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The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse[1]

Brad Davidson
San Francisco, California

Increases in immigration have led to an enormous growth in the number of cross-linguistic medical encounters taking place throughout the United States. In this article the role of hospital-based interpreters in cross-linguistic, internal medicine 'medical interviews' is examined. The interpreter's actions are analyzed against the historical and institutional context within which she is working, and also with an eye to the institutional goals that frame the patient-physician discourse. Interpreters are found not to be acting as 'neutral' machines of semantic conversion, but are rather shown to be active participants in the process of diagnosis. Since this process hinges on the evaluation of social and medical relevance of patient contributions to the discourse, the interpreter can be seen as an additional institutional gatekeeper for the recent immigrants for whom she is interpreting. Cross-linguistic medical interviews may also be viewed as a form of cross-cultural interaction; in this light, the larger political ramifications of the interpreters' actions are explored.

KEYWORDS: Interpreting, medical discourse, medical anthropology, discourse analysis, immigration, institutional ethnography

> 'Interpreters are the most powerful people in a medical conversation.'
> *Head of Interpreting Services at a major private U.S. hospital, May 1999.*

1. INTRODUCTION

In this article, I examine the linguistic and social roles played by hospital-based interpreters in medical discourse. The need for interpreters has become a fact of contemporary medical practice; one study of 83 U.S. public and private hospitals found that 11 percent of all patients required the services of an interpreter (Ginsberg et al. 1995). Since Shuy (1976), a growing number of researchers has become interested in close linguistic analyses of medical discourse, but very little has been said to date about the linguistic and social

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108 Cowley Road, Oxford OX4 1JF, UK and 350 Main Street, Malden MA 02148, USA.

role of the interpreter in cross-linguistic medical discourses. Yet these encounters are common, and it is the interpreter, the only conversational participant with the ability to follow both sides of the cross-linguistic discourse, who is uniquely positioned within these discourses, to control the flow of information necessary for the achievement of the participants' medical and social goals.

In addition, in an era of massive population movements, the increase in number and frequency of cross-linguistic medical encounters can also be viewed as an increase in an institutional form of cross-cultural encounter (Blackhall et al. 1995; Erzinger 1991; Marcos and Trujillo 1984; Martinez, Lenoe and Sternback de Medina 1985; Phillips et al. 1996; Thamkins 1995), with the interpreter acting as the point of negotiation and exchange between the social contexts inhabited by the physician and the patient (Davidson 1998, 1999; Kaufert and Koolage 1984). In this article, then, I explore the contextually and historically situated nature and role of the interpreter within these socio-medical interactions.

That there *is* a social component to hospital interpreting is itself a reasonably uncontroversial, but largely unstudied, hypothesis. Hospital administrators and physicians alike insist that it is both possible for, and the duty of, medical interpreters to interpret without adding or subtracting meaningfully from the content and intentions, and thus the effects, of utterances (to the degree to which she does do so, she is considered incompetent). The problem lies in that most, if not all, serious analyses of interpretation acknowledge that perfection in interpretation is unattainable. At the very least, differences in linguistic form lead, inevitably, to differences in meaning and reception, however small, and semantically 'identical' utterances in different languages vary greatly in their social and contextual evaluation by speakers (e.g. Bendix 1988; Cartellieri 1983). In addition, the time constraints placed on interpreters forces them, in the cases I observed, to do more than simply change the nuances of utterances: they edit, and in some cases delete wholesale, conversational offerings on a regular basis. There is considerable slippage, then, between how the tasks that hospital personnel set for interpreters are believed to work in practice, and the actual functions and linguistic actions that interpreters perform.

The question remains as to what are the patterned ways in which the interpreter influences the discourses she interprets through these small, and in some cases not-so-small, changes in linguistic form; what is the 'interpretive habit' of the socially positioned agents known as 'interpreters' in a typical medical encounter, and how do they conceive of their role in achieving conversational goals? Interpreters interpret *for a reason*, because there is some communicative or social goal that needs to be met; they do not simply wander upon two speakers shouting at each other in different languages and offer their services. From this point of view, the measure of the interpreter's success may not be an abstract count of how 'accurate' they are, but rather the degree to which she allows, through her actions, the speakers first to negotiate and then to achieve their goals for the speech event in question.

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The mediated negotiation of conversational goals, however, is no trivial matter; such goals are determined, for each conversational participant, by historical contexts that frequently preclude any analysis of social equality between the primary speakers. Many researchers have already noted that even same-language medical discourse can be viewed as a form of interaction between unequals, in which patients, as clients of the institution of the hospital clinic, find it difficult to establish a voice outside of the expected parameters of medical practice (Mishler 1984; Waitzkin 1991; West 1984; Wodak 1996). In the data examined in this article, the addition of a conversational mediator (the interpreter) increases tremendously the patient's difficulty in making herself, or her agenda for the discourse, heard. The fact that the patients for whom these interpreters are speaking are recent immigrants, mostly from the Third World, highlights the fact that what interpreters are mediating in hospital discourse is not only the diagnosis and care of patients, but also a form of cross-cultural encounter between immigrants and agents of the institutions of the First World; it is these agents who both provide services to these immigrants while simultaneously educating them as to their role within the modern nation-state (cf. Gupta and Ferguson 1997).

2. BACKGROUND

Historically, most analyses of interpretation (the conversion of utterances from one language into another) have been based on an oral model of *translation* (the conversion of written texts), which has meant that most analyses of interpretation have focused on *monologues*. Students of discourse have rarely focused their attention squarely on interpretation itself, instead producing in passing a tacit model of discourse interpretation as a sequence of discrete linguistic conversions of isolated utterances. Interpreters are seen as conduits, not conversational participants. For example, Hymes (1972), in his famous SPEAKING mnemonic, lists the interpreter's role as that of 'spokesman' or 'sender', but not as a 'source' or 'addresser'; similarly Goffman (1981) calls the interpreter an 'animator', or one who makes noises, but not an 'author' or 'principal', one to whom the meaning of utterances can be attributed (see also Clark 1992, 1996).

But in interpreting a monologue one does not need to worry about turn-sequence, the rights of hearers to become speakers, or even the level at which the primary speaker is being understood by the audience; monologues involve one-way transmission, and the audience is largely unable to respond or to act in setting the agenda for what will be discussed. However, the act of oral interpretation of *discourse* is very different (cf. Roy 1999); it must take into account all of these factors, but it is often reduced, in passing analyses, as the interpreter's obligation to be a perfect echo of the primary interlocutors.

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2.1 The interpreter as conversational participant

Recently, however, students of language and discourse have turned their attention to the nature and, to some degree, consequences of the interpreter's role as an historical agent. This has led to a number of works that examine the role of the interpreter or translator as linguistic and social intermediary (Bassnet and Trivedi 1999; von Flotow 1997; Hatim 1997; Hatim and Mason 1989; Rafael 1993; Snell-Hornsby 1988; Roy 1999; Venuti 1998; Wadensjö 1998). All of these works share the common analysis that interpreters or translators, far from 'merely' converting and conveying the words of others, are centrally employed in the work of mediating the achievement of conversational or interactional goals, and that to a large degree responsibility for the achievement of these goals lies squarely with the interpreter herself. Interpreters do not merely convey messages; they shape, and, in some very real sense, create those messages in the name of those for whom they speak. The context of the interpreted speech event itself has also received considerable attention, and the influences of the social and historical facts surrounding an interpreted speech event are seen to influence greatly the interpreter's choices and the resulting outcomes of the interaction (cf. Rafael 1993).[2]

2.2 Institutions and the mediation of post-colonial discourses

One significant factor influencing the manner and effects of interpretation is the location of interpreted speech events within an historical-political timeline. With the exception of business or diplomatic interactions, the majority of interpreted discourses in the U.S. take place within the context of state-sponsored or -run institutions (the hospitals, schools, and judicial/legal system), between agents of those First World institutions and the Third World immigrants who require or are subjugated to the services provided. Institutional discourse is defined, in large part, by the fact that institutionally defined goals and the institutionally reinforced habits for achieving them provide clear signposts for how communication should, and does, proceed, at least to those speakers familiar with the institution in question (Bourdieu 1977; Cicourel 1983; van Dijk 1993; Gupta and Ferguson 1997; Schegloff 1992; Wodak 1996; inter alia).

These institutional interactions thus stretch the notion of 'neutrality' in interpretation to the limit, as interpreters 'are *always* placed in this contested arena between being providers of a service and being agents of authority and control.' (Candlin, in the introduction to Wadensjö (1998): xvii; italics in the original). Wadensjö (1998: 68–69) writes:

> 'As do all professionalized intermediaries, interpreters work at providing a particular *service*. Simultaneously, they – of necessity – exercise a certain *control*. Obviously there is a potential conflict between the service and the control aspects, which sometimes

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> surfaces in dilemmas reported in the literature on institutional communication. It largely remains to be investigated how this conflict is handled in institutional interpreter-mediated talk, where the gatekeeping is, in effect, doubled.' (italics in the original)

Institutional interpretation has, then, a potentially disruptive social component that cannot be ignored.

There have been several excellent studies of interpreted courtroom discourse, all of which have pointed to the legal habit of selecting, privileging and codifying certain utterances as 'facts' (Scheppele 1989) as being the dominant factor in determining how interpreters are allowed, and not allowed, to interpret (Berk-Seligson 1990; Edwards 1995; Hewitt 1995; Mikkelson 1998). In this article, I examine the 'interpretive habits' of hospital interpreters through a close analysis of their actions within the structured speech event known to physicians as the medical interview; these habits are influenced directly by both the medical habit of differential diagnosis and the institutional reality of chronic time shortages in contemporary clinical practice.

2.3 Medical discourse and medical interpretation

There have been numerous, detailed studies of physician-patient discourse, focusing primarily on the difficulties patients and physicians have in communicating effectively with each other (Ainsworth Vaughn 1994; Cicourel 1983; Frankel 1990; Hein and Wodak 1987; Mishler 1984; Robins and Wolf 1988; Sarangi and Stembrouk 1996; Waitzkin 1983, 1991; West 1984; West and Frankel 1991; Wodak 1996; inter alia). Most of these analyses center on one type of medical discourse, the named speech event 'medical interview'; this is a structured, practiced interaction between the physician and the patient, taught in medical schools, designed to quickly elicit the patient's complaint(s) so that they may be diagnosed and treated. Medical interviews are thus a type of verbal and physical investigation, a matching of unorganized experiences against familiar patterns and processes of human vulnerability to disease. The overt, elaborated goals of the medical interview are: 1) from the data provided, determine what, if anything, is wrong with the patient; 2) elaborate a plan of treatment for that ailment; and 3) convince the patient of the validity of the diagnosis so that treatment will be followed. However, the elicitation of medical 'facts', or from another point of view the creation of medical facts through medical practice, is heavily influenced by a social evaluation of the meaning and importance of whatever facts are thus uncovered or created (Foucault 1963; Waitzkin 1991); the practice of medicine, like the practice of interpreting, has a social dimension that cannot be ignored.

Diagnosis is, then, an interpretive process in which the patient's physical and verbal data is passed, by physicians, through a grid of medical meanings (biological *and* social) and re-analyzed, so that 'irrelevant' input from the

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patient may be excluded and the story of the disease constructed (Foucault 1963; Kleinman 1988; Mishler 1984). Indeed, this is the unmarked use of the word 'interpreting' in medical contexts; when I first told the physicians at the General Medical Clinic I would be conducting a study of interpreting, they universally assumed that I meant a study of the ways in which physical and verbal input are re-read as signs and symptoms of disease processes.

In fact, very little has been said about the concrete forms or effects of interpretation of medical discourse. There are exceptions to this trend (Bendix 1988; Erzinger 1991; Marcos and Trujillo 1984; Martinez, Lenoe and Sternback de Medina 1985; Weaver 1982), but the majority of literature written about medical interpretation has come from two camps: physicians who use interpreters (Baker et al. 1996; Baker, Hayes and Fortier 1998; David and Rhee 1998; Ebden et al. 1988; Putsch 1985; Vasquez and Javier 1991; Woloshin et al. 1995), and interpreters themselves (Haffner 1992; Juhel 1982; Kaufert and Koolage 1984). The physicians generally lament the difficulties of diagnosing patients, establishing a clinical relationship, or providing adequate care to patients when using an interpreter; the interpreters tend to focus on their role as 'linguistic ambassadors' for the patient, a stance in favor of overt 'advocacy' interpretation. Neither group, however, rests their arguments on analyses that explore exactly *how*, in discourse, interpreters advocate or obfuscate the conversational process.

It is not surprising that physicians have taken a recent interest in interpretation: it would be hard to imagine a physician in practice or training today who has not had to use an interpreter at least once to converse with a patient. At Riverview General Hospital, the large, public county hospital in Northern California where I conducted my research, the recent increase in interpretation is readily apparent in Table 1. While Riverview may be unusual in the degree to which multilingualism pervades everyday life, it is typical in the way that the number of patients who need interpreters has increased in the last two decades. It is also typical in that Spanish is both the most prevalent non-English language, and in that it will remain so for the foreseeable future (cf. Berk-Seligson 1990). For this reason, in addition to the fact of my own bilingual abilities in English and Spanish, Spanish language visits were chosen as the subject of study.

Table 1: Riverview General Hospital patient demographics, by year

Year	# of patients seen	# of patients requesting interpreter	% of total patient population
1981	67,000	14,000	21
1993	133,000	53,000	40

Spanish-language visits in 1993: 34,000 (25% of *all* visits)

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2.4 Methods and data

In the Spring and Summer of 1996, I conducted fieldwork at Riverview General Hospital's General Medicine Clinic (GMC), the outpatient unit of the internal medicine division of the hospital. The patients there were undergoing treatment for a variety of long-term illnesses, ranging from chronic back pain to stroke rehabilitation to diabetes to congestive heart failure; their physicians were also the primary care physicians within the hospital hierarchy, meaning that patient referrals to other specialist physicians and clinics were orchestrated by these internists.

Data collection centered on the ways in which hospital-based interpreters were utilized within the clinic, how their presence during medical interviews helped to shape the course and content of those interviews, and how they mediated the potential clash of goals between the achievement of the overt institutional goals of diagnosis and treatment that are set by standard medical practice, and the not-necessarily identical goals held by the patients. I approached the study as a political, social, and linguistic enterprise, with an eye towards answering the following questions:

- What is the role of the interpreter within the goal-oriented, learned form of interaction known as the 'medical interview'?
- What is the 'interpretive habit', and how does one engage in the practice of interpreting?
- If interpreters are *not* neutral, do they challenge the authority of the 'physician-judge' (cf. Foucault 1979), and act as patient 'ambassadors' or 'advocates' (as Haffner 1992, Juhel 1982, and Kaufert and Koolage 1984 suggest); or do they reinforce the institutional authority of the physician and the health-care establishment, and should we create a model for the 'interpreter-judge'? (cf. Foucault 1979)

In order to answer these questions, I observed both the interpreted medical interview itself, and the institutional context that supported and gave meaning to this speech event. Every physician and interpreter asked, and almost every patient, agreed to participate in the study, most of them enthusiastically. It was typical for patients, especially patients waiting for an interpreter to arrive, to tell me that they thought it was an excellent idea for someone to study how physicians talked to patients, largely because they thought it wasn't very well at all.

The interpreters who form the focus of this article were professional in the sense that they were paid employees of the hospital; none, however, had any formal degree in interpretation or translation, and in this they appeared to be quite typical of all of the hospital interpreters I have observed or spoken with in Northern California. The specifics of training are different from hospital to hospital in the San Francisco Bay Area, but in general they constitute nothing more than a period of time following an interpreter on her daily rounds, an

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assurance that the interpreter in question is actually bilingual in the relevant languages, and paperwork documenting that the interpreter is informed (somewhat) about issues of patient confidentiality. In this sense Riverview General was 'normal' – interpreters were neither trained extensively nor supported institutionally, and they performed their work in an ad-hoc vacuum of accountability; the hospital monitored if they were present at a certain number of physician-patient encounters, but expressed virtually no interest in determining what they actually *did* in these encounters.

The data reported on here come from observations of over one hundred patient visits, 50 of which were both observed and audiotaped. For those interactions that were taped, all participants were requested to fill out a questionnaire, and most were interviewed, at the end of the visit. The audiotaped encounters included visits with both hospital-based staff and family members acting as interpreters, and also monolingual interviews conducted all in English or all in Spanish with no interpreter. There was a total of 10 Spanish-English, professionally interpreted medical interviews taped. These 10 visits were matched with 10 English-English visits, as closely as possible, for similarity of patient, physician, and interpreter age, race, religion, and ethnicity, and for nature of the interaction (first time visit, routine check-up) and the patients' illnesses (diabetes, high blood pressure, etc.). The data presented here, then, represent an exhaustive accounting of the data collected on hospital-based interpreters specifically. The analyses of linguistic data below are drawn from the set of 20 fully transcribed medical interviews, and from the ethnographic and survey data collected on the clinic as a whole.

3. THE INTERPRETER IN MEDICAL INTERVIEWS

During the study at Riverview, one factor stood out as being overwhelmingly contextually salient: the scarcity of time in modern medical institutions. The amount of time patients spent waiting for their physician, the even longer amounts of time spent waiting for interpreters, and the brevity of the physician-patient-interpreter encounter, added to the time constraints on modern medical practice in general, seemed to be overriding factors in how interpreted medical interactions took place. In myriad ways, all patients were shown that, from the minute they entered the clinic until the minute they left, their time was not as valuable as that of the physician, or of any other member of the clinic (cf. Elliot 1999). Patients who used interpreters had this message delivered in even stronger terms. Often they were left alone in windowless examining rooms, sometimes for up to an hour, while they waited for the interpreter to arrive. In such cases the physicians would not wait, but rather would move on to the next patient.

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3.1 The interpreter as co-interviewer

One common scenario for interpreted medical interviews at Riverview was, then, that the interpreter would arrive while the physician was busy elsewhere, and she would begin some form of interaction with the patient before the physician arrived. This had two effects. The first was that, from the physician's point of view, the process of elaborating a Chief Complaint (a named entity in medical practice, usually written in chart notes as the abbreviated 'CC') from the patient was (apparently) simplified; the interpreter might greet the physician at the door of the examining room with an announcement of whatever the patient had specified as his or her problem, as in Excerpt 1, where 69 lines of transcript have occurred before the physician enters the room. The second effect was, however, that the interpreter thus set the focus of the initiation of the interview, and would occasionally go so far as to conduct the initial portions of the interview herself:

Excerpt 1 (from Visit 30):[3]

(Dr enters the room)

70	Pt	Anda, a ver que dice el doctor.
		Well, let's see what the doctor says.
71	Dr	Hi:!
72		how are you doing?
73	Int	Doctor, I was looking for something to put over there because he
74		wants to show you his:
75	(1.5 seconds)	
76		foot but I didn't find something.
77	Dr	Oh.
78		Let's see:=
79	Int	=One of those (xx)s, or.
80	Dr	Maybe he: re, no:
81	Int	Maybe in the (xx). ((banging noises – searching for a stool))
82	(2 seconds)	
83	Dr	Wouldn't surprise me.
84	(6 seconds)	
85	Int	At least we are not (xx).
86		Levante(te?) un poquito la pierna. (louder than previous English)
		Lift your foot a little bit.
87	Pt	Sí, sí, señora.
		Yes, yes, ma'am.
88		Ahora bien.
		Okay now.
89		[x]
90	Int	[¿Cuál] es el malo?
		[Which] is the bad one?
91	Pt	¿Mande?
		Excuse me?
92	Int	¿Cuál es el [enfermo?]
		Which is [the 'sick' (bad) one?]

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93	Pt		[Éste.]	
			[This one.]	
94	Int	A ver,		
		Let's see,		
95		quitense el caletín y el [XXX] por favor.		
		take off your sock and [XXX] please.		
96			[(loud banging noise)]	
97	Pt	Oh, no.		
98	(2 seconds)			
99	Int	He says that, ah,		
100		you explained to him the last time then ah, . . .		

It is impossible, in this stretch of text, to construe what the interpreter is doing as 'merely' conveying information. She is essentially running the interview, not interpreting sequences of utterances. She asks the questions, and begins the physical exam; her only interaction with the doctor is a request to help her find a stool for the patient to elevate his foot, and at line 99 the beginning of a recapitulation to the physician of what was said in his absence. In taking charge of the interview, she is preventing a potential initial greeting phase between the physician and patient, and nowhere does she ask the patient, nor allow the physician to ask the patient, what exactly has brought him to the clinic today. Note that in line 70, the patient expresses an interest in hearing what his *physician* has to say about his problem, but it is the interpreter with whom he converses.

The interpreter has not, however, misunderstood the patient's earlier expressions of concern over his foot, which is, as becomes clear throughout the interview, his true Chief Complaint; nor does the physician seem concerned that the interpreter is conducting the preliminary physical exam. The only problem, then, is that the interpreter has sacrificed completely the notion that the physician and the patient are participating, at this moment, in a conversation *with each other*.

The patient and the physician appear to understand that the interpreter is not interpreting, in the strict sense, but rather maintaining parallel and related conversations that inform them, approximately, of the other's general verbal offerings. They frequently make it clear when they want the interpreter to actually interpret by telling her explicitly to do so. Excerpt 1 is taken up, below, a little further along in the interview:

Excerpt 1 (from Visit 30), continued:

195	Int	He says he feels:
196		good except his foot,
197	(.5 seconds)	
198		ah: =
199	Dr	=can I see his other foot?
200	Int	A ver,
		Let's see,

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201 Pt Dígale que,
Tell him that,
202 Int Y, y it stops when, when,
203 it's worse, when he walks.
204 (3 seconds)
205 Pt Y yo, ya sí me siento bien.
And I, now I feel good.
206 (2 seconds – Dr takes off Pt's sock and looks at other foot).
207 Ah, (que esos?) no los pongo, si no los (pide?).
Ah, (that these?) I won't wear these, if he doesn't (ask?).
208 Int Oh my god, it's totally (xx) – (very softly, aside to Dr).
209 (1.5 seconds)
210 Pt Dígale que eso no me duele, eso es solo como una reventadita.
Tell him that this doesn't hurt me, it's like a little eruption.
211 Int He says that one is nothing, and it's like a little,
212 (xx?)
213 (3 seconds)
214 ¿Pero se acuerda que así le empezó el otro?
But do you remember that the other one started this way?
215 Pt Sí, así como está ése.
Yes, just like this one is.
216 Que bien que Ud. se acuerde.
How good that you remember.
217 Int I mentioned that remember then the other one start the same way.
218 Dr I know. ((e.g. that the other foot started the same way))
219 Int And he said, yeah, that's good that you remembered that.

The interpreter is still not following a model of strict sequential interpretation: the only straightforward sequence of utterance-interpretation happens in lines 210–212. Even a request for interpretation may not be granted. In lines 201 and 210, the patient expressly asks the interpreter to interpret his words by prefacing his statements with *dígale*, 'tell him', but the patient's subsequent offering after line 201, presumably the 'I feel good now' in line 205, is not interpreted. It is not only the patient who has his offerings left untranslated, however: line 199 from the physician is not put into words, either, although his request to 'see [the patient's] other foot' is fulfilled. Notice also that the interpreter, who knows the patient from past interactions, comments upon the state of the patient's foot as being the same way that the other foot started to have problems (line 214), a comment which elicits a response from the patient directed at her ('Ud.', line 216) and not the physician; only when this interaction, initiated by the interpreter herself, is completed does she recount what she has said to the physician.

The patient's problem is not minor: he is in danger of having his toes amputated as a result of complications from unmanaged diabetes. The physician knows this, the interpreter knows this; the one conversational participant who does not seem to grasp the severity of the problem is the

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patient himself, who at the end of the interview remains unconvinced by the physician's warnings that if his diet does not change he will lose, not only his toes, but eventually his feet as well. The patient manages to get a referral to the wound management clinic to have his feet cleaned, which was his initial goal; but if one of the institutional goals of a medical interview is to not only elaborate a diagnosis and plan of treatment, but also to convince the patient of the validity of the diagnosis and plan, this interview has failed in that the patient leaves completely unconvinced that his problems are as severe as the physician and interpreter tell him they are. It is not possible to say with certainty that this is the result of the interpreter's actions; what is clear, however, is that the patient's voice is significantly modified by having to speak through an interpreter, and that the interpreter is frequently speaking, not as an echo, but in her own voice.

3.2 Quantifiable patterns of interference in interpreted medical interviews

One could ask at this point, as did many of the physicians who took part in this study (acting perhaps as devil's advocates), what is the harm in the interpreter assisting the physician in conducting the medical interview, especially if time is short and it speeds the interview process along? The first response would be that nowhere is it stated that speed is the *primary* goal of a medical interview; these are institutional constraints, but they are universally decried as having a detrimental effect on the physician-patient experience. Time *is* scarce in hospitals today, however, and interpreters are conscious of their role as facilitator and editor; during one interaction (visit 11), after several minutes of conversation with the patient in the absence of the physician, the interpreter looked at me and said, 'you chose one that's hard to keep on track'. The patient had been providing a detailed history of the difficulty he had had at various clinics affiliated with Riverview General. The interpreter's statement made it clear that she felt this was extraneous information, and that it was her job to keep the patient on track, as measured against what *she* believed to be relevant information for a medical interview. It was not clear that the patient's narrative was, however, irrelevant; the 'Social History' relating to an illness is part of the routine medical interview, coded in patient charts under the heading 'SH'.

The consistent attempt to keep patients 'on track' led to a number of quantifiable phenomena in the discourse. Tables 2 and 3 show how patient-generated direct questions were dealt with in the two sets of interviews. For both sets of interviews, almost all of the direct questions asked were answered. However, for the patients using an interpreter over half (18/33) of all of the questions which were directed at the physician were answered by the interpreter, without the physician ever hearing the question. The significance of this pattern of short-circuiting question-and-answer sequences between patients and physicians is not only that patients are receiving answers from their interpreter and not their physician; it is also that physicians have no idea

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Table 2: Treatment of patient-generated direct questions in 10 same-language visits

	# of questions from patient	Answered by physician	Not answered by physician
Total	55	53	2

Table 3: Treatment of patient-generated direct questions in 10 interpreted visits

	# of questions from pt	Passed on to Dr	Not passed on to Dr	Answered by Dr	Answered by interp	Not answered
Total	33	15	18	12	17	4

that their interpreted patients are asking questions at all, which increases the likelihood that these Hispanic patients will be seen as 'passive' (cf. Baker, Hayes and Fortier 1998; Erzinger 1991) and also prevents the physician from following up on difficult questions or questions that display a deep misunderstanding, on the part of the patient, as to what the diagnosis or plan of treatment are.

Another possible analysis for this treatment of direct questions is that these questions pose a threat to the physician's authority within the medical interview (Ainsworth-Vaughn 1994). In medical interviews it is the physician, and not the patient, who typically asks the questions (cf. Mishler 1984). We have already seen in Excerpt 1 that interpreters are themselves capable of producing spontaneous requests to patients, thus taking on the physician's right to ask questions; the interpreters' habit of *answering* questions might be viewed as a move to insulate the physician, and thus the institution of the clinic, from patient challenges to its authority. We will return to this issue in Section 3.3, below.

In a related vein, patients' physical complaints themselves, the *raison d'être* of the medical interview, are often lost in the conversational shuffle. Table 4 shows the number and content of identifiable patient complaints from two matched interviews, interviews 6 and 7. They have been chosen for detailed comparison because of the large number of similarities they share: both interviews took nearly the same time, and dealt with 'typical' patient complaints at the GMC – chronic discomforts that did not appear life-threatening and which were difficult to diagnose and subsequently treat. Both interviews took place on the same day, with the same physician, and the patients were roughly the same age. Both the English speaking patient in visit 7 and the Spanish speaking patient in visit 6 produced new complaints, in addition to a number of vaguely-defined and

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difficult to treat conditions that had been addressed in previous visits. The two visits were also representative in that, given roughly similar clinical scenarios, in comparison to the same-language visit the interpreted visit was marked, as were nearly all of the observed interpreted visits, by severe communicative difficulties. These were of a type and to a degree that far surpassed the 'normal' communicative difficulties encountered by same-language patients and reported in research on physician-patient discourse.

The complaints offered by the English speaking patient were all addressed directly, in one form or another, and nearly all of them were diagnosed and treated; for the Spanish speaking patient, however, most of his complaints were left undiagnosed and untreated, most significantly the one complaint that he is most concerned with (see Excerpt 2, Section 3.3). This was due to one of three processes: to the physician not hearing the complaint because the interpreter didn't pass it along; to the physician hearing the complaint but not addressing it, leaving the interpreter with nothing to say to the patient; or to the physician hearing and addressing the complaint, but the interpreter not passing the physician's commentary on to the patient. The majority of the patient's complaints, in visit 6, were left without a concrete or even partial diagnosis or plan of treatment. Notice also that the final diagnosis for most of the Spanish speaking patient's complaints are 'general pains, which the physician sees as related to his "mood" '; his illnesses are considered psychosomatic, to a large degree, which is common for patients who speak Spanish (Erzinger 1991; Marcos and Trujillo 1984). The English speaking patient, a recovering intravenous drug abuser, was no less depressed, but his complaints of physical discomfort were taken seriously enough by the physician to have them addressed individually and concretely. One of the most negative effects of

Table 4: Complaints addressed and diagnosed in visits 6 and 7

	Diagnosis supplied	Treatment suggested
Complaints: visit 6, Spanish		
Vision (new)	No	No
Foot pain	No	No
Arm/hand pains	Yes	No
General pains	Yes	Yes
Mood	No	Yes
Complaints: visit 7, English		
Wrist pain (new)	No	Yes
Cough (allergy)	Yes	Yes
High blood pressure	Yes	Yes
Frequent urination (new)	Yes (possible diagnosis)	Yes
Prostate node (new)	Yes	Yes (urologic referral)

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interpretation at Riverview, in fact, is the tendency for physicians to see patients who can't speak for themselves, as a result of the conversational difficulties, as 'cranks' or patients who complain of phantom problems (Davidson 1998). What is left to examine is the role played by the interpreter in interview 6, to determine what part she played in thwarting the elaborated goals of diagnosis and care delivery.

3.3 The loss of patient complaints

In Excerpt 2 we see portions of the interview in visit 6, which took place between a Spanish speaking male patient in his mid-40s, an English speaking, male, Anglo physician in his mid 30s, and a Spanish-dominant, professional female interpreter in her mid 40s (a different interpreter from that in Excerpt 1). This is not the first visit between the patient and the physician, who have known each other for three years; the interpreter, too, knew the patient, as this was the 'third or fourth' time she had interpreted for him. The excerpt begins after the patient and the physician had already had a chance to interact, briefly, an interaction that I observed; the patient had enough English to say his 'eyes hurt', but he could say no more than this, at which point the physician decided to call the interpreter (why, after a 3 year clinical relationship, the physician decided to call the interpreter *after* trying to converse with the patient, remains unclear). The patient had been left waiting in the examining room for over 45 minutes, as the physician moved on to his next patient rather than wait for the interpreter to show up.

The excerpt begins, then, with the physician and the interpreter (and myself) arriving in the exam room to see the patient, who has at this point been waiting alone in a windowless room. Notice that the interpreter is licensed, in the physician's first turn, *not* simply to interpret, but rather to explore 'what did [the patient] mean by this?' (line 23) when he said his 'eyes hurt'. From the very beginning of the interaction, she becomes responsible, then, for not only conveying information, but for first collecting it, in immediately usable fashion, in the name of the physician. The interpreter's subsequent actions should be judged in the light of this request from her institutional superior, the physician for whom she is interpreting, to actively clarify the patient's verbal output.

Notice also that, from the beginning, we hear the physician, patient, and interpreter struggling to construct a coherent account of the patient's Chief (or at least initial) Complaint about his eyes, but that they fail to establish anything more than that the patient's eyes have a problem relating to 'burning', 'tearing', and cloudiness or a possible complete loss of vision. The interaction was perhaps even more muddled than the transcript shows; when the interpreter struggles to convey exactly what the patient has said, it is because what he is saying is not entirely clear, a fact which is not commented upon by either the physician or the interpreter. The problem of definition, central to medical diagnosis, is never resolved:

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Excerpt 2 (from visit 6):

15 Dr Mr. X was telling me – no, come sit *here*.
16 We have all these chairs, no there's two chairs.
17 Grab a seat.
18 Ok,
19 Int mm-hm.
20 Dr So: he was telling me tha: t
21 he was having problems no: w, he said, with his vision.
22 He said sometimes he can't see at all.
23 What did he mean by this?
24 Int Mm-hmm.
25 Dice el doctor que está teniendo problemas con la vista
The doctor says that you are having problems with your vision
26 que unas veces
that some times
27 no puede VER?
you can't SEE?
28 Pt Ah, sí, sí, xx en la: la vista, se me,
Ah, yes, yes, xx in the:, the vision,
29 empieza a salir agua
water starts to come out
30 aunque estoy en xxx
even though I am in xxx
31 y-y: como que tengo chile allí
and-and like I have chili there
32 Int Eyes get teary,
33 and, burning, feels like,
34 hot chili.
35 Dr Hot chili. But it's not that his eyes go black
36 it's that his eyes ar: e.
37 Int Pero no es que la vista se le
But it is not that your vision
38 se le ponga totalmente oscura, negra.
goes completely 'obscure' (opaque), black.
39 Pt Bueno: =
Well: =
40 Int =Es simplemente que le arden los ojos.
=*It's simply that your eyes burn.*
41 Pt A veces se me pone, se me va la vista.
Sometimes it gets, sometimes my vision goes.
42 Cuando pasa esto se me va la vista.
When this happens my vision goes.
43 Int Se le va la vista=
Your vision goes=
44 Pt =Sí
=*Yes*
45 Int ah:, ¿que muy oscuro?
ah:, what very dark?

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46 Pt Muy oscuro.
Very dark.

One aspect of this transcript fragment seems immediately apparent, which is that this opening phase of the interview, which phase typically concerns the elicitation and elaboration of the patient's complaint, neither clarifies nor furthers the physician's understanding of what, exactly, is wrong with the patient's eyes. To this point in the transcript, very little has been established beyond the fact that the patient's eyes hurt him, they may go dark, and they burn. The doctor has entered, in his attempt to clarify the patient's complaint, what the colonial missionary Father Murillo, cited in Rafael, referred to as '"a labyrinth without a clue" . . . beset with digressions and non-sequiturs' (Rafael 1993: 133); while Rafael is referring to the difficulty in hearing cross-linguistic confessions from native Tagalogs in the colonial Philippines, the phrase could easily apply to the physician's attempts at clarification and definition of the patient's problem with his eyes.

The confusion that is evident in the transcript was equally evident in the actual interview; the physician was visibly upset that he could not get a clear picture from the patient of what was wrong, and the patient was also visibly upset that he was asked the 'same' question over and over. Clark (1992, 1996) describes the 'achievement' of a contribution to a discourse as the moment when both parties understand what has been said, and believe that the other also understands; at this point in the excerpt, nothing substantial that would aid in diagnosis has been achieved in the medical interview.

It should be noted here also that the interpreter's changes to the dialogue are not entirely related to problems inherent in the act of linguistic conversion itself. Her insertion in line 40, for example, of the evaluative adverb *simplemente*, 'simply', to modify the question about the patient's eyes burning, is a judgment that is hers and hers alone. The physician, by his negative question, implies this relative scale of severity (burning eyes are less serious than loss of vision), but it is the interpreter who puts this implication into concrete form. In addition, her follow-up question to the patient at the end of the fragment, in line 45, represents a small but significant departure from the notion that the interpreter conveys all and only what was said; she is asking the patient to clarify, to her, what he is saying, before she attempts to pass this information along to the physician. In the end, lines 47–83 do not serve to pin down the complaint, and the physician finally moves on. In lines 84–85, below, he turns from the problem of definition of symptoms to the question of duration of these (still vaguely defined) symptoms, asking, 'Ok, so, how often does this happen?'

To this point in the encounter the patient can infer from the interpreter's offerings that both he and the physician understand that he is concerned about his eyes, and that the physician now shares this concern. But when the patient reports that his eyes burn and get teary, the question that is addressed to him in

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reply to this report is the negative, 'but it is not the case that you lose your vision' (lines 37–38). What may be inferred, by the patient, from this question is that the physician has taken the patient's reported symptoms, not as a positive affirmation of illness, but rather as a negative affirmation of a more serious illness. The patient then states that he *does* lose vision when his eyes tear and water, although he then modifies that, after being led by the interpreter (line 45), to agree that, instead of losing sight, his vision goes 'very dark'.

I do not wish, here, to overstate the analyses of what the conversational participants are attempting to achieve with their turns-at-talk; it is not possible to say, with absolute certainty, the goals of the different conversational offerings that each participant proffers. Epistemic and emotional states are not available for definite analyses, and it is impossible to fully catalogue the intended effect of utterances. It is possible to claim, with some very high degree of certainty, that the interview in Excerpt 2 has very quickly become bogged down in an attempt, on the part of the physician, to determine what exactly the nature of the Chief Complaint is, centering, not on a differential diagnosis, but on the establishment of an agreed upon set of symptoms that the patient is reporting. With this in mind, it is noteworthy that the physician chooses to move on in the interview at all, from defining the complaint to finding out about the temporal markers of diagnosis, that is, frequency, intensity, and duration of the (as yet undefined) symptoms (lines 84–85, below).

The next transcript fragment from visit 6 shows how the question of the patient's eyes is resolved within the interview. Here the interpreter's role as co-diagnostician comes to the fore: the physician asks for a further clarification of time-of-onset of the complaint, to which the patient answers in an indirect, but entirely relevant, fashion. The interpreter, however, ignores the patient's offerings in lines 105–111, and instead re-tracks him to give a strictly temporal answer to the physician's initial question:

Excerpt 2, continued:

84 Dr Ok, so,
85 And how often does this happen?
86 Int Uh, ¿cuánto le sucede esto?
Uh, how often does this happen to you?
87 Pt Pues, uh:,
Well, uh:,
88 unas dos veces yo creo al mes,
about two times I think a month,
89 me sucede.
it happens to me.
90 Int two times
91 [a month.]
92 Pt [más o menos]
[more or less]
93 Int [more or less.]

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94	Dr	[Twice a month.] For how long?
95	Int	¿Por cuánto tiempo le [(xxx)]?
		For how long does it [(xxx)] (to you)?
96	Pt	[me dura como:]
		[it lasts (me) like:]
97		(1 second)
98		a veces me dura casi media hora.
		Sometimes it lasts almost a half hour.
99	Int	Sometimes he takes, ah, i-it lasts
100		uh-h, half an HOUR when it happens
101	Dr	Ok, right
102		So::
103		And how long has it been going on for?
104	Int	¿Y por cuánto tiempo le ha venido sucederle esto?
		And for how long has this been happening to you?
105	Pt	Pues, yo traté de decirle al doctor de
		Well, I tried to tell the doctor
106		de hace más,
		more than,
107		cuatro cinco visitas para atrás
		four five visits ago
108	Int	mm- [hm]
109	Pt	[que] ya me estaba sucediendo.
		[that] it was already happening to me.
110		Pero:,
		But,
111		Que no sé si él me entendía o no.
		I don't know if he understood me or not.
112	Int	Pero, ¿hace,
		But, since,
113		ha-hace cuándo que le comenzó a,
		Si-since when did this start,
114		a suceder esto?
		to happen to you?
115	Pt	Mas o menos como un año, yo creo.
		More or less about a year, I think.
116	Int	About a year.
117	Dr	Ok. (9 second pause)
118		And it goes away by itself?
119	Int	Ah:
120		y, it.
121		Así como le viene esta molestia,
		And as this discomfort comes to you,
122		se le quita sola.
		it goes away by itself?
123	Pt	Me quita, sí.
		It goes away (from me), yes.
124	Int	Yes, it goes away by itself.

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Lines 101–116 are critical to this analysis. After a string of successful closed questions (lines 85–100), the physician asks for how long the patient has been suffering these (uncertain) symptoms (lines 101–103), and the interpreter relays this question (line 104). But the answer, from the patient, is not a direct one: instead he replies that he has been trying to tell the physician for quite some time that his eyes are bothering him, but that he is unsure if the physician has heard (and by implication understood) him or not (lines 105–111).

The reply is indirect, but relevant. The patient is not simply replying to the question, but is rather addressing himself to the inferable basis of the question; this is that a commonly-held and agreed upon medical fact has not been established, despite the patient's repeated attempts to establish it over time. The patient does not believe that the physician has assimilated his complaint into the medical record, and the patient has every reason to suspect this is the case given the nature of the physician's question in line 103. The patient does not know if a crucial piece of information has been accepted by the physician, and suspects, correctly, that it has not, because he has never had a reply, in this or prior visits, that would make it possible for him to infer that this is the case. The interpreter's subsequent action, which is an attempt to re-focus the dialogue on the immediate semantic basis of the physician's original question (lines 109–114), is met with a reply of 'one year' (line 115).

The interpreter's verbal actions in lines 104–116 are critical. Having been asked to initially determine 'what the patient meant' by his complaint about his eyes, the interpreter has moved on to determining the relevance of an utterance to the process of diagnosis at hand: the physician has asked a question, presumably in anticipation of a strict temporal reply, and the patient answers with a more complicated, albeit entirely relevant, answer about the nature of the question itself. The interpreter here evaluates the patient's response and dismisses it as irrelevant ('but . . .', line 112) to the initial closed question, denying its entry into the discourse. The interpreter is acting as pre-filter for patients' utterances, screening them for relevance to the physician's questions: as noted earlier, however, converting data by passing it through a grid of medical meanings is the central component of the process of diagnosis itself. In addition, it is entirely possible that the interpreter here is not merely screening the patient's answer for relevance, but that she is deleting it wholesale, to protect the physician and the institution of the hospital from the critique that the patient's complaint has been repeatedly ignored.

This maneuver effectively obliterates the chance that in this visit, as in prior visits, the patient will be able to establish the medical fact that, not only do his eyes bother him, but that he has been attempting to report this problem for quite some time. With respect to patient complaints in general, the physicians who took part in this study often spoke about the importance of determining, not only the exact complaint, but why the complaint has become significant or urgent enough to be brought up by the patient *now*. The fact that the report has

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been made repeatedly, over time, is important, because it supplies the physician with the information that this complaint is neither trivial nor recent. The physician, however, does not question the interpreter with regards to what the patient has said in lines 106–111; he hears a coherent reply to a closed question, and moves on.

Far from being a valid CC, the report of burning eyes now becomes a somewhat trivial complaint, for how bad could it be if a year has passed and only now the patient is bringing the symptom to the physician's attention? The physician's subsequent question, in line 118, adds credence to the analysis that, because the physician receives a strictly temporal reply via the interpreter, he no longer takes the patient's complaint seriously: the question, 'it goes away by itself?', may be read, in a medical context, as the question, 'is this ailment self limiting (e.g. self-correcting), and do I need to seriously address it?' Self-limiting ailments, such as colds (which go away in a few days regardless of the medical care delivered or withheld) are generally considered non-issues by medical practitioners, because there is nothing that can be done, medically, to fix them. When the reply comes back that yes, the symptom cures itself (line 124), the physician quickly works, over the next 50 lines of transcript, to move the interview past the report. When the physician hears, finally, that perhaps the patient's need of glasses may in the future give permanent relief, he resets the interview with an open question, still in search of a valid CC upon which to focus:

Excerpt 2, continued:

179	Dr	Oh, good.
180	(8 seconds).	
181		And:,
182		Is there any, other,
183		main thing that is bothering him today?
184		I know there's a lot of problems,
185		but if there was only one
186		other thing he was gonna tell me about today, what would he choose?

Notice that the question in lines 182–186 can be read as serving several functions: the first, of course, is to re-set the interview, so that a 'valid' Chief Complaint may be identified and addressed. Another, however, is that the physician here is himself trying to keep the patient on track, by asking him to pre-evaluate, on his own, what is most medically important. One final message which might be read into this question is that the physician may be serving notice to the patient that he has wasted a certain amount of time with his complaint about his eyes, and that there is now time for only one more of his complaints to be addressed before the physician will close out the interview. The problem is that the patient's problem with his eyes is, in fact, a valid Chief Complaint. The interpreter's pre-evaluation and de-facto editing of the patient's contributions to the interview result, in this case, not in keeping that patient 'on

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track', but rather in un-tracking the achievement of the institutional goals (diagnosis and treatment) of the interview itself.

4. CONCLUSIONS AND DISCUSSION

In this article I have outlined the role of interpreters in one form of medical discourse, the internal medicine 'medical interview'. The linguistic data, both quantitative and qualitative, points strongly away from a conclusion that interpreters are acting as 'advocates' or 'ambassadors' for interpreted patients, but are rather acting, at least in part, as informational gatekeepers who keep the interview 'on track' and the physician on schedule. While the interpreters do in fact convey much of what is said, they also interpret selectively, and appear to do so in a patterned (non-random) fashion. There is no evidence in the data presented here (nor in the larger data set) of interpreters putting forth the patient's agenda vigorously, as is claimed by Haffner (1992) and others. This is not the inevitable role that interpreters must take in hospital discourses, however, and the reasons they act in this way at Riverview is largely a result of their position within the hospital hierarchy.

The practice of medical interpreting is not highly valued within the hospital clinic; when I began my study, I was told by a sympathetic physician that he had also been interested in studying interpreters, but had been told by a hospital administrator not to do 'any studies that tell me I need to hire more interpreters; we can't afford the ones we have now'. There were only seven full-time Spanish-English interpreters at Riverview General Hospital, not nearly enough to take care of the 33,000 patients who needed Spanish interpretation, even given the large number of bilingual physicians and family-member interpreters utilized in individual clinics. The training given to these interpreters was scant; the requirements for becoming an interpreter at Riverview were a good grasp of both English and Spanish, and the ability to translate 50 medical terms on a test with complete accuracy. There was no training in discourse processes, and the training for how medical interactions worked was on-the-job. Physicians, for their part, received absolutely no training in how to use interpreters, beyond being told how to call them to come interpret.

The clinic staff were also consistently wrong in their predictions of who would need an interpreter, and more often than not would be forced to call an interpreter for an unscheduled interpretation, rather than scheduling in advance. Consequently, the interpreters were always running behind, postponing scheduled interpretations and answering pages through the day that added to a large list of patients who needed their services. In addition, during my study over 100 nurses were fired at the hospital, at the same time that the physicians themselves were being asked to see more and more patients in a shorter and shorter time period.

These time pressures all gave rise to competing mandates for the interpreters. Institutionally, they are officially required to act as an 'instrument', saying all and only what has been said; in practice, however, they are encouraged to keep

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the interview short, and to keep patients 'on track'. In competition, it was almost always the latter requirement that won out, and interpreters frequently engaged in furthering the physician's perceived agenda for the discourse. This happened, not only because of time pressures, but because hospital based interpreters are, in the end, members of the hospital community where they work and interact daily; they are institutional insiders, and ally themselves as such.

The larger ramifications of the interpreter's role in medical discourses are also significant. Of the power of institutional encounters to define citizens' relations with the state itself, Foucault writes (1979: 304):

> We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the "social-worker"-judge; it is on them that the universal reign of the normative is based . . .

All that is needed to make this quote perfectly relevant to the analysis at hand is to add the words 'the society of the interpreter-judge', for it is interpreters with whom and through whom recent immigrants interact with institutions of the state.

Interpreters are not, and cannot be, 'neutral' machines of linguistic conversion, both because they are faced with the reality that linguistic systems are not 'the same' in how they convey information contextually, and also because they are themselves social agents and participants (albeit special ones) in the discourse. It is possible for them to interpret evenly, however, and it is *not* the case that professional, hospital based interpreters need to work as an extra gatekeeping layer through which patients must pass in order to receive medical care. One could argue, as I would, that the interpreters' wholesale alignment with the institution of Riverview General Hospital (which is, not coincidentally, their employer) is both unethical and a truly poor form of interpretive practice.

As stated earlier, however, it is the context of communication that is fundamental in defining how the interpreter will carry out her role, and how she should be judged in that role; given that the physicians' command was, first and foremost, to keep the interview short, interpreters at Riverview may in fact be doing a good job at a bad task. The real issue is that they are doing a job that is different, in daily practice, from the job they are typically assumed to be doing. This means that they are not trained, nor licensed within the institution (i.e. they cannot write referrals or prescriptions, and may not make notes in the patient's permanent record), to do the things they are in fact doing (collection and analysis of data; establishing a 'therapeutic rapport' with the patient); nor are they given any form of institutional support for the true nature of the work that they do. The construction of the interpreter as a simple instrument of semantic conveyance is only possible when those who hire and use interpreters imagine that it is possible for interpretation to be the task of merely echoing content faithfully. It is this conceptualization of the interpreter's work that renders her daily practice of acting as co-diagnostician invisible, which in turn engenders a vacuum of responsibility, both within the discourse and with respect to the delivery of health care to non-English speaking patients in

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general. This slippage, between what interpreters are asked, officially, to do, and what they are really doing in daily practice, allows the practice to continue unmonitored and unevaluated; the invisible nature of the interpreter's role as co-diagnostician is the effect, rather than the interpreter's incompetence being the cause, of the broad dissatisfaction physicians and patients at Riverview express towards medical interpreting in general.

NOTES

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2. In this view, one might call interpretation the pre-eminently contextual linguistic act, or at least the most consciously contextual of linguistic behaviors.
3. Transcription Conventions:

[ ]	overlapping turns
=	simultaneous beginning of one speaker's turn/end of another's turn (latching)
:	lengthening
CAPS	loud
Italics	translation of Spanish
(text?)	difficult to hear
(noise)	description of non-verbal noise
(xx)	impossible to hear; each x is one syllable, if syllables can be discerned
((text))	description of physical actions, or meta-commentary on discourse

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REFERENCES

Ainsworth Vaughn, Nancy. 1994. Is that a rhetorical question? Ambiguity and power in medical discourse. *Journal of Linguistic Anthropology* 4: 194–214.

Baker, David W., Ruth M. Parker, Mark V. Williams, Wendy C. Coates and Kathryn Pitkin. 1996. Use and effectiveness of interpreters in an emergency room department. *Journal of the American Medical Association* 275: 783–788.

Baker, David W., Risa Hayes and Julia Puebla Fortier. 1998. Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care* 36: 1461–1470.

Bassnett, Susan and Harish Trivedi. 1999. *Post-colonial Translation: Theory and Practice*. London and New York: Routledge.

Bendix, Edward H. 1988. Metaphorical and literal interpretation: Cross-cultural communication in medical settings. *CUNYForum* 13: 1–16.

© Blackwell Publishers Ltd. 2000

Berk-Seligson, Susan. 1990. *The Bilingual Courtroom: Court Interpreters in the Judicial Process*. Chicago and London: The University of Chicago Press.

Blackhall, Leslie J., Sheila T. Murphy, Geyla Frank, Vicki Michel and Stanley Azen. 1995. Ethnicity and attitudes toward patient autonomy. *Journal of the American Medical Association* 274: 825.

Bourdieu, Pierre. 1977. The economics of linguistic exchanges. *Social Science and Information* 16: 645–668.

Cartellieri, Claus. 1983. The inescapable dilemma: Quality and/or quantity in interpreting. *Babel* 29: 209–213.

Cicourel, Aaron V. 1983. Language and the structure of belief in medical communication. In Sue Fisher and Alexandra Todd (eds.) *The Social Organization of Doctor-Patient Communication*. Washington, D.C.: Center for Applied Linguistics. 221–240.

Clark, Herbert H. 1992. *Arenas of Language Use*. Chicago: University of Chicago Press/ Center for the Study of Language and Information.

Clark, Herbert H. 1996. *Using Language*. Cambridge: Cambridge University Press.

David, Rand A. and Michelle Rhee. 1998. The impact of language as a barrier to effective health care in an underserved urban hispanic community. *The Mount Sinai Journal of Medicine* 65: 393–397.

Davidson, Brad. 1998. Interpreting medical discourse: A study of cross-linguistic communication in the hospital clinic. PhD Dissertation. Department of Linguistics, Stanford University.

Davidson, Brad. 1999. Dialogue in cross-linguistic medical interviews: The interpretation of interpretive discourse. Proceedings from the Sixth Annual Symposium on Language and Society, Austin.

Diaz-Duque, Ozzie. 1989. Communication barriers in medical settings: Hispanics in the United States. *International Journal of the Sociology of Language* 79: 93–102.

van Dijk, Teun A. 1993. Principles of critical discourse analysis. *Discourse and Society* 4: 249–285.

Ebden, Phillip, Arvind Bhatt, Oliver J. Carey and Brian Harrison. 1988. The bilingual consultation. *The Lancet* 1988: 347.

Edwards, Alicia Betsey. 1995. *The Practice of Court Interpreting*. Amsterdam: John Benjamins Publishing Company.

Elliot, Carl. 1999. *A Philosophical Disease: Bioethics, Culture, and Identity*. New York: Routledge.

Erzinger, Sharry. 1991. Communication between Spanish-speaking patients and their doctors in medical encounters. *Culture, Medicine, and Psychiatry* 15: 91–110.

Flotow, Luise von. 1997. *Translation and Gender: Translating in the 'Era of Feminism'*. Ottowa: University of Ottowa Press.

Foucault, Michel. 1963 (1973). *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage Books.

Foucault, Michel. 1979. *The History of Sexuality, Vol. 1*. London: Allen Lane.

Frankel, Richard. 1990. Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In George Psathas (ed.) *Interaction Competence*. Lanham, Maryland: University Press of America, Inc. 231–262

Ginsberg, C., V. Martin, Dennis Andrulis, Yoku Shaw-Taylor and C. McGregor. 1995. *Interpretation and Translation Services in Health Care: A Survey of U.S. Public and Private Teaching Hospitals*. Washington, D.C.: National Public Health and Hospital Institute.

Goffman, Erving. 1981. Footing. In Erving Goffman (ed.) *Forms of Talk*. Philadelphia: University of Pennsylvania Press. 124–159.

© Blackwell Publishers Ltd. 2000

Gupta, Akhil and James Ferguson (eds.). 1997. *Culture Power Place: Explorations in Critical Anthropology*. Durham: Duke University Press.
Haffner, Linda. 1992. Translation is not enough: Interpreting in a medical setting. In Cross Cultural Medicine – A Decade Later [Special Issue]. *The Western Journal of Medicine* 157: 255–259.
Hatim, Basil. 1997. *Communication across Cultures: Translation Theory and Contrastive Text Linguistics*. Exeter: University of Exeter Press.
Hatim, Basil and Ian Mason. 1989. *Discourse and the Translator*. London: Longman.
Hein, Norbert and Ruth Wodak. 1987. Medical interviews in internal medicine: Some results of an empirical investigation. *Text* 7: 37–65.
Hewitt, William E. 1995. *Court Interpretation*. Williamsburg, Virginia: National Center for State Courts.
Hymes, Dell. 1972. Models of the interaction of language and social life. In John J. Gumperz and Dell Hymes (eds.) *Directions in Sociolinguistics: The Ethnography of Communication*. New York: Holt, Rinehart and Winston, Inc. 35–71.
Juhel, Denis. 1982. *Bilinguisme et traduction au Canada: role sociolinguistique du traducteur*. Quebec: International Center for Research on Bilingualism.
Kaufert, Joseph M. and William W. Koolage. 1984. Role conflict among 'culture brokers': The experience of native Canadian medical interpreters. *Social Science and Medicine* 18: 283–286.
Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. Harper Collins: Basic Books.
Marcos, Luis R. and Manuel Trujillo. 1984. Culture, language, and communicative behavior: The psychiatric examination of Spanish-Americans. In Richard P. Durán (ed.) *Latino Language and Communicative Behavior*. New Jersey: Ablex Publishing Co. 187–194.
Martinez, Deborah, Elizabeth A. Lenoe and Jennifer Sternback de Medina. 1985. Language as a barrier to health care. In Lucia Elias-Olivares (ed.) *Spanish Language Use and Public Life in the United States*. Berlin: Walter de Gruyter and Co. 153–164.
Mikkelson, Holly. 1998. Towards a redefinition of the role of the court interpreter. *Interpreting* 3: 21–45.
Mishler, Elliot G. 1984. *The Discourse of Medicine: Dialectics of Medical Interviews*. New Jersey: Ablex Publishing Company.
Phillips, Russel S., Mary Beth Hamel, Joan M. Teno, Paul Bellamy, Steven K. Broste, Robert M. Califf, Humberto Vidaillet, Roger B. Davis, Lawrence H. Muhlbaier, Alfred F. Conners, Joanne Lynne and Lee Goldman. 1996. Race, resource use, and survival in seriously ill hospitalized adults. *Journal of General Internal Medicine* 11: 387–396.
Putsch, Robert W. III. 1985. Cross cultural communication: The special case of interpreters in health care. *Journal of the American Medical Association* 254: 3344–3348.
Rafael, Vicente. 1993. *Contracting Colonialism: Translation and Christian Conversion in Tagalog Society under Early Spanish Rule*. Durham and London: Duke University Press.
Robins, Lynne S. and Frederic M. Wolf. 1988. Confrontation and politeness strategies in physician-patient interactions. *Social Science Medicine* 27: 217–221.
Roy, Cynthia. 1999. *Interpreting as a Discourse Process* (*Oxford Studies in Sociolinguistics*). New York: Oxford University Press.
Sarangi, Srikant and Stefaan Stembrouk. 1996. *Language, Bureaucracy, and Social Control*. London and New York: Longman.
Schegloff, Emanuel. 1992. On talk and its institutional occasions. In Paul Drew and John

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Heritage (eds.) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press. 101–136.

Scheppele, Kim Lane. 1989. Telling stories. *Michigan Law Review* 87: 2073–2098.

Shuy, Roger. 1976. The medical interview: Problems in communication. *Primary Care* 3: 365–386.

Snell-Hornby, Mary. 1988. *Translation Studies: An Integrated Approach*. Philadelphia: John Benjamins Publishing Company.

Solis, Julia M., Gary Marks, Melinda Garcia and David Shelton. 1990. Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982–1984. *American Journal of Public Health*, Volume 80 Supplement: 11–19.

Thamkins, Theresa. 1995. Culture influences patients' desire to hear unfavorable diagnosis. *Asian Medical News*: October 1995.

Vasquez, Carmen and Rafael A. Javier. 1991. The problem with interpreters: Communicating with Spanish-speaking patients. *Hospital and Community Psychiatry* 42: 163–165.

Venuti, Lawrence. 1998. *The Scandals of Translation: Towards an Ethics of Difference*. London and New York: Routledge.

Wadensjö, Cecilia. 1998. *Interpreting as Interaction* (Language in social life series). London and New York: Longman.

Waitzkin, Howard. 1983. *The Second Sickness: Contradictions of Capitalist Health Care*. New York and London: The Free Press.

Waitzkin, Howard. 1991. *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. New Haven and London: Yale University Press.

Weaver, Charlotte Ann. 1982. Role evolution of language translators in a major medical center. PhD Dissertation: University of California at San Francisco.

West, Candace. 1984. *Routine Complications: Troubles with Talk between Doctors and Patients*. Bloomington: Indiana University Press.

West, Candace and Richard Frankel. 1991. Miscommunication in medicine. In Nikolas Coupland, Howard Giles and John Wiemann (eds.) *''Miscommunication'' and Problematic Talk*. Newbury Park: Sage. 166–194.

Wodak, Ruth. 1996. *Disorders of Discourse*. London and New York: Longman.

Woloshin, Steven, Nina A. Bickell, Lisa M. Schwartz, Francesca Gany and Gilbert Welch. 1995. Language barriers in medicine in the Unites States. *Journal of the American Medical Association* 273: 724–728.

Address correspondence to:

Brad Davidson
649 15th Avenue
San Francisco
California 94118
U.S.A.

bcdling@hotmail.com

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