

Toward understanding practices of medical interpreting: interpreters' involvement in history taking



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GALINA B. BOLDEN

UNIVERSITY OF CALIFORNIA, LOS ANGELES

ABSTRACT This article examines the role of medical interpreters in structuring interaction between physicians and their patients. Through a detailed analysis of interpreters' involvement in the history-taking part of medical consultations, it is demonstrated that their participation in this activity is organized by their understanding of its goals rather than by the task of translation alone. Specifically, the different ways in which interpreters participate in history taking display their orientation to obtaining from the patient and conveying to the doctor medically relevant information about the patient's symptoms – and doing so as effectively as possible. Medical interpreters are found to share the physicians' normative orientation to obtaining objectively formulated information about relevant biomedical aspects of patients' conditions. Thus, far from being passive participants in the interaction, interpreters will often pursue issues they believe to be diagnostically relevant, just as they may choose to reject patients' information offerings if they contain subjective accounts of their socio-psychological concerns.

KEYWORDS: *doctor–patient interaction, interpreting, medical history taking, participation, questioning*

Introduction

This work examines the role of medical interpreters in structuring interaction between health care providers and their patients. It aims to dismantle the traditional image of interpreters as 'non-participants' whose involvement in interaction is limited to transforming messages from one language into another. Through a detailed analysis of interpreters' participation in actual medical consultations, I will demonstrate that interpreters' actions are primarily structured by their understanding of the ongoing activity and only secondarily by the task of translation.

The relevance of this type of work in the current geopolitical situation cannot be overemphasized. The growing trend in migration throughout the world has

increased the number of linguistic minorities who are not proficient in their new country's majority language. According to the 1990 US census, approximately 6.1 percent of the population have limited English proficiency. In states like Hawaii, New York, New Mexico, and Texas, this number exceeds 10 percent, and in California 16 percent. Nearly 14 percent of Europeans speak a language other than the official language of the country they live in (European Bureau for Lesser-Used Languages). It has also been estimated that in urbanized Western Europe a third of the population under the age of 35 will have an immigration background (Broeder and Extra, 1999). The 1996 Australian census revealed that 11 percent of the population considered themselves to have a limited proficiency in English.

The growing number of linguistic minorities has contributed to a wider recognition of the need to provide adequate linguistic services (and, in particular, medical interpreting services) to those who do not speak the majority language. In the United States, linguistic rights of the minorities have been protected by Title VI of the Civil Rights Act of 1964, which prohibits linguistic (and other) discrimination in federally funded programs. In addition, several states have enforced specific language access laws that require health care facilities to ensure communication with patients of limited English proficiency. In California, for example, the Dymally-Alatorre Bilingual Services Act imposes direct obligations on state and local agencies to provide appropriate translation services.

Despite the growing need for medical interpreting and the recognition of its importance, very little is currently known about the role interpreters play in the interaction between medical practitioners and their patients. Among the few studies into medical interpreting, the majority have been based on interview, observation, or survey data (for example, Baker et al., 1996; Brooks, 1992; Giacomelli, 1997; Hatton, 1992; Hatton and Webb, 1993; Hornberger et al., 1996; Hornberger et al., 1997). While this sort of research is valuable in obtaining a general understanding of interpreters' work and the ways in which health care institutions deal with linguistic minority patients, these studies can provide little insight into what happens during real life medical encounters conducted through an interpreter.

In order to understand how interpreters affect the ongoing interaction, researchers need to conduct detailed analyses of recorded consultations. To date, few studies have attempted to do this. Among the most notable are Downing's (1991) and Athorp and Downing's (1996) studies of health care interpreting in the United States and Wadensjö's (1992; 1998) research in Sweden.¹ A brief review of this work will help situate the current project vis-a-vis the findings attained by prior research.

Most work has underscored the problems that arise in using interpreters and attempted to explain interpreters' performance. For example, Bruce Downing (1991) demonstrates that the unskilled bilinguals often used as interpreters in hospitals and doctor's offices may actually impede communication between the doctor and the patient. In the interaction analyzed in Downing's paper the inter-

preter was found to ignore or mistranslate the utterances he either fails to understand or lacks the vocabulary to translate adequately; to provide his own responses to questions; to fail to interpret and to distort the messages in the process of interpretation. The study shows that the interpreter's low linguistic proficiency and his lack of understanding of the interpreter's role make it difficult, if not impossible, for the doctor and the patient to communicate with each other.

A study carried out by Catherine Athorp and Bruce Downing (1996) also found that non-professional interpreters have a negative impact on doctor-patient interaction. The investigators conducted a comparative analysis of monolingual and bilingual medical interviews that contrasted 'monolingual' (doctor and patients speak the same language), 'bilingual helper' (bilingual nurse acts as an interpreter), and 'interpreted' (professional interpreter is used) modes of communication. The study found that in the 'bilingual helper mode', the bilingual nurse often assumes a caregiver role, which results in reducing the number of direct doctor-patient interactions and patient-initiated turns (compared to the 'monolingual mode'). However, in the 'interpreted mode' (with a professional interpreter), the distribution of turns between the speakers is comparable to that in the 'monolingual mode', and the interpreter's utterances are, for the most part, translations of the doctor's or the patient's words. Thus, Athorp and Downing's work suggests that using professionally trained interpreters (as opposed to bilingual hospital staff) has a positive effect on communication between medical providers and patients when they lack a common language.

Downing's (1991) and Athorp and Downing's (1996) studies have focused on evaluating interpreters' performance by looking at how closely interpreters' contributions match the words of the other participants. A somewhat different definition of 'good' interpreting has emerged from the work of Cecilia Wadensjö (1998), who took a closer look at the situations in which interpreters are forced to step outside the strict interpreting role. Her book, *Interpreting as Interaction* (1992; 1998), reports the results of her Sweden-based study of interpreter-mediated interactions in medical and police settings. Adopting an interactive approach to 'dialogue interpreting', the author distinguishes between the interpreter's 'normative role', which presupposes a close translation of everything that is being said by each party, and the 'typical role' which the interpreter can adopt in order to coordinate the conversation (and, in particular, to resolve or prevent a communicative problem). Wadensjö argues that the two roles do not necessarily have negative consequences for the interaction. In fact, dialogue interpreters are often expected to use both of these roles in their work.

To summarize, all interaction-oriented studies on medical interpreting have emphasized the crucial role that interpreters play in managing communication between doctors and their patients. Researchers have found that inadequate linguistic proficiency or conflicting professional roles imposed on the interpreter can impede interaction between doctors and their patients. Additionally, in their attempt to describe the different ways in which interpreters participate in the interaction, investigators have noted the different options available to interpreters

in organizing their participation. In the first place, interpreters can try to provide a close rendition of each utterance; secondly, they can choose to take on a more active role by regulating the flow of the interaction. However, aside from Wadensjö's (1998) work on resolving interactional difficulties, the issue of how interpreters' moment-by-moment behavior fits into the activity currently in progress has largely been neglected. Instead, researchers have opted for a more global analysis of interpreters' involvement that does not distinguish between the different activities that constitute medical encounters and the different requirements they impose on the participants. Without taking into consideration the specific activities in which interpreters engage, however, it is impossible to understand what guides interpreters' actions at any particular time.

This article is an attempt to fill this gap in our understanding of interpreting practices by means of a close analysis of actual interpreter-mediated consultations. The article will examine one activity that commonly takes place during medical consultations: taking the patient's medical history. Through an analysis of several consultations, I will investigate how an interpreter's understanding of the ongoing activity and the most appropriate ways of participating in it structure his actions, and in what ways these understandings affect interaction between medical providers and their patients.

What is interpreting?

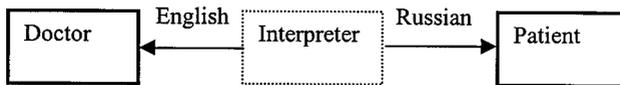
The view of interpreting that underlies the discussion in this article contrasts with the traditional perception of interpreting as simply a means of conveying verbal messages between people who do not share a common language. A popularly held metaphor used to describe interpreters' work is that of a 'voice box' or a 'translating machine'. According to this view, each utterance in language A is transformed by the interpreter into an equivalent utterance in language B. Then, in dialogic situations, a response in language B is converted into an equivalent utterance in language A, and so forth. Thus, the interpreter's contributions to the interaction are limited to translations (in the next turn) of the previous speaker's utterance.

The analysis presented in this article will demonstrate that this view of interpreter-mediated interaction is extremely simplistic and does not account for the wide range of phenomena found in real life communication. I will argue that interpreting should be understood more broadly, as an activity in its own right, coordinated with and embedded within an ongoing set of actions. In fact, what interpreters do or say is only partially, and sometimes hardly at all, limited to translating other people's talk. Instead, interpreters' actions manifest a choice between several alternatives available to them at any particular time within the frame of the ongoing activity. These alternatives, ranging from being a 'translating machine' to having an independent interactional position, embody interpreters' moment-by-moment decisions about what role will be the most appropriate in a particular interactional environment.

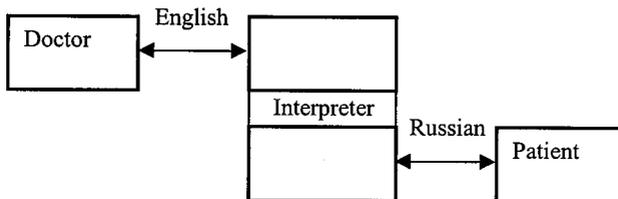
Thus, interpreters, as full-fledged social actors, have different options in organizing their participation in the unfolding activity. Structurally, their choices may result in two distinct types of interaction (see Figure 1 for a graphical representation). First, the interaction may take the shape of a single conversation between the two principal parties (in the case of a medical consultation, the doctor and the patient). In this situation, the interpreter *directly interprets* what has been said in the previous turn by one of the participants. The doctor and the patient primarily address each other rather than the interpreter. Second, the interaction may take the shape of two interweaving but separate conversations. In this case, the interpreter acts as an independent participant in each interaction, *mediating* the conversation instead of directly translating what has been said. As a result, rather than communicating directly with each other, the doctor and the patient interact mainly with the interpreter.²

Note that the first type of interaction emerges, for example, when the interpreter chooses to embrace the role of a ‘translating machine’. This mode of interaction does not, however, mean that the interpreter’s contributions are necessarily limited to ‘neutral’ translations of other parties’ talk. Even when the interaction is organized in this way, the interpreter’s turns display his orientation to the objectives of the specific activity taking place at the time.

This article will be concerned with ways in which interpreters’ actions are structured by the roles they adopt within the interaction and how these roles fit into the overall organization of the activity. We will see that in the medical encounters examined here, the interpreter’s involvement in the activity of history taking is organized by his understanding of what this activity needs to achieve. Specifically, the interpreter’s involvement in this part of the consultation displays



(a) ‘Directly interpreted’ interaction



(b) ‘Mediated’ interaction

FIGURE 1. *Types of doctor/interpreter/patient interaction*

his orientation to obtaining from the patient and conveying to the doctor medically relevant information about the patient's symptoms – and doing it as effectively as possible. In this article, I will detail how this orientation to the goals of the activity organizes the interpreter's actions.

Data

The data for this article come from a corpus of video- and audio-recorded interpreter-mediated consultations between English-speaking doctors and Russian-speaking patients. The two interviews analyzed here were audio-recorded at a large urban hospital in the Midwestern part of the USA. At the time of the recording, the interpreter participating in these interviews was an on-staff interpreter at the hospital. He was highly proficient in both languages and had had some professional interpreting training. The participants in each of the consultations knew each other from prior visits. In both interviews, the patients' main medical concern was the chest pain and the symptoms related to it. Information about the participants is summarized in Table 1.

The interpreter's participation in history taking

A prototypical medical consultation consists of the following major phases (see Byrne and Long, 1976; Waitzkin, 1991):

- the opening (when a relationship between the doctor and the patient is established);
- presentation of the problem (the patient presents the reason for the visit);
- history taking and physical examination (the doctor questions the patient about his or her condition and conducts a physical examination);
- the diagnosis (the doctor presents the diagnosis);
- the treatment (the doctor and the patient discuss treatment); and
- the closing (the consultation is terminated).

TABLE 1. *Summary information about the participants in analyzed consultations*

| | <i>Interpreter</i> | <i>Medical Providers</i> | <i>Patients</i> |
|-----------------------|---|--|--------------------------------------|
| Consultation 1 | native Russian-speaker; male; around 25 | physician; male; around 40 | Russian immigrant; male; around 65 |
| Consultation 2 | | <i>Doctor 1</i> : same as above; <i>Doctor 2</i> : cardiologist; male; around 45; invited by Doctor 1 for a consultation | Russian immigrant; female; around 70 |

During the history-taking stage of the consultation (which is our focus here), the doctor conducts a verbal interview in order to obtain information about the patient's symptoms (the process often referred to as 'differential diagnosis'). The physician's goal is to collect information that would make it possible for her to diagnose the problem and to prescribe appropriate treatment (see, for example, Bates et al., 1995; Billings and Stoeckle, 1989; Greenberger and Hinthorn, 1993; Heath, 1986; Robinson, 1999; Seidel et al., 1995; Swartz, 1998; Zoppi, 1997).

The history-taking part of consultations normally consists of sequences of doctor-initiated questions pertaining to various aspects of the patient's condition (Frankel, 1990). If the interpreter adapts the role of a 'translating machine' and restricts his or her participation to providing close translations of previous turns, doctor-initiated questioning sequences during the history-taking phase will be organized in the following way (see Figure 2):

- the doctor asks a question (in English);
- the interpreter translates the question (into Russian) for the patient;
- the patient provides an answer (in Russian);
- the interpreter then translates the answer (into English) for the doctor.

I have found, however, that in my data the questioning sequences are organized quite differently (see Figure 3). A doctor-initiated question in English launches a questioning sequence in Russian. The first question in the Russian-language sequence (Question A) is usually a translation of the doctor's initial question. After the patient provides an answer to this question (Answer A), the interpreter poses another question (Question B). After the patient answers that question, the interpreter may continue asking additional questions. The sequence comes to a close when the interpreter provides a summary translation of the patient's replies, sometimes followed by a comment in which the interpreter remarks on the course of the discussion, the patient's state, etc.

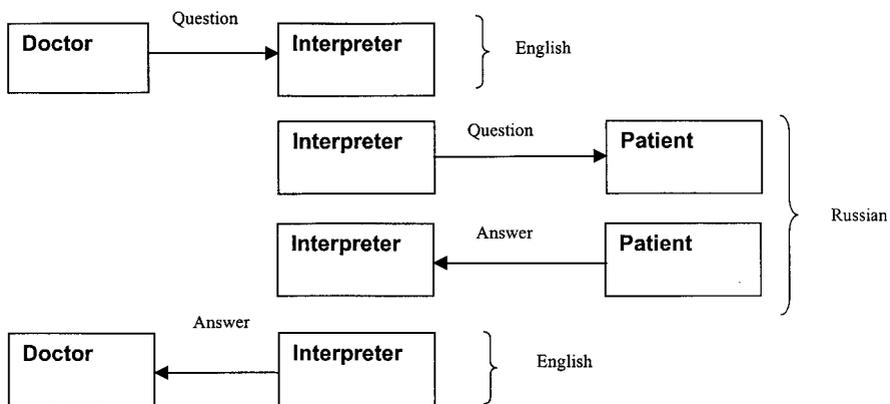


FIGURE 2. *A possible organization of doctor-initiated question and answer sequences*

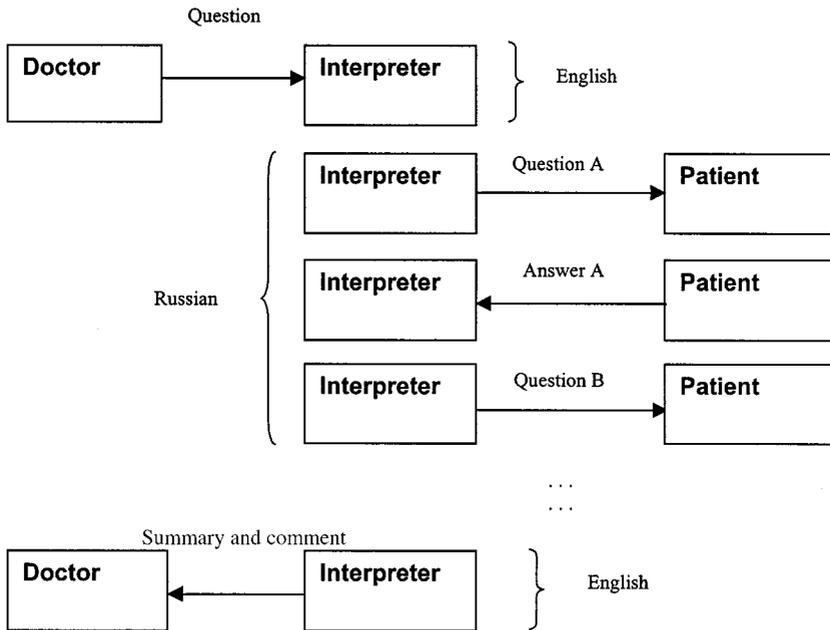


FIGURE 3. *The organization of doctor-initiated question and answer sequences*

Questioning sequences of this sort occur regularly in interpreter-mediated consultations, and in my view their occurrence is not accidental. Rather, they manifest the interpreter's systematic orientation to the particular activity the participants are engaged in. Moreover, I will argue that the interpreter's questions and summary translations are designed in such a way as to further the activity of the history-taking interview.

Medical contingencies for diagnosis and treatment

The verbal examination of the patient is conducted in order to diagnose the patient's medical problem and to prescribe appropriate treatment. In other words, at this stage of the consultation the doctor is oriented to collecting information about a set of issues related to a particular medical condition. The specific problems raised by the doctor will, of course, vary depending on the particulars of the situation (for example, the patient's symptoms, the doctor's prior knowledge of the patient, and the patient's medical history). However, it is possible to compile a list of issues that are likely to be brought up during the course of the verbal examination. An analysis of several consultations with patients who have a history of chest pain has shown that doctors orient toward the following set of contingencies for diagnosis and treatment:

- a symptom's presence, frequency, duration, and development over time (i.e. whether the condition is getting worse or better);

- a symptom's description (for example, whether the pain is dull or sharp);
- causality (i.e. what seems to cause the occurrence of the symptom); and
- the presence of other related symptoms.

If the symptom has been treated before, the doctor may inquire about

- the effects of the current treatment, and
- the presence of any side-effects associated with the treatment.

If the symptom has *not* been previously treated, the doctor may ask about

- the patient's own remedies.

These contingencies for diagnosis and treatment specify a domain of relevance (see, for example, Mishler, 1984) – a set of issues that not only the doctor but also (as I will show) the interpreter consider important and worth attending to. This set of medical contingencies also designates certain topics as irrelevant, and thus excludable from the discussion. In other words, the goals of the history taking, as a particular kind of an activity system, specify the topics participants can and cannot legitimately address.

Presentation of medical information

The goals of the history-taking interview not only specify the domain of relevance but also the ways in which diagnostically-relevant information is talked about. Several researchers have found that physicians (at least those working in the western medical tradition) display a preference for objective and decontextualized presentations of information over personalized descriptions (see, for example, Drew and Heritage, 1992; Frankel, 1990; Korsch and Negrete, 1972; Meehan, 1981; Mishler, 1984; Roter and Hall, 1992; Ten Have, 1991; Waitzkin, 1985). Mishler (1984), for example, developed a concept of the 'voice of medicine' which, in contrast to the 'voice of the lifeworld', 'reflects a "technical" interest and expresses a "scientific attitude"' (p. 104). Commonly adopted by medical professionals, the 'voice of medicine' is characterized by its focus on decontextualized descriptions of reality in terms of its objective features. Physicians may prefer this form of presentation due to the fact that decontextualized, objective symptom descriptions fit into the traditional biomedical model of disease. Having been trained within such a model, physicians might be expected to be most efficient in diagnosing a medical problem presented in such a traditional 'scientific' manner.

The 'voice of medicine' does not simply formulate reality in a wide variety of objective terms, but only in those terms that are specifically relevant to the unfolding activity. Thus, the activity of history taking with its goal to diagnose a particular medical condition makes relevant a specific coding scheme (Goodwin, 1994) that delimits ways in which symptoms are described. For example, in medical interviews, pain is routinely talked about as being 'sharp' or 'dull' the onset of

pain as being 'sudden' or 'gradual', etc. In other words, the 'voice of medicine' should not be loosely equated with the voice of science, but seen as being continuously adapted to the contingencies of a specific activity.

The question which arises is whether medical interpreters share physicians' normative orientation to obtaining objectively formulated information about a patient's medical condition. If they do, interpreters may be expected to systematically reject patients' information offerings if they contain subjective, contextually grounded accounts of their 'lifeworld' concerns presented in terms that lie outside a particular coding scheme. In the following sections, I will describe how one interpreter's understanding of the activity of history taking shapes the way in which he interacts (a) with the patient (i.e. the sorts of questions he asks and how he reacts to the patient's contributions), and (b) with the doctor (i.e. what sort of information the interpreter conveys to the doctor). These two sides of the interpreter's involvement in history taking will be first exemplified in an analysis of one questioning sequence and then described more systematically in the later sections.

An analysis of one questioning sequence

If the interpreter shares the doctor's orientation towards addressing the contingencies for diagnosis and treatment, we can expect to find that interpreter-initiated questions will elicit information directly related to this set of contingencies. Thus, after translating the doctor's question concerning a particular symptom, the interpreter may selectively attend to and topicalize those aspects of the patient's response that are directly related to medical contingencies, at the same time ignoring issues that he deems to be irrelevant. In addition, the design of the interpreter's questions may display his orientation to obtaining depersonalized descriptions of the symptoms rather than accounts grounded in the patient's life experiences.

This is exactly what happens in the segment of interaction presented in Excerpt 1. The transcript follows conventions developed by Jefferson (see, for example, Sacks et al., 1974). Letter D stands for the doctor, I for the interpreter, and P for the patient. Utterances in italics are idiomatic translations from Russian.

Excerpt 1 (Consultation 1)

- 1 D Ah::: ar- (0.5) are you ah (0.8)
- 2 h-having a problem with uh chest pain?
- 3 (0.5)
- 4 I Болит-ли сердце у вас,
hurts-QM³ heart with you
Do you have a chest pain,
- 5 (4.0)
- 6 P °Ну как сказать, кто его знает. Оно (1.5)°
well how to + say who it knows it
°*Well how should I put it, who knows. It (1.5)°*

- 7 ИНОГДА БЫВАЕТ ДА:
 sometime happens yes
SOMETIMES IT DOES HAPPEN.
- 8 (0.4)
- 9 I Раз в неделю:, раз в две недели,
 once a week once in two weeks
Once a week, Once every two weeks,
- 10 P <Нет бывает тогда такое смотря: от- (.) от
 no happens then such depending on on
<No this thing happens then depending on- (.) on
- 11 обстано:вки (0.5) жи:зненной.
 circumstance of + life
the ci:rcumstances (0.5) of li:fe.
- 12 I <Ну в- в данный момент ваша жизненная
 well in in given moment your life
<Well at- at this partic:ular moment do your life
- 13 обстановка вызывает у вас боль раз в неделю или-
 circumstance causes with you pain once a week or-
circumstances cause you pain once a week or-
- 14 или чаще.
 or more + often
or more often.
- 15 P Бывает и чаще
 happens and more + often
Sometimes more often
- 16 I Бывает и чаще
 happens and more + often
Sometimes more often
- 17 I Once or twice a week maybe: (0.6) a:nd

The sequence is initiated by the doctor's inquiry concerning the presence of a particular symptom (chest pain): 'Ah::: ar- (0.5) are you ah (0.8) h-having a problem with uh chest pain?' (lines 1–2). The inquiry gets translated in line 4. The translation, while preserving the format of the doctor's turn,⁴ is somewhat more constricting than the initial question. Thus, the doctor's question not only invites the patient to confirm the presence of the chest pain, but also to describe in what ways the patient's experiences constitute a problem. By contrast, the interpreter's question simply invites confirmation of the presence of the chest pain. (A conforming answer to the interpreter's question would consist of *yes* or *no* (Raymond, 1998). However, this question is designed for, and, thus, 'prefers'⁵ a *yes* response.) This change in the scope of the question seems to be achieved by replacing the doctor's reference to 'a problem' with the chest pain by the interpreter's inquiry into the presence of the chest pain specifically:

4 I Болит-ли сердце у вас,
hurts-QM heart with you
Do you have a chest pain

The patient seems to have trouble with the format of the interpreter's inquiry. Instead of simply confirming that he does indeed have a chest pain, the patient (after a long pause in line 5 which is indicative of the upcoming 'dispreferred' character of the answer⁶) first states that he is unable to answer the question:

6 P °Ну как сказать, кто его знает. Оно° (1.5)°
well how to + say who it knows it
°*Well how should I put it, who knows. It (1.5)°*

Note that the reference to the heart ('it')⁷ in the second turn-constructural unit (Sacks et al., 1974) indicates that the patient might be on his way to offer an alternative description of what is wrong with his heart.⁸ However, he abandons this turn-constructural unit (TCU), and offers a qualified affirmative response instead:

7 ИНОГДА БЫВАЕТ ДА:
sometime happens yes
*SOMETIMES IT DOES HAPPEN.*⁹

The qualification ('sometimes') brings up the issue of the frequency of the chest pain. This, of course, is one of the medical contingencies for diagnosis and it gets topicalized in the immediately following discussion between the interpreter and the patient.

It is necessary to emphasize that the patient's response (lines 6–7), even if hedged, can serve as a valid and clear answer to the doctor's question (lines 1–2). It can, therefore, be translated back to the doctor without any further discussion. Given physicians' orientations during this part of medical encounters to obtaining information about medical contingencies and given that one such contingency has been brought up by the patient, the doctor would be likely to ask the patient to explain how often the chest pain occurs. The interpreter, however, does not translate the patient's response at this point, but, instead puts forward his own question about the frequency of the chest pain, thus preempting what was the doctor's most likely next question. The interpreter's actions at this juncture of the consultation thus demonstrate that, being familiar with how such sequences normally proceed, he is oriented to achieving the goals of the history-taking interview in a most efficient manner.

The interpreter's question ('*Once a week, Once every two weeks*', in line 9) displays his orientation to collecting information about issues that may be diagnostically relevant (such as the frequency of the symptom). In addition, the question displays the interpreter's analysis of certain types of information as being more appropriate within the framework of a medical interview. Thus, the turn offers two examples of acceptable descriptions of the frequency of the chest pain. Both are objective, situation-independent measures of frequency. Thus, the design of

the interpreter's question embodies his preference for more precise, quantifiable symptom descriptions. In addition, the list format of the question is designed to obtain a short, unelaborated answer.

The patient's response (in lines 10–11) however, does not contain a description of the frequency of the chest pain that is compatible with the format suggested in the interpreter's question. In fact, the patient seems to reject not just the two alternatives but the entire thrust of the interpreter's question. This rejection is evident in the turn-initial placement of an undelayed and unmitigated negation marker 'no' followed by an alternative symptom description:

- 10 P <Нет бывает тогда такое смотря: от- (.) от
 no happens then such depending on on
 <No this thing happens then depending on- (.) on
- 11 обстановки (0.5) жизненной.
 circumstance of + life
 the ci:rcumstances (0.5) of li:fe.

After the initial negation marker, the patient reformulates his chest pain as being causally related to his life circumstances, and thereby variable. Note that the variability of the symptom sharply contrasts with the underlying assumption of regularity in the interpreter's preceding question (in line 9). The interpreter's next question is designed to de-emphasize the variable character of the pain, insisting on an objective measure of frequency:

- 12 I <Ну в- в данный момент ваша жизненная
 well in in given moment your life
 <Well at- at this particular moment do your life
- 13 обстановка вызывает у вас боль раз в неделю или-
 circumstance causes with you pain once a week or-
 circumstances cause you pain once a week or-
- 14 или чаще.
 or more + often
 or more often.

By starting the turn with 'well', the interpreter characterizes the patient's previous response as being in some way problematic.¹⁰ He, then, proceeds to fix the time at 'this particular moment', thus eliminating the relevance of variability as a factor in pain description. Moreover, by questioning the frequency of the pain rather than the life circumstances that might cause it, the interpreter prevents the topicalization of the relationship between pain and life circumstances. Thus, the interpreter's question, while clearly built upon the patient's prior response, has the effect of eliminating from the discussion the two aspects of the chest pain that the patient has brought up (i.e. its variability and dependency on life circumstances). The question also re-formulates the two alternatives for characterizing the frequency of pain. The new alternatives (lines 13–14) are less specific than the original ones offered in line 9 ('once every two weeks' in line 9 versus

'more often' in line 14) and suggest that the pain may occur more frequently (cf. 'once every two weeks' in line 9 versus 'once a week or more often' in lines 13–14). The patient now picks one of the alternatives (the less specific and the more frequent one), adding again a reference to the pain's variable character ('sometimes'): '*sometimes more often*' (line 15). This response is accepted by the interpreter and translated for the doctor: 'Once or twice a week maybe: (0.6) a:nd' (in line 17).

Interestingly, the translation replaces the variable aspect of the pain insisted upon by the patient (e.g. 'sometimes' in line 15) with a marker of uncertainty ('maybe' in line 17). After providing the summary translation, the interpreter does not wait for the doctor to pose another question but instead initiates a questioning sequence designed to obtain more information about the patient's heart problem. Specifically, the interpreter's questions address the issue of causality – one of the medical contingencies relevant for diagnosis and treatment of chest pain:

Excerpt 2 (continued from Excerpt 1)

18 I А эт- это вот- это в' относится к стрессу да?
and th- this EMP this EMP refers to stress yes
And th- this thing- this is related to stress right?

19 P Да
Yes

20 I Не к физической нагрузке,
not to physical load
Not to physical work,

21 (0.7)

22 P Ну физической нагрузки у меня нету.
well physical load with me absent
Well I don't have any physical work

23 <Я: пробывал даже заниматься;
I tried even exercise
I: even tried to exercise,

24 I И сердце не в- не начинает болеть когда вы
and heart not v not begins hurt when you
And the heart d- doesn't begin to hurt when you

25 [спортом занимаетесь?
[sports do
[exercise?

26 P [(Вос-)восстанавливать нормал[ьное =
[res- restore normal
[(Res-) To restore nor[mal =

27 I [Uh huh

- 28 P = дыхание или что-нибудь. <У меня есть (()
 breath or something I have
 = *breathing or something.* <*I have* [()
- 29 I [Но сердце
 but heart
 [*But you don't*
- 30 не болит у вас когда вы в'т занимаетесь спортом да?
 not hurt with you when you EMP do sport yes
have the heart pain when you exercise right?
- 31 (.)
- 32 Или когда вы ходите по улице.
 or when you walk on street
or when you walk outside.
- 33 (1.0)
- 34 P Бывает да
 happens yes
Sometimes yes
- 35 I Бывает болит.
 happens hurt
Sometimes there is pain
- 36 P Да.
 Yes.
- 37 I Ah:::m: (0.5) sometimes the chest pain is stress
 38 related sometimes it's exertion related_

The interpreter's question in line 18 appears to be related to the patient's reference to 'life circumstances' in lines 10–11:

- 18 I А эт- это вот- это в' относится к стрессу да?
 and th- this EMP this EMP refers to stress yes
And th- this thing- this is related to stress right?

The question's contingency on prior talk seems to be marked by the Russian conjunction 'a', which can be translated as either 'and' or 'but', depending on context.¹¹ Interestingly, the patient's initial reference to 'life circumstances' as a factor in the chest pain is here replaced with 'stress' – a medicalized version of what the patient might have meant by 'life circumstances'. Notably, the interpreter's question is a *yes/no* question in the form of an assertion followed by a tag ('right?') (Sacks et al., 1974). This question format (as opposed to more open-ended questions) limits the patient's opportunities for elaboration. In addition, 'assertion + tag' questions in Russian carry a strong preference for conforming responses.¹² Thus the interpreter's question is designed to get a brief confirmation that a relationship between the stress and the chest pain exists, and not to get a description of such a relationship.

After getting the confirmation in line 19 (note the undelayed, brief character of the patient response), the interpreter proceeds to specify other factors that might be related to the chest pain:

20 I Не к физической нагрузке,
not to physical load
Not to physical work,

This question, designed as an increment to the prior turn (Sacks et al., 1974), has an effect of moving the discussion even further away from the patient's psychosocial concerns (alluded to in the patient's reference to 'life circumstances'). The question is negatively framed with the negative polarity item 'не' (not) and, thus, designed to prefer a minimal negative response (Boyd and Heritage, forthcoming). By posing his question in this way, the interpreter shows his orientation to obtaining diagnostically relevant information from the patient in the fastest possible way.

The patient's answer, however, disaligns with the question's preference. Instead of confirming the absence of a relationship between the chest pain and the physical work, the patient topicalizes physical work as an aspect of his social circumstances:

22 P Ну физической нагрузки у меня нету.
well physical load with me absent
Well I don't have any physical work

23 <Я: пробывал даже заниматься.,
I tried even exercise
I: even tried to exerci:se,

The patient first indicates that the presupposition of the interpreter's question in line 20 (that the patient does physical work) is incorrect. The lack of physical work is formulated by the patient as a problem requiring a remedy (see line 23). The patient, however, is not given an opportunity to elaborate on this, since the interpreter's next question is designed to shift the focus of the discussion from the patient's concerns back to the relationship between the physical work and the chest pain:

24 I И сердце не в- не начинает болеть когда вы
and heart not v not begins hurt when you
And the heart d- doesn't begin to hurt when you

25 [спортом занимаетесь?
sports do
[exercise?

Note that the interpreter's question is prefixed with 'и', which appears to function similarly to the 'and' prefix in English questions. Relying on English language material, Heritage and Sorjonen (1994) demonstrated that *and*-prefixing may be used strategically 'to warrant a forward topical movement or shift in a possibly problematic environment' when, for example, the question is 'initiated in the con-

text of an answer that is “non-minimal” and unexpected’ (p. 21). In such cases, *and*-prefixed questions implicate agenda as an account for the topic shift and for closing off troubles talk. This is similar to what seems to be happening here. The ‘and’ prefix on the interpreter’s question allows the interpreter to close off and to move away from a discussion of the problem presented in the patient’s previous response. Without overtly rejecting the patient’s answer, the interpreter re-invokes the continuing relevance of his line of questioning (and specifically, his question in line 20) for the ongoing activity of the history taking. Note also that the interpreter’s question in lines 24–5 is a negatively formulated yes/no question that (similarly to line 20) prefers a brief confirming response.

Instead of responding to the interpreter’s question in lines 24–5, the patient attempts to elaborate on his initial response in lines 22–3. Note particularly that lines 26 and 28 are designed as an increment to the patient’s prior turn and that they sequentially delete (Lerner, 1987) the interpreter’s prior question in lines 24–5. However, the patient’s elaboration attempts are interrupted by the interpreter who pursues his own line of questioning:

- 26 P [(Вос-)восстанавливать нормал[ьное =
res- restore normal
[(Res-) To restore nor[mal =
- 27 I [Uh huh
- 28 P = дыхание или что-нибудь. <У меня есть [()
breath or something I have
= *breathing or something*. <I have [()
- 29 I [Но сердце
but heart
[But you don’t
- 30 не болит у вас когда вы в’т занимаетесь спортом да?
not hurt with you when you EMP do sport yes
have the heart pain when you exercise right?
- 31 (.)
- 32 Или когда вы ходите по улице.
or when you walk on street
or when you walk outside.

The interpreter’s question in lines 29–30, done as a virtual repeat of his prior question in lines 24–5, is now prefixed with a ‘но’ (‘but’). Unlike the subtler ‘and’ in line 24, this contrastive conjunction rejects the appropriateness or the relevance of the patient’s prior utterance. As a result of the interpreter’s action, the patient’s utterance in lines 26 and 28 is sequentially deleted (Lerner, 1987; Schegloff, 1987). In addition, the interpreter’s question (lines 29–30) is a negatively formulated assertion followed by a tag. This question design, once again, prefers a brief confirming response from the patient. When none is forthcoming (see the brief silence in line 31), the interpreter adds an increment (line 32) in

pursuit of a response from the patient, which he offers only after a substantial silence (line 33). The patient's disaligning response ('*sometimes yes*' in line 34) is, thus, clearly done in a dispreferred manner.

After reconfirming the patient's answer (lines 35–6), the interpreter provides a summary translation for the doctor (lines 37–8). The translation ('Ah:::m: (0.5) sometimes the chest pain is stress related sometimes it's exertion related_') presents information in very medical terms (e.g. 'exertion' replaces physical work', 'exercise', and 'walking'). Notably, it also omits any reference to other concerns mentioned by the patient: for example, the lack of physical work, the fact that he exercises in order to remedy that, etc. Thus, the interpreter's translation demonstrates his orientation to providing the doctor with the information related to medical contingencies for diagnosis and treatment, and presenting that information in a scientific, objective fashion.

To summarize, the analysis of this questioning sequence has shown that the interpreter's involvement in this interaction is structured by his orientation to obtaining information directly related to the goals of history taking (i.e. information he believes to be diagnostically relevant). In addition, the interpreter's actions embody his orientation to achieving these goals in the fastest and most efficient way. On the one hand, the interpreter is found to question the patient himself and then present the doctor with summary translations containing only medically relevant information offered in a form that would allow for an easy diagnostic decision. On the other hand, the interpreter's questions to the patient are repeatedly designed in such a way as to obtain brief confirming responses. Thus, the questions are overwhelmingly yes/no questions formatted to display a strong preference for aligning answers.

Relevance of medical contingencies for diagnosis and treatment to the organization of questioning sequences

This section will provide further evidence for the claim that medical contingencies for diagnosis and treatment play an important role in shaping both the interpreter's questions and the content of the summary translations given to the doctor. Two brief examples will illustrate the pervasive influence they exert over the interpreter's participation in the history-taking part of the consultations.

In the following excerpt (Excerpt 3), the doctor's question about the patient's familiarity with a medication prompts the interpreter to pose a series of related questions about the medication (marked with arrows on the transcript):

Excerpt 3 (Consultation 2)

- 1 D2 Does she know what Nitroglycerin is?
- 2 I А вы зна-
you kno-
You kno-
- 3 I <Yeah I'm sure she does.

- 4 → I A: : вы не принимаете нитроглицерин?
 ah you not take nitroglycerin
Ah:: you don't take Nitroglycerin?
- 5 (0.8)
- 6 P He-з, он же мне не выписал.
 no- he EMP me not prescribed
No-o, he didn't prescribe it.
- 7 Мне надо нитроглиц[е-
 me need nitroglyce-
I need Nitroglyc[e
- 8 I [Нитроглицерин вам нужен, да?
nitroglycerin you need right
[You need Nitroglycerin right?
- 9 P Да [:
Yes [:
- 10 → I [А когда вы принимаете он помогает вам д[а?
 and when you take it helps you right
[And when you take it it helps you r[ight?
- 11 P [да
 [Yes
- 12 (0.4)
- 13 I When she takes it, [ah:
- 14 P [Зажимает го[лову но: помогает.
 squeezes head but helps
[It squeezes my hea:d but it helps.
- 15 I Uh:: she gets som- uh (0.2)
- 16 a lit'l:e (.) uh:: headpressure headache,
- 17 but it does help.

After the doctor poses his question (line 1), the interpreter starts to translate the question (line 2), but abandons his translation halfway through, choosing instead to answer the question himself (line 3). The interpreter then proceeds to question the patient about her use of this medication (line 4):

- 2 I А вы зна-
 you kno-
You kno-
- 3 I <Yeah I'm sure she does.
- 4 → I A: : вы не принимаете нитроглицерин?
 ah you not take nitroglycerin
Ah:: you don't take Nitroglycerin?

The interpreter's actions in lines 2–4 demonstrate that he treats the doctor's question (in line 1) as a preliminary to an inquiry about the patient's use of the medication (Schegloff, 1988). Such treatment of the question clearly shows the interpreter's orientation to the medical activity projected by the doctor's question. Specifically, the interpreter's actions display his understanding that questions during a history-taking interview are posed to obtain information relevant to the diagnosis and treatment, and not simply to inquire into the patient's familiarity with various medications. Note that the question the interpreter poses is a question about one such contingency (prior treatment of the problem).

After ascertaining that the patient needs this medication (lines 7–9), the interpreter inquires into another medical contingency – the medication's effects (line 11). After receiving a one-word affirmative response to his question, the interpreter starts to report the treatment effects to the doctor (line 13):

- 13 I When she takes it, [ah:
 14 P [Зажимает го:лову но: помогает.
 squeezes head but helps
 [It squeezes my he{a:d but it helps.
 15 I Uh:: she gets som- uh (0.2)
 16 a lit'l:e (.) uh:: headpressure headache,
 17 but it does help.

The summary translation is interrupted by the patient who mentions some side-effects she experiences from the medication (line 14). The interpreter then includes the issue of side-effects (another medical contingency) in his continuing report to the doctor (lines 15–16).

The next excerpt (Excerpt 4) provides further illustration of the role of medical contingencies in organizing the interpreter's questioning of the patient. Here, the sequence is initiated by the doctor's question concerning the effects of a particular symptom on the patient's regular activities (line 1).

Excerpt 4 (Consultation 2)

- 1 D2 No:w- can she: y'think sh- c'n she wa:lk up some s-stai:rs
 or things like tha[t
 2 I [По лестнице можете подниматься?
 on stairs you+can climb
 [Can you *climb* some stairs?

((several lines omitted))

- 16 I <So on the second s- uh floor: (.)
 17 she needs to make three sto:ps.
 18 (0.5)
 19 D2 (Beacu:se there)
 20 (0.2)

- 21 I Из-за чего вы останавливаетесь?
 because + of what you stop
Why do you stop?
- 22 (0.8)
- 23 P Ну сердце не дает.
 well heart not allow
Well my heart doesn't let me.
- 24 (1.2)
- 25→I Отдышка или боль в сердце.
 shortness + of + breath or pain in heart
Shortness of breath or heart pain.
- 26→I Или о[ба.
 or both
Or b[th.
- 27 P [Боль.
 [*Pain.*
- 28 (0.5)
- 29 P Бо[ль.
 Pa[in.
- 30 I [Боль в сердце. <Отдышки нет, да?
 pain in heart shortness +of + breath no right
[Heartpain. No shortness of breath, right?
- 31 (0.8)
- 32 I Pain.
- 33 (0.5)
- 34 I Not- not adispia, just- pain.

In the first part of this questioning sequence (omitted from the transcript above), the interpreter poses a series of questions to specify how climbing up the stairs affects the patient. After the interpreter reports the results of this discussion to the doctor (lines 16–17), the inquiry about the patient's symptoms is reopened (by the doctor, if the hearing of line 19 is correct). After the patient provides a response to the question about the reason for her physical difficulty (line 23), the interpreter reformulates the question in line 21 to obtain a more precise description of the patient's symptoms (lines 25–6). The design of the interpreter's question is fitted to the ongoing activity of history-taking in that it uses a particular set of medical distinctions necessary for diagnosing the patient's specific medical problem:

- 25→I Отдышка или боль в сердце.
 shortness+of+breath or pain in heart
Shortness of breath or heart pain.

26→I Или о [ба.
or both
Or bo [th.

27 P [БОЛЬ.
[Pain.

After confirming the patient's response, the interpreter summarizes his findings about the patient's symptom to the doctor:

32 I Pain.
33 (0.5)
34 I Not- not adispia, just- pain.

Thus, in this case, the interpreter's questions display an orientation to obtaining information about the causal relationship between the patient's symptoms and her everyday activities.

To summarize, the analysis of several excerpts from the history-taking stage has demonstrated that patient-directed questions initiated by the interpreter are not random. Rather, they address a set of medical contingencies for diagnosis and treatment related to the symptom raised in the doctor's initial question. In addition, the interpreter's reports to the doctor include the information related to the contingencies and leave out those of the patient's remarks which are not relevant to them (see a later section for more discussion).

Relevance of the 'voice of medicine' to the organization of questioning sequences: sequencing of questions

As already mentioned, many of the interpreter's questions are designed in such a way as to elicit decontextualized, objective information about the patient's condition. This section will examine how the interpreter sequences questions in such a way as to further delimit the patient's responses.

A brief look at one segment of interaction will show that the interpreter may start with an open-ended question and change it to a more close-ended question in his pursuit of a specific response from the patient. This is what happens in Excerpt 5:

Excerpt 5 (Consultation 2)

21→I Из-за чего вы останавливаетесь?
because+of what you stop
Why do you stop?
22 (0.8)
23 P Ну сердце не дает.
well heart not allow
Well my heart doesn't let me.
24 (1.2)

- 25→I Отдышка или боль в сердце.
 shortness+of+breath or pain in heart
Shortness of breath or heart pain.
- 26→I Или о[ба.
 or both
Or both.
- 27 P [Бо[ль.
 [Pain.
- 28 (0.5)
- 29 P Бо[ль.
 Pa[in.
- 30→I [Бо[ль в сердце. <Отдышки нет, да?
 pain in heart shortness + of + breath no right
[Heartpain. No shortness of breath, right?
- 31 (0.8)
- 32 I Pain.
- 33 (0.5)
- 34 I Not- not adispia, just- pain.

Here the interpreter first poses a restricted *wh*-question (line 12), followed by a question in a list form (lines 25–6) and then a *yes/no* tag question (line 30). While the *wh*-question leaves the range of appropriate responses relatively open, the question formatted as a list presents several instances from a class of suitable answers. This sequencing of questions allows the interpreter to first specify (lines 25–6) and then confirm (line 30) the patient's response. Sequencing of questions is thus another piece of evidence for the interpreter's orientation towards obtaining clearly formulated and definitive responses from the patient.

To summarize, we have seen that the interpreter's involvement in the history-taking part of the consultations is shaped by his orientation to the 'voice of medicine'. Specifically, the norms of the 'voice of medicine' (such as a preference for decontextualized objective symptom descriptions) find their realization in how the interpreter's questions are sequenced.

Summary translations: what does the doctor hear?

Interpreter-mediated interactions are unique sites for a study of participants' orientations, alignments, and understandings because they commonly provide room for the participants to voice their stances. Thus, interpreters have structurally-established places where their understandings of the ongoing actions and activities are articulated. In the case of the history-taking interviews described in this article, such places are summary translations provided to the doctor at the end of each questioning sequence (see Figure 3). An examination of what these summaries contain (as well as what they systematically miss) can give

an important insight into what the interpreter believes to be relevant and important for the ongoing activity, and what he considers to be unimportant or irrelevant.

We have so far observed that the interpreter's involvement in history-taking interviews seems to be shaped by his orientation to obtaining information related to medical contingencies for diagnosis and treatment and, specifically, information formulated in the 'voice of medicine'. Given this fact, we may expect that issues considered by the interpreter to be irrelevant for diagnostic decisions, especially those formulated as subjective, contextually-grounded experiences, will be excluded from summary translations offered to the doctor. At the same time, issues related to medical contingencies which are formulated in the 'voice of medicine' will be included in summary translations. A brief analysis of summary translations offered after several questioning sequences will demonstrate that this is, in fact, the case.

Here is a summary translation offered by the interpreter after the questioning sequence discussed earlier as Excerpt 4:

Excerpt 6 (Consultation 2)

- 32 I Pain.
 33 (0.5)
 34 I Not- not adispia, just- pain.

We can see that the translation is telegraphic in form and that it presents information obtained from the patient in medical terms ('audispia') that are unlikely to be in the patient's vocabulary.

The following example is another illustration of the interpreter's orientation towards obtaining description of symptoms presented in the 'voice of medicine':

Excerpt 7 (Consultation 2)

- 1 D1 How- how o:ften do you have the (0.2)
 2 chest pain over here?
- 3 I как часто у вас боль (.) здесь (0.2)
 how often with you pain here
How often do you have pain (.) here (.2)
- 4 I в гру- в левой стороне.
 in che- in left side
in the che- on the left side
- 5 P часто.
Often.
- 6 (2.2)
- 7 Ну: во:т з:- Особенно перемена погоды, (0.8)
 well EMP uh especially change of + weather
We:ll uh:- Especially a change in weather; (0.8)
- 8 и я тогда лежу: пла:стом.
 and I then lie flat
and then I lie fla:t on my ba:ck.

- 9 I Фаина, вуз часто сколько как часто это бывает.
 Faina ? often how + many how often this happens
Faina (?) often how often does it happen.
- 10 Это раз в неделю, три ча- три раза
 this once a week three of- three times
Once a week, three of- three times
- 11 в неде[лю] каждый день,
 a week every day
a wee[k, every day,
- 12 P [()]
- 13 P И три раза, и: пять раз, и: как когда.
 and three times and five times and how when
And three times, a:nd five times, a:nd it depends.
- 14 (1.0)
- 15 →I Pretty much every day.
- 16 → (1.0)
- 17 →I °The way I understand.°

During the discussion, the patient mentions that her condition is related to outside factors, such as changes in weather, which make her chest pain particularly bad (lines 7–8). This correlation between the patient’s condition and the weather is left out of the interpreter’s translation. Among the possible reasons for this might be the fact that such a correlation comes from the realm of folk theories of illness, and that it presents the pain as a contingent – and thus, subjective and somewhat uncontrollable – matter. Both of these factors come from outside the typical ‘voice of medicine’ accounts, so it is not surprising that the patient’s observation gets excluded from the summary translation.

Note also that the interpreter’s summary translation contains a commentary on the patient’s answers (‘°The way I understand.°’ in line 17). This commentary embodies a complete departure from the traditional interpreting role that limits the interpreter’s involvement to presenting somebody else’s words in another language. Here the interpreter clearly shows his own analysis, in his own words, of his interaction with the patient.

A final example comes from a segment in which the interpreter elicits from the patient a particular description of the chest pain:

Excerpt 8 (Consultation 1)

- 1 D What- what kind of pain is it.
 <Is it a sha:ɹp pain, or du:l pain,
- 2 I Могли бы’ли вы описать эту боль.
 could COND you describe this pain
Could you describe this pain.
- 3 (0.4)

- 4 I это (.) тупая боль, (0.5) острая, (1.0) или давление.
 this dull pain sharp or pressure
Is this a dull pain, (0.5) a sharp one, (1.0) or the pressure.
- 5 (1.2)
- 6 P Ну какая боль, Просто вот у меня бывают случаи да:,
 well what pain simply EMP with me happen occasions yes
Well what kind of pain, Simply there are occasions ri:ght,
- 7 (0.8) °если я вот я пробывал заниматься,°
 if I EMP I tried to + exercise
(0.8) °if I tried to exercise,°
- 8 (0.8) з::: мне кажется что:::
 ah me seems that
(0.8) ah::: it seems to me tha::t
- 9 (1.5) ну: остано:вится сердце.
 well will + stop heart
(1.5) we:ll my he:art is going to sto:p.
- 10 (0.5)
- 11 P Мне надо (1.3) двигаться сюда туда чтоб'
 me need move here there to
I have to (1.3) move back and forth to
- 12 I <То есть Это не боль, (.) рто просто чувство
 that is this not pain this simply feeling
 <That is it's not a pain? (.) This is just the feeling
- 13 что сердце [>остановится,<
 that heart will + stop
 that your heart [>is going to stop<
- ((several lines omitted))
- 25 P Ну (1.0) Это не то чтоб постоянно,
 well this not that that constantly
Well (1.0) this is not like constantly,
- 26 <периодически бывает б:оль такая что >я говорю<
 periodically happens pain such that I say
 <periodically there is such p:ain that >I mean<
- 27 я не могу (.) кажется оно встанет
 I not can seems it will+ stop
I can't (.) it seems like it's gonna stop
- 28 и Это самое <м:не надо (0.4) д:ви:гаться
 and this such me need to + move
 and I kind of have to (0.4) m:o:ve
- 29 я не могу вот [(тут)
 I not can EMP here
 I can't just [()

- 30 I [Но (.) вы не можете сказать
but you not can say
[But (.) can't you say if
- 31 острая она или тупая.
sharp it or dull
it's sharp or dull.
- 32 (0.5)
- 33 I Острая Это сильная боль и резк' как-будто ножем,
sharp this strong pain and harsh as if by + knife
*Sharp means a lot of pain and acute as if
with a knife,*
- 32 а тупая она больше как давит.
and dull it more like presses
and dull means it's more like pressure.
- 33 P Нет не резкая.
no not sharp
No not sharp.
- 34 I Не резк[ая].
not sharp
Not sha[rp
- 35 P [Нет не резкая [(нет).
no not sharp no
[No not sharp [(no)
- 36 →I [So it's more uv a dull pain a:nd
37 → he has a hard time ah: describing it,
38 → (0.8)
39 →I Ah:: at the same time (0.2) uh:: (0.4) he- (.) he-
40 → it fee:ls like ah: the heart is going to stop.

During the discussion between the interpreter and the patient, the patient brings up several issues that are related to his medical condition. For example, in lines 6–9, and then later in lines 25–9 (Excerpt 8), the patient mentions that he tries to exercise to alleviate his symptoms. This issue, while potentially relevant to the diagnosis and treatment, is excluded from the interpreter's summary translation to the doctor, possibly because on both occasions it is brought up as part of a narrative description that presents the patient's medical condition in an experiential, subjective format. To be noted also is the interpreter's comment ('he has a hard time ah: describing it' in line 37) that similarly to the previous excerpt, presents the interpreter's own analysis of his interaction with the patient.

On the basis of the analysis in this section, it is possible to conclude that the interpreter displays a preference for objective, decontextualized representations of symptoms. In fact, patients' narrative, contextualized, subjective accounts, especially those presenting the causally contingent nature of the symptoms, are rejected and, sometimes, sanctioned by the interpreter. For example, the inter-

preter is found to suppress patients' lay explanations of illness which correlate occurrences of physical symptoms to weather conditions. In other words, the interpreter's summary translations are given in the 'voice of medicine'. At the same time, the interpreter dismisses patients' contributions offered in the 'voice of lifeworld' and does not include them in the summary translations (Mishler, 1984: 114).

The effects for the doctor of the exclusion of the patient's voice from the translation are, of course, hard to overestimate. Since interpreters have no (or very little) medical education, they are not qualified to make medical decisions about what is and what is not relevant for the diagnosis and treatment of the patient's condition. Thus, the observed conflict between the two 'voices' – the 'voice of medicine' and the 'voice of the lifeworld' – is not simply a theoretical issue. In fact, it may result in the exclusion of the patients' perspective from the medical interaction, and, in some cases, in the misrepresentation of medically relevant facts.¹³

Conclusion

The analysis of the interpreter's involvement in the activity of history taking has shown that the interpreter's actions are organized vis-a-vis the goals of this activity. Thus, first, interpreter-initiated questions directed to the patient are found to address a set of medical contingencies for diagnosis and treatment related to the symptom brought up in the doctor's initial question. In other words, the interpreter's questions pursue issues that are diagnostically relevant. Second, these questions display the interpreter's orientation to obtaining objective, decontextualized representations of information – information that could be used more easily in diagnosing the patient's condition. Third, the questions are designed and sequenced in such a way as to expedite the task of collecting relevant information from the patient. We have seen that in pursuit of appropriate patient responses, the interpreter poses questions that are progressively more close-ended, thus placing more limits on what the patient can appropriately do in response. Additionally, many of the interpreter's questions are negatively formulated *yes/no* questions that prefer minimal responses from the patient and, thus, attempt to limit patients' possibilities for presenting elaborate accounts of their concerns.

The interpreter's orientation to achieving the goals of the history-taking interview in a most efficient manner is also evident in summary translations offered to the doctor. Usually, in summarizing his conversation with the patient, the interpreter only conveys information related to the medical contingencies, and leaves out information presented by the patient if it is unrelated to that set of contingencies. Additionally, patients' narrative, experiential, subjective accounts are rejected and excluded from summary translations.

These findings have two important implications – one social and one analytical. We have seen that during history-taking interviews interpreters may adopt what Elliot Mishler (1984) calls the 'voice of medicine'. In other words, inter-

preters' turns can be designed in such a way as to display their exclusive orientation towards obtaining and conveying information that is relevant within the medical epistemological framework. Such involvement on the part of the interpreter decreases or even eliminates patients' chances of literally getting 'heard' by their doctors. Given interpreters' lack of medical expertise, their interventions may have negative consequences on the quality of medical care received by patients who lack linguistic skills in the majority language.

This problem raises the issue of importance of conducting an interactionally-sophisticated analysis of actual interpreting practices. The article has demonstrated that interpreting is a complex activity that cannot be understood as the straight forward rendering of other people's talk in another language. Interpreters' actions are shaped not only by other people's talk, but also by their own independent analysis of the ongoing activity and the specific requirements it poses for the participants. Clearly, further research on interpreting is needed to elucidate details on how different activity systems organize the interpreter's participation in the interaction. However, it is already apparent that in order to provide an adequate account of the practice of medical interpreting – an account that would give an accurate representation of what actually happens in doctors' offices – we need to analyze interpreting as a situated, locally organized activity embedded in a particular setting.

NOTES

1. Wadensjö (1992) reviews a number of other studies on medical interpreting.
2. A similar distinction is made by Knapp-Potthoff and Knapp (1986) and Wadensjö (1992).
3. QM stands for 'question marker'.
4. Note that in Russian verbs are not marked for progressive vs. habitual aspect. Therefore, the interpreter's words in line 4 can be translated as either 'Do you have a chest pain?' or 'Are you having a chest pain?' Note also that the appropriate Russian term for 'chest pain' is, literally, 'heart pain'. Therefore, the interpreter's translation of the doctor's 'chest pain' as 'heart pain' is quite accurate.
5. See, for example Pomerantz (1984) and Schegloff and Sacks (1973).
6. See, for example, Pomerantz (1984) and Sacks (1987).
7. The fact that 'it' refers to the heart is fully transparent in Russian. The pronoun is co-referential with 'it' in the previous TCU which, in turn, is co-referential with 'heart' in line 4 (the pronouns and the noun are marked for the same neuter gender).
8. This, again, is clearer in Russian than it is in the English translation. When a problem with a body part is described, the body part in question appears in the subject position of the sentence (in the nominative case), followed by a predicate formulating what the problem is. For example: 'The heart/the throat/the leg . . . hurts/aches/ . . .'
9. Note that the patient uses an impersonal verb form in Russian with no overt subject noun phrase that can be translated into English as 'it happens'. So the pronouns 'it' in lines 6 and 7 are *not* co-referential.
10. To my knowledge, the interactional functions of the 'ny' particle in Russian have not been investigated. I have noticed that when it prefixes second pair parts (such as responses to questions), 'ny' seems to function similarly to English 'well'. When pre-

fixing questions, however, 'ну' seems to imply problematicity or rejection of the preceding turn.

11. This conjunction is, thus, different from the English 'and', in several ways. For example, *a*-prefixed questions do not seem to have the interactional functions of the *and*-prefixed questions in English described in Heritage and Sorjonen (1994). The interactional properties of this conjunction have not been investigated, however (for a functional account, see, for example Grenoble, 1998; Yokoyama, 1981).
12. In Russian, *yes/no* questions can be formulated in three principal ways: (a) by adding the question marker 'ли' (usually after the verb); (b) as an assertion with questioning intonation; and (c) as an assertion with a tag. The three alternatives are not equal in terms of preference organization. It can be suggested that the three formats are ranked in the following way:
 - (a) Questions with the question marker are the most neutral. For example:

Боли́т-ли у вас се́рце?
hurts-QM with you heart?
Do you have chest pain?
 - (b) Assertions with questioning intonation prefer a conforming response. For example:

У вас се́рце боли́т?
with you heart hurts
You have chest pain?
 - (c) Assertions with a tag strongly prefer a conforming response. For example:

У вас се́рце боли́т, да?
with you heart hurts right
You have chest pain, don't you/right?

These observations are, however, subject to further research.

13. For a discussion of the exclusion of patients' perspective and the consequences of such exclusion on medical care, see, for example, Barsky (1981), Fisher (1991), Larsson, Säljö and Aronson (1987), Lipkin et al. (1995), McWhinney (1981, 1989), Sankar (1986), and Todd (1984, 1989).

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GALINA B. BOLDEN is a doctoral student in the Department of Applied Linguistics at the University of California, Los Angeles. Her research interests include interpreting, doctor-patient interaction, conversation analysis and analysis of institutional interaction. ADDRESS: Department of Applied Linguistics, 3300 Rolfe Hall, University of California, Los Angeles, Box 951531, Los Angeles, CA 90034, USA. [email: gbolden@ucla.edu or briskina@humnet.ucla.edu]