioned notion of a conflict of voices, what is suggested here is that the selection of a more assertive style by the patient – which may be due to personality, medical knowledge or cultural models – may act as a powerful counterweight to institutionally determined or even phase-specific asymmetries. For the purposes of the present study, let us consider in particular the impact that cultural patterns may have on interactional behaviour. Hall’s theory of contexting (1976, 1983) offers an interesting paradigm to assess an individual’s communicative

style in terms of his or her reliance on explicit information (text) versus implicit information (context), as dictated by the conventional orientations of the culture he or she belongs to. The author's basic distinction between high- and low-context cultures has since been expanded to include other sets of related dichotomies – i.e. direct vs. indirect, and egalitarian vs. hierarchic. Figure 1 below, which is a slightly modified version of the contexting cline suggested by Victor (1992:143), shows the positioning of the three cultures, namely Italian, British and Polish, involved in the encounters discussed in this paper.

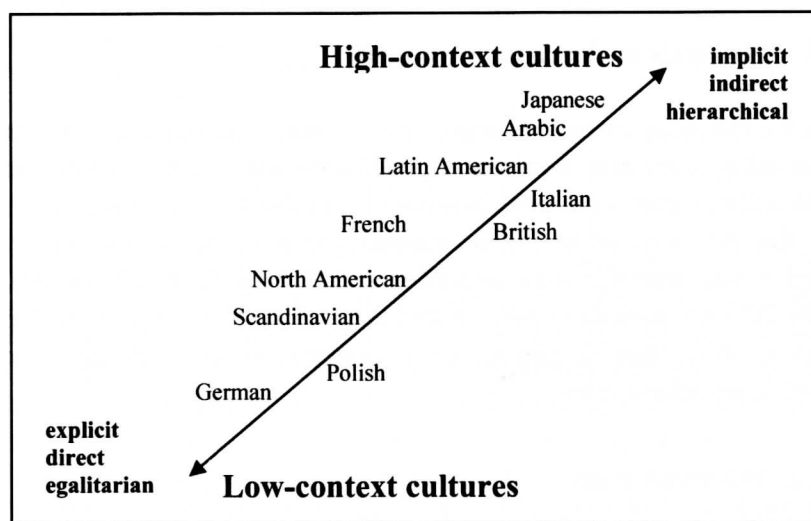


Figure 1: Contexting cline

Whilst the Italian and British cultures are somewhat closer to the Japanese end of verbal restraint and hierarchic positioning, than to the German preference for explicitness and egalitarianism, the Polish culture – which has been added to the cline following Goddard and Wierzbicka's (1997) description of Polish discourse style – endorses extreme frankness and directness. Given the marked distance between these culture-specific interactional models, a third line of investigation will thus be pursued in the analysis of the recorded sessions. This will be done in full awareness that the limited number of cases under examination cannot obviously be taken as supporting evidence for the validity of theoretical assumptions about culturally divergent patterns of interaction. Cultural modelling will be used here as a supplementary

tool, to offer possible explanations of the patients' interactional behaviour, besides personal inclinations and preferences.

If one moves from monolingual settings – either culturally homogeneous or heterogeneous – to linguistically mediated encounters, the picture becomes even more complex, given that the interpreter, who is usually the sole bilingual, is in a somewhat unique position to control the content, direction and organization of the verbal exchange. Depending on her reproduction or modification of the participants' normative orientations or interactional styles,<sup>9</sup> the encounter can be expected to develop along different pathways and produce more or less symmetrical configurations.

## 5. Analysis of the data: who leads?

In the following analysis, examples will be organized into three sections according to the party who is monopolizing the initiative at that moment. We will start from sequences where the doctor controls the question-answer cycles, the patient refrains from formulating requests and gives very short and factual answers, and the interpreter confines herself to translation acts. We will then move on to more marked interactional forms, where first the interpreter and then the patients (or their parents) are seen to deviate from their conventional roles.

### 5.1. *The doctor leads*

In T1 a Polish baby girl is taken to the emergency ward by her parents because she has had a high temperature for two days and some red dots have appeared on her body. In the following sequence the doctor is clearly seen to proceed through a pre-set agenda. He interrupts the interpreter, before she has finished translating the father's answer, to state his intention to examine the baby (line 128). He then disregards the father's attempt to explain that although the baby did not cry the night before, they as parents know that she is not feeling well (line 130), and asks the mother to hold the baby's head still, thus forcing the interpreter to translate his instruction instead of the father's comment. Lastly, he announces the diagnosis, i.e. an inflammation of the nose.

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<sup>9</sup> See also Merlini and Favaron (2005).

[1] T. 1(121-133)<sup>10</sup>

- 121 D: **allora la bambina ha pianto durante la notte**†  
*now did the girl cry during the night*
- 122 I: did she cry during the night† ((the question is first addressed to the mother  
 123 who does not speak English then to the father)) did she cry during the night†=  
 124 F: =no not at all=  
 125 I: =no not at all  
 126 F: she is rather silent because=  
 127 I: =è abbastanza silenziosa la bambina [ >°non ha pianto°<  
*the girl is rather quiet she did not cry*  
 128 D: **va bene vorrei vedere un attimo questo**  
*alright I would like to examine this*
- 129 I: [ °she<sup>11</sup> wants to°  
 130 F: [ we know that she's ill  
 131 D: **le tiene ferma la testa**  
*can you keep her head still*
- 132 I: °could you keep please the head°  
 133 D: **va bene comunque la bambina ha in atto una una rinite**  
*okay in any case the girl has an inflammation of the nose*

T2 presents the case of an English woman complaining of cloudy vision. The doctor, after asking a series of questions aimed at ascertaining the symptoms she is experiencing, changes topic abruptly, cutting short the interpreter's last sentence (line 55) in what had been a long-winded and laborious translation, where the lack of an English word ("shadow") had required the joint efforts of the doctor, who kept offering synonyms for the Italian word ("ombra"), and of the patient, who kept repeating the same concept over and over. Once order is restored, an unmarked sequence follows which sees the doctor regaining total control of the question-answer mechanism (line 57). As reported in the literature on medical interviews,<sup>12</sup> the doctor refrains from utterances indicating his information processing. He simply acknowledges the patient's answers through discourse markers such as *yes*, *mmm*, *okay*, and proceeds to check the patient's blood pressure, without any explanation (line 64).

<sup>10</sup> Examples are numbered progressively. The acronyms T. 1, T. 2, T. 3, etc. identify the transcript from which a given excerpt has been taken, whilst the numbers in parentheses refer to the place of the reported lines in the transcript. For easier reference, the latter also appear beside each line. Idiomatic translations into English of the Italian utterances are shown in italics. Features of interest are shown in bold. For the transcription key, see appendix 1.

<sup>11</sup> Here, the interpreter's use of "she" instead of "he" to refer to the male doctor is simply a slip of the tongue.

<sup>12</sup> For a review of studies on the physicians' uses of third turns, see ten Have (1991).

- [2] T. 2 (50-67)
- 50 I: <sup>L</sup>insomma<sup>J</sup> lei vede una forma ner a:=  
*so she sees a black shape*
- 51 D: si  
 yes
- 52 I: =rotonda::  
*round*
- 53 D: mhm
- 54 I: a black shape [round
- 55 D: okay okay
- 56 P: yes round
- 57 D: **la signora soffre di ipertensione la signora** †  
*does the lady suffer from hypertension*
- 58 I: do you suffer from hypertension hypertension †
- 59 P: no
- 60 I: no
- 61 D: **no ha preso qualche trauma al capo** †  
*has she had any head trauma*
- 62 I: have you got any:: any: trauma †
- 63 P: ((shakes her head))
- 64 D: **no va be' intanto le misuro la pressione eventualmente**  
*no okay in any case I'll check her blood pressure*
- 65 I: we check your pressure=
- 66 P: =okay=
- 67 I: =blood pressure

## 5.2 The interpreter leads

Let us now look at sequences where the translation mechanism – i.e., the conversion of each original utterance into an equivalent utterance in the target language – is dropped, and the interpreter is seen either to respond to a primary interlocutor or to take the initiative by introducing new topics. As was previously said, the first person foreign patients meet when coming to the emergency ward is the interpreter, who takes down their names and inquires about the nature of the complaints. It is, therefore, not surprising to see the interpreter introducing the patient and her problem at the beginning of the session, as shown in the following example:

- [3] T. 3 (1-7)
- 1 D: si  
 yes
- 2 I: **le si è gonfiato un po' le caviglie** †  
*her ankles are a little bit swollen*
- 3 D: come si chiama la signora †  
*what's the lady's name*

- 4 I: **S. ((spells the surname))**  
 5 D: sì (.)la signora soffre di ipertensione †  
*yes does the lady suffer from hypertension*  
 6 I: umm suffer do you suffer hypertension †  
 7 P: no

Equally natural is the interpreter's attempt to engage the 7-year old British girl in T4, whom she has already met in the waiting room, in a brief conversation so as to make her feel a bit more relaxed while the doctor is examining her ear:

- [4] **T. 4 (16-21)**  
 16 D: si siede qua un attimo †  
*would she come and sit here*  
 17 ((the doctor starts examining the girl))  
 18 I: °how old are you C. †°  
 19 P: °seven°  
 20 I: °seven°  
 21 D: è la prima volta che le capita † questo problema † †  
*is it the first time that she has had this problem*

Whilst autonomous initiatives of these kinds are almost negligible when occurring in type 1 episodes, which are characterized by a marked conversational quality, in type 2 and type 3 episodes, the interpreter's attempt at controlling the interaction may have more serious repercussions. Going back to T3, as the doctor examines the British woman's ankles, Tina, the interpreter, first addresses the latter to comment on her symptoms (line 53), then re-expresses her opinion in Italian (line 55), thus inviting the doctor to respond by selecting him as next speaker:

- [5] **T.3 (53-56)**  
 53 I: °do you think they are very swollen or (.) they don't seem to be very swollen ( )°  
 54 P: [yeah o-on ( )  
 55 I: [non sembrano tanto gonfie=  
*they don't look so swollen*  
 56 D: =un pochino qua mi sembra un po' gonfie qua  
*a little bit here I think they are a bit swollen here*

In sequence [6], the doctor's later remark, i.e. that the swelling of the left ankle is visibly due to an insect bite, is mistranslated by Tina as a diagnosis for the overall problem (line 96), to which the patient understandably asks whether the puncture on the left ankle can be the cause of the swelling in

both ankles. Instead of translating back the patient's question, Tina self-selects as primary interlocutor and reiterates the diagnosis; interestingly enough, at this point she switches from reported speech ("in his opinion he says...") to the first person plural to associate herself with the diagnosis, thus projecting the idea that she is part of the medical staff (lines 98-99). The hesitations in her utterance are, however, an indicator that she sees the point the woman is trying to make. In her next turn, she therefore checks again with the doctor whether he thinks that the swelling might be caused by the insect bite. Unfortunately, she then sticks to the same statement (lines 106-107) instead of translating the doctor's intention to check the patient's pulse. It will take many more turns before the woman is explicitly told that the problem might derive from her high blood pressure.

[6] T.3 (94-107)

- 94 D: L qua si è gonfia:ta > perché la signora < è stata punta da un  
*here it is swollen because the lady was bitten by an*
- 95 insetto sicuramente  
*insect for sure*
- 96 I: **in his opinion he says you have been bitten by an insect**
- 97 P: and would that make both ankles to swell↑
- 98 I: **yes we-w- yes we suppose >this is the< the reason why you are why your**
- 99 **ankles are so swollen**
- 100 P: right
- 101 I: tu pensi che sia così gon { fio↑=  
*do you think it is so swollen*
- 102 D: { è molto probabile { il polso↑  
*it's very likely* *her pulse*
- 103 I: { =per una puntura  
*because of the puncture*
- 104 d'INSETTO↑  
*of an insect*
- 105 D: perché il problema circolatorio adesso le misuro anche la pressione { però il polso  
*because the circulation problem now I'll also take her blood pressure* *yet her pulse*
- 106 I: { yes he
- 107 **probably says you have been bitten by an insect**

In T2, the interpreter's behaviour is potentially dangerous for the patient's health.<sup>13</sup> The interaction has reached the stage in which the doctor is formulating a possible diagnosis, a detached retina, and decides to refer the patient to an eye specialist (lines 68-69). In subsequent sequences, and up

<sup>13</sup> For an in-depth discussion of this session, see Merlini (2007).



to the very end of the encounter, this diagnosis is never once translated into English for the patient, who is only told that she needs to see some specialist (lines 82 and 84). Tina is repeatedly found to shift topics and use her translation slots to interact as a powerful primary interlocutor with either the patient, as in [7], or the doctor, as in [8] and [9]:

[7] T. 2(68-84)

68 D: *eventualmente la mandiamo a fare una visita urgente specialistica da un oculista*  
*possibly we should make an urgent appointment for her to see an eye specialist*

69 *perché potrebbe essere un distacco della retina °per cui° adesso vediamo*  
*because it could well be a detached retina so now*

70 I: **so please sit here (.) how long are you staying↑**

71 D: *>dove la mandiamo↑<=*  
*where shall we send her*

72 P: [ ( )

73 D: *>dove la mandiamo a XX*  $\left[ \begin{array}{l} X^{14}<\uparrow \\ X \end{array} \right.$   
*where shall we send her to XX*

74 P: *back home on Saturday °go home on*

75 *Saturday°*

76 D: *può stare seduta*  
*you can sit down*

77 I: *you can sit*

78 D: *>sit down<*

79 I: *yes sit down here yes just-just NOW sit può star seduta vero:↑ (.) relax yourself*  
*she can sit down can't she*

80 **don't worry**

81 P: ((smiles))

82 I: *maybe you need a specialist to visit you*

83 P: *all right*

84 I: *you need you need to be visited by a specialist ( )*

An interesting feature, aside from the patient's submissiveness (lines 81 and 83), is Tina's attempt to reassure her ("relax yourself don't worry", lines 79-80), which may indicate that the non-translation of the diagnosis is a deliberate choice on her part not to frighten the woman. This interpretation is further supported by a reiteration of the reassuring utterance a few exchanges later, as shown in excerpt [8], line 107. The sequence also contains an aside initiated by Tina, who asks the doctor to comment on the

<sup>14</sup> The 3 X's stand for the name of a nearby hospital.

blood pressure reading she has just translated into English (line 97), without then conveying his answer to the patient, who is left with a meaningless string of numbers:

[8] T. 2 (95-107)

95 ((the doctor checks the patient's blood pressure))

96 D: (novanta) centoquarantanove  
*ninety one-hundred and fortynine*

97 I: ninety one-hundred and fortynine **e com'è quindi**↑  
*how high is this then*

98 D: **leggermente** altina quanti anni ha la signora↑  
*slightly high how old is the lady*

99 I: what how old are you↑

100 P: fiftythree

101 I: fiftythree ((smiles)) **cinquantatré**  
*fiftythree*

102 D: **cinquantatré**  
*fiftythree*

103 I: yes

104 D: >**sentiamo un attimo il cuore**<  
*let's listen to the heart*

105 I: °he wants to check to check your heart° (.) **deve togliersi la** [maglietta↑=  
*does she have to take off her* T-shirt  
°si°  
yes

106 D:

107 I: = YES >you have to (< °**don't worry**°

In [9], as the consultation is coming to a close, Tina is seen to interrupt a primary speaker and shift topics, thus exhibiting once again the behaviour of a powerful participant in Furlough's (1992) terms. Instead of translating the doctor's reiterated indication that there might be some problem with the woman's retina requiring urgent attention, she asks him to confirm the hospital facility where the patient is to be sent (line 123), and then concentrates on practical details as to the way in which the latter can reach it.

[9] T.2 (120-131)

120 D: l-l'iride è normale il riflesso della pupilla è normale però e:videntemente  
*the iris is normal the pupil reflex is normal but clearly*

121 **potrebbe esserci qualcosa a livello della retina personalmente: io la mando a fare**  
*there might be something wrong with the retina personally I would have her*

122 una visita [specialistica=  
*examined* by a specialist

123 I: °**allora la mandiamo a XXX:**↑°  
*so shall we send her to XXX*

- 124 D: =urge:nte: da un oculista  
*an eye specialist through an urgent appointment*
- 125 I: **okay (.) you have two choices (.) first possibility you're going to drive to XXX**
- 126 **have you got a car↑**
- 127 P: no
- 128 I: °no niente macchina okay° so you can't go to XXX because we are  
*no car okay*
- 129 all together the same hospital and we don't have the the: specialist here you have
- 130 to go to you have to drive to XXX OR you can go to private o può andare da  
*or she can see a*
- 131 un privato  
*private doctor*

Sequences [6] to [9] are clearly more of an example of how the interpreter can actually mislead rather than lead the conversation. In the following section, we will see how this incomplete and highly incoherent set of instructions spurs the British woman to change tack.

### 5.3 *The patient leads*

The sequence discussed above continues with a series of questions posed by the woman who is clearly concerned about her health and probably scared by what she perceives as a reticence to break bad news:

#### [10] T.2 (132-157)

- 132 P: **is it urgent is it urgent↑**
- 133 I: yes the doctor says it's urgent=
- 134 P: =urgent ((she turns to the doctor for confirmation))
- 135 D: sì ((whispered))  
*yes*
- 136 P: [ [ **where's** ] X=
- 137 I: [ [ **facciamo:** ] ]  
*let's*
- 138 P: =**where's X- where's this place X-↑**
- 139 I: >XXX< but come here sit down here
- 140 P: (**my pressure**)
- 141 I: it's light high than usual è un po' dico lievemente  
*shall I say it is a bit*
- 142 D: [ *più elevata*  
*higher*  
*si::*  
*yes* ]
- 143 I: just a little bit
- 144 D: =centoquarantanove su novanta diciamo  
*one-hundred and forty-nine over ninety*
- 145 I: [ > *dunque* < considerando l'età:↑  
*so considering her age*  
one-hundred and forty-nine over ]

- 146 ninety
- 147 P: **my heart is okay**↑>**my heart is okay**<↑
- 148 I: il suo cuore è a posto↑  
*is her heart okay*
- 149 D: si il cuore è a posto però il solito [ problema: ] che può essere correlato (=)  
*yes her heart is okay but this [ problem is usually related*
- 150 I: °it's okay°
- 151 D: =al momento >comunque< la pressione non è preoccupante=  
*at the moment however her blood pressure is not worrying*
- 152 I: =mhm=
- 153 D: =certo è che:: sarà meglio che insomma che sia vista da un medico °perché°  
*in any case she'd better be examined by a specialist because*
- 154 deve esserci un problema all'interno dell'occhio ehm un problema vascolare  
*there must be a problem inside the eye a vascular problem*
- 155 °(all'interno dell'occhio)°  
*inside the eye*
- 156 ((interpreter and patient exit the room; the interpreter makes the appointment  
157 with the eye specialist and explains to the patient how to reach the other hospital))

Although, as stated earlier on, patient-initiated questions are more common in the closing stages of a medical encounter, here this typically unassertive British woman is driven to take the initiative not so much by the delivery of diagnostic news – since almost none has so far been given – as by the interpreter's behaviour. Tina's preoccupation not to alarm the patient has in fact had the opposite effect. Despite her questions, however, the patient will still leave the ward unaware that her eye problems might be due to as serious a condition as a detached retina (lines 156-157).<sup>15</sup>

Let us end this analysis with sequences where the parents of both the

<sup>15</sup> Investigating Spanish-speaking patients' knowledge of their discharge diagnosis at a public hospital emergency department in Los Angeles, Baker *et al.* (1996) found markedly lower subjective ratings of understanding for patients who communicated with the English-speaking healthcare personnel through an interpreter compared with those who thought an interpreter was unnecessary and did not have one. More specifically, 16% of patients for whom an interpreter was not needed and not used stated that the physician "did not say the diagnosis", compared with 29% for whom an interpreter was not used although the patient thought one should have been used, and 32% for whom an interpreter was used. In their attempt to explain the reasons why the assistance of interpreters did not improve the patients' understanding of their diagnoses, the authors point to suboptimal interpreting performances, resulting from the use of untrained interpreters, such as other hospital personnel or family members and friends. Although no such *ad-hoc* interpreters are involved in the present study, the lack of formal training in interpreting, particularly in professional ethics, is an underlying concern in our case too.

Polish baby girl (T.1) and the Polish baby boy (T.5) are seen to consistently introduce new topics throughout the two encounters. Only a few exchanges into the data-gathering phase (type 3 episodes), the father of the baby girl offers unasked-for information, as in the following example, where he self-selects as next speaker and starts producing a full account of the previous day, even though the doctor was still inquiring about the dose of Ibuprofen that had been administered to the girl to bring the temperature down:

## [11] T. 1 (30-44)

- 30 D: e gli ha dato quanti millilitri↑  
*and how many millilitres did you give her*
- 31 F: [two point two point five]  
 32 I: [due punto cinque] ogni sei ore ha detto due virgola cinque  
*two point five every six hours he said twopoint five*
- 33 °milligrammi° ogni sei ore  
*milligrams every six hours*
- 34 ((background noise))
- 35 F: **and in the night in the night=**
- 36 I: =yes=
- 37 F: =we were on the beach after uh afternoon because he we asked if we can go=
- 38 I: =°mhm°=
- 39 F: =outside ( ) so we were afternoon on the beach=
- 40 I: mhm
- 41 P: =there were no: higher [ temperatures
- 42 I: ah so you-you-you went to the beach with the
- 43 child↑
- 44 P: yes

A few exchanges later, as the doctor is asking to examine the red dots on the baby's body, the father intervenes again to inform him that his child has an allergy:

## [12] T. 1(85-91)

- 85 D: [va be' vediamola un attimo  
*okay let's have a look at her*
- 86 I: [e un'altra sulla schiena°  
*and another one on the back*
- 87 F: **she's she's an allergician but umm**
- 88 I: s-she's a↑
- 89 F: al-aller she has a-an allergy=
- 90 I: =which one↑=
- 91 F: =of the milk

Similar instances of interactional control are also found during the doctor's prescription of the therapy at the end of the physical examination.

In [13], seeing that only the temperature problem has been addressed (lines 150-151), the father brings the discussion back to the red dots, thus inviting the doctor to have a closer look at the baby:

[13] T. 1(150-157)

- 150 D: allora umm per il momento l'unica cosa da fare >se vuol tener la bambina< è  
*now for the time being the only thing you can do can you hold the baby still is*
- 151 quella di fare una terapia antifebbrile dandogli l'ibuprofene  
*to treat her with Ibuprofen for fever relief*
- 152 I: what we can do now is a therapy against [ the fever and=  
153 F: [against the fever
- 154 I: =that's all
- 155 F: **mhm mhm and the dots**†
- 156 I: e queste macchioline che dice perché è venuto principalmente per quello  
*and what about the dots because he says that he's come here mainly for them*
- 157 D: sì sì eh le macchioline vediamole meglio un attimo alla luce  
*yes yes the dots let's have a better look at them by the light*

The father's direct and explicit questioning goes on right to the end of the encounter, when the interpreter has already started dealing with the paperwork formalities, as the sequence 14 shows:

[14] T. 1(243-248)

- 243 I: devo stampare† venticique e ottantadue non hanno titolo  
*shall I stamp twenty-five eighty-two they have no title*
- 244 F: **air conditioned can we use in the room**† **air conditioned can**  
245 [we use (in the room)
- 246 I: [possono usare l'aria condizionata [ nella stanza†  
*can they use air conditioning* [in the room
- 247 D: [ecco meglio evitare [no better not
- 248 I: it's better to avoid it (.) for the moment all right†

(257-259)

- 257 F: **and vitamin vitamin C**
- 258 D: vitamina se vuole [ gliela può dare  
*if he wants to give her the vitamin* [he can
- 259 I: [yes these vitamins you can

The same interactional style is displayed in T5 by the mother of the Polish boy. Our last example is taken once again from the closing phase of the consultation:

## [15] T. 5(168-184)

- 168 D: il modello centoundici  
*the one-hundred-eleven form*
- 169 I: you have any copy of the: e one-hundred-eleven module so coz I left it in the  
170 office
- 171 M: mhm
- 172 I: °just to see the ( ) thank you°
- 173 M: **and his throat is is is infected his throat**↑
- 174 D: è infiammata è infiammata  
*it is inflamed it is inflamed*
- 175 I: it's inflamated inflamated
- 176 M: **inflamated and kind of angina or so**↑
- 177 I: °angina°
- 178 D: be' è angina ma per il momento non c'è non ci sono placche digli non ci sono  
*well it is angina but for the moment there are no plaques tell her that there are no*
- 179 placche  
*plaques*
- 180 I: there's not plaques inside the throat it's not plaques
- 181 M: **so it's not s-serious**↑
- 182 I: dice se è  
*she asks whether*
- 183 D: no: 

al	momento no
for	<i>the moment no</i>
no	
- 184 I:

Observation of sessions T.1 and T.5 would seem to reveal the above-mentioned orientation of Polish culture towards text-based, equal-to-equal communication (see section 4). This behaviour stands in stark contrast to the extremely low level of interactivity displayed not only by the two English women, but also by the English parents in T4. Throughout the latter encounter, which cannot be further exemplified owing to constraints of length, the couple never once take the initiative, and mostly confine their interventions to yes/no answers to the doctor's questions, clearly not out of inadequate knowledge of English. The fact that out of a 600-word interaction only 30 are uttered by the English parents (their seven-year-old child speaks only once to answer the interpreter's question about her age, as shown in [4] above) is particularly revealing.

## 6. Conclusions

The main theoretical concern of this paper was with the identification of those factors which can determine a higher or lower degree of interactional

control by any one of the participants in the medical encounter. We will therefore attempt to summarize the findings of our analysis by answering a series of questions.

Firstly, is asymmetry a function of the doctor's adherence to an institutionally determined distribution of talking rights and obligations? If in a monolingual encounter the doctor may decide to monopolize or else share his/her interactional power with the patient on the basis of his/her personal inclination towards a more or less empathic conversational style, in linguistically mediated communication his/her moves are necessarily dependent, at least in part, on the interpreter's translation choices and management of turns. Evidence of this was found in our sessions, where throughout the same encounter (see, for instance, excerpts from T.1 and T.2), the same doctor displays varying degrees of interactional dominance, as rapid and restrictive questioning alternates with more informally and cooperatively negotiated topic development.

Secondly, is asymmetry a function of a given phase in the medical consultation? As previously mentioned, the literature on medical communication indicates that patient-initiated questions are most strongly dispreferred in the data-gathering phase (type 3 episodes), whilst they are more acceptable after diagnosis and treatment have been announced (type 2 episodes). The analysis of our sessions has not produced unequivocal evidence of phase-specificity. Whilst in T.2 and T.5 patient-initiated questions did tend to appear towards the end of the encounter, in T.1 they were a constant feature throughout all the stages of the consultation, including history-taking.

Thirdly, is asymmetry a function of the patient's preference for directness vs. indirectness, possibly dictated by reference to prevailing cultural paradigms? A significantly higher concentration of patient-initiated questions and hence a less marked asymmetry were indeed observed in the encounters involving the Polish parents (T.1 and T.5), as compared with the generally passive interactional behaviour of the English participants. Although this may depend on an individual's disposition and character, rather than on adherence to a given cultural orientation, the latter hypothesis was thought to offer an interesting enough explanation, bar mere coincidence, for the recurrence of similar communicative styles in the two nationally diverse groups of patients, albeit in the restricted and statistically irrelevant confines of our sessions. At the same time, however, we have also seen a submissive British woman become progressively more assertive, as a consequence of information gaps in the interpreter's – not the doctor's – delivery of the diagnosis.



Fourthly and lastly, is asymmetry a function of the interpreter's independent assessment of the goals and requirements of the ongoing activity? Here, two different trends have been observed. On the one hand, a more empathic and less asymmetrical conversational model clearly emerged when the interpreter engaged in small talk with the patients, in particular during the physical examination. On the other hand, in less informal phases of the encounter the interpreter's attempts to exert interactional control often resulted in an increased asymmetry, as she topicalized the practical aspects of the doctor's utterances whilst leaving out more medically relevant information in the translations for the patient. This behaviour, which put the patient in a position of even greater knowledge inferiority, eventually led to a redressing of the imbalance, as the latter shifted to more assertive patterns. It is worth noting that this kind of asymmetry was recurrently found only in the encounters interpreted by Tina. This would further suggest that interpreters are fully-fledged social actors, who may have different perceptions of their roles and different views on how to organize their participation in a mediated encounter. Our study has shown that this may entail independent analyses and decisions as to what the patients should or should not be told. However, as Bolden (2000:415) warns, "given interpreters' lack of medical expertise, their interventions may have negative consequences on the quality of medical care received by patients".

To conclude, what seems to emerge from the preceding analysis is a complex interplay of different factors, which explains why symmetrical and asymmetrical configurations are in a state of constant flux within any communicative event, and are only partially determined by institutional norms or individual preference. In this view, interactional control is to be seen as a shifting variable, or rather as a "micro-political achievement, produced in and through actual turns at talk" (Frankel, in West 1984:95-96) by all interlocutors, doctor, patient and interpreter alike. The polymorphic nature of medical encounters, especially when occurring across linguistic and cultural barriers, is vividly depicted in the following quotation, which aptly summarizes the present discussion:

Consultations are sometimes almost like conversations. At other times, they resemble interrogation. But mostly they are somewhere in between, zigzagging between the two poles in a way that is negotiated on a turn-by-turn basis by the participants themselves. (ten Have 1991:162)

## APPENDIX: Transcription key

Symbols		Meaning
A	[ well I said	utterances starting simultaneously
B	[ Yes	
A	she's [ right	overlapping utterances
B	[ huh mm]	
A	I agree=	latched utterances
B	=me too	
	(.)	untimed pause within a turn
	((pause))	untimed pause between turns
	↑	rising intonation
	wo:::rd	lengthened vowel or consonant sound
	word – word	abrupt cut-off in the flow of speech
	<u>word</u>	emphasis
	WORD	increased volume
	°word°	decreased volume
	>word<	quicker pace
	((word))	relevant contextual information; characterisations of the talk; vocalisations that cannot be spelled recognisably
	(word)	transcriber's guess
	( )	unrecoverable speech

Fillers		Meaning
<i>English</i>	<i>Italian</i>	
umm	umm	doubt
mhm	mhm	expression or request of agreement
ah	ah; eh	emphasis
eh	eh	query
uh	ehm	staller
oh	oh	surprise

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