ABSTRACT

A Pragmalinguistic Analysis of Missed Opportunities for Building Rapport in Interpreted Medical Interviews with Spanish-Speaking Patients

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Interpreted medical discourse presents significant challenges for communication because portions of the original message are often reduced, omitted, or revised (Aranguri, Davidson, & Ramirez, 2006), particularly by lay interpreters. Linguistic devices that contribute to rapport and politeness, such as mitigation, are often perceived as unimportant or unnecessary and are therefore omitted. Thus, when messages are conveyed without interpretation of politeness and rapport attempts, pragmatic issues and misunderstandings occur. The present investigation analyzed 43 transcriptions of interpreted medical consultations previously recorded at a family medicine clinic in Central Texas. The analysis quantified which rapport-building attempts most frequently occurred but were not interpreted and examined specific and general effects of non-interpretation, as well as potential consequences for physician-patient communication and rapport.

A Pragmalinguistic Analysis of Missed Opportunities for Building Rapport in Interpreted Medical Interviews with Spanish-Speaking Patients

by

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CHAPTER ONE

Introduction

As the Limited English Proficiency population has grown in the United States, the need has increased for medical interpreters to bridge the gap between language-discordant physicians and patients. Interpretation in medical consultations presents significant challenges for communication since portions of the original message are often reduced, omitted, or revised (Aranguri, Davidson, & Ramirez, 2006). This issue particularly occurs with bilingual employees who have not had professional training in interpretation yet regularly are called on to serve as interpreters. Their task is frequently complicated by the employees' dual role function as both a healthcare professional and language advocate.

The present study resulted from a pilot reading of several transcribed conversations at a family medicine clinic in Central Texas. It appeared that many of the physician's "polite" or "friendly" utterances were not interpreted, as if they were extraneous to the conversation at hand. The resulting interpretations seemed to lack personal warmth and politeness due to pragmatic issues; that is, factors affecting meaning in a certain context. After the pilot reading, seven rapport-related variables were identified for the present study: affiliative humor, mitigation of directives, inclusive pronouns for solidarity, ritual greeting and leave-taking, words of empathy, compliments, and apologies.

In this investigation, I will discuss 43 transcribed medical consultations with regard to the frequency with which these variables occurred yet were not interpreted.

This study additionally examines the effects that non-interpretation of these rapport-building variables had on physician-patient rapport. The ultimate goal of this study is to contribute awareness of the importance of interpreting rapport-building attempts in order to improve the physician-patient relationship through pragmatically effective medical interpretation.

Organization

The study is divided into five chapters: the Introduction, a Critical Review of the Literature, Procedure and Method, Data Analysis and Results, and the Conclusion. Chapter Two reviews literature on the physician-patient relationship and the importance of physician-patient communication. The complex role of the medical interpreter is discussed, along with the challenges that occur in language-discordant medical consultations. This chapter also examines literature on politeness and rapport, as well as specific linguistic categories related to both.

Chapter Three explains in detail how the data was collected in the study and defines each rapport-building variable analyzed. Examples are given for each variable. The chapter also outlines the research questions guiding the study.

In the fourth chapter, final results are detailed and discussed, and the initial research questions are examined with respect to the data. The chapter also includes specific examples from the transcripts and further classifications. The last section of this chapter discusses the overall effect that non-interpretation of the analyzed variables likely had in regard to physician-patient rapport.

The final chapter addresses the research questions posed at the beginning of the study and summarizes conclusions based on the results. Limitations are also discussed, as well as application of the study's findings and suggestions for future research.

CHAPTER TWO

Critical Review of the Literature

Physician-Patient Communication

"Healthcare in twenty-first century America is still largely delivered in the old-fashioned way: one conversation at a time" (Henry, Holmboe, & Frankel, 2013, p. 395). In 2007, these conversations, or medical consultations, occurred an estimated 2.7 million times per day in the United States (Hsiao, Cherry, Beatty, & Rechtsteiner, 2010). Furthermore, during a 40-year professional career, a primary care physician will conduct between 160,000 and 200,000 patient visits (Lipkin, Putnam, & Lazare, 1995, p. 65). Although doctors today utilize x-rays, medications, blood tests, and other tools to meet therapeutic goals, communication is still "the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved" (Roter & Hall, 2006, p. 4), especially in the context of face-to-face consultations. Upon meeting together, doctor and patient enter into a relationship based on the expectations each has of the other (Roter & Hall, 2006, p. 23).

Physicians bring to the table a lifetime dedicated to mastery and application of medical knowledge. The intensity of their training, the complexity and depth of their knowledge base, and the uniqueness of their daily experience create an unbridgeable gap between the physician and the lay world (Roter & Hall, 2006, p. 24). On the other hand, patients contribute valuable insights into their own functional status, physical condition, and quality of living (Roter & Hall, 2006, p. 9). Additionally, physicians have internalized a worldview anchored in the domains of biochemistry and technology, while

“a complex web of personality, culture, living situations, and relationships” (Roter & Hall, 2006, p. 25) comprise the patient’s world and influences their experience of illness. Therefore, a conflict often arises between two incomplete perspectives: “the biomedical view loses the context of the patient's life, while the patient’s experience may lack insight into science and potential medical intervention” (Roter & Hall, 2006, p. 25). The emphasis on the patient’s voice and perspective has shifted throughout the years. Some historians have attributed this depersonalization of medicine to the drug revolution begun by the 1930’s discovery of sulfa drugs, followed by the discovery of penicillin in the World War II era (Shorter, 1985). With the emergence of chemistry-oriented sciences such as pharmacology, microbiology, immunology, genetics, and biochemistry came a biomedical perspective of disease as an entity to combat with drugs (Shorter, 1985). Therefore, interest in the patient’s personal experience of illness declined, and “the battle lines were drawn between the doctor and the aberrant molecules" (Roter & Hall, 2006, p. 4). Unfortunately, "the patient was often left on the sidelines” (p. 4). Medical interviews were recast as objective and scientific, and a series of previously outlined yes-no questions often curtailed patients’ speech (Roter & Hall, 2006, p. 4). Indeed, Western medicine has traditionally operated within a biomedical framework that reduces health to a biological phenomenon (Cordella, 2004). That is, medical training emphasizes “technical-specific skills and the diagnosis of specific diseases," and "rather than the patient being viewed as a person, the person is viewed as a patient" (Mishler, 1984, p. 9). The distinct “voice of medicine,” the biomedical, technical assumptions of medicine, and the “voice of the lifeworld,” the natural attitude of everyday life, often operate together in

medical discourse (Mishler, 1984, p. 14). However, the former often domineers and interrupts the latter (Mishler, 1984, p. 63).

Various expressions of power exist within the medical consultation. For example, the physician may take on the role of consultant, teacher, or authoritative parent, and he or she may explore the patient's values or leave them unexamined (Emanuel & Emanuel, 1992). Roter and Hall (2006) delineated four relationship models based on expressions of power in the doctor-patient relationship: paternalism (doctor-centered), consumerism (patient-centered), mutuality, and default (in which neither participant controls the interaction). The mutuality prototype offers a moderate alternative to the extremes of paternalism and consumerism and affirms that both participants contribute resources and strengths to the relationship (Roter & Hall, 2006, p. 35).

Despite the last century's depersonalization of medicine, recent years have seen a growing emphasis on a patient-centered approach to the medical interview. In patient-centered encounters, the patient is treated as a "partner in the medical dialogue, rather than as [a reporter] of symptoms" (Rivadeneyra, Elderkin-Thompson, Silver, & Waitzkin, 2000, p. 470). In these exchanges, the doctor seeks to facilitate expression of patients' thoughts, expectations, and feelings, as well as to understand symptoms (Rivadeneyra et al., 2000). Erzinger (1991) recommended that doctors encourage patients to communicate their concerns, as well as to show interest in what Mishler (1984) deemed the patients' "lifeworld." Furthermore, physicians who adopt a socio-relational framework (rather than a biomedical one) listen well to what the patient says, use the patient's own life experiences to build up the discourse, and respect the patient as a whole person (Cordella, 2004, p. 25). Cordella (2004) also identified distinct "voices" that

doctors use throughout the medical consultation: doctor voice (questioning the patient about his or her health and dictating actions to be taken), educator voice (providing medical information to the patient to increase understanding and adherence), and fellow human voice. With the fellow human voice, physicians develop empathy by facilitating and assisting the telling of patients' stories, showing special attentiveness to patient's stories, and by asking questions unrelated to patients' health (Cordella, 2004, p. 121).

Similarly, "communication should go beyond biomedicine to reflect and respect the patient's experience of life," especially by recognizing the link between patients' mental states and their physical symptoms (Roter & Hall, 2006, p. 12). The majority of primary care patients suffer from symptoms which cannot be tied to a specific diagnosis or disease (in the biomedical sense), but are reactions to daily life (Roter & Hall, 2006). Due to family relationships, jobs, and financial struggles, patients suffer stress that may be reflected by headaches, rashes, dizziness, fatigue, stomach disorders, aches, and weight fluctuations (Roter & Hall, 2006, p. 12). A common patient misconception is that patients should refrain from talking about such "nonmedical" topics as stresses, because they are not pertinent or appropriate in the medical consultation (Roter & Hall, 2006, p. 13). However, "problems with emotional and stress dimensions constitute a major component of medical practice" (Roter & Hall, 2006, p. 13), and physical manifestations can be often be addressed effectively once the underlying distress is explored.

Research has shown that physicians and patients seem to benefit from patient-centered approaches to the medical interview. By asking more than strictly medical questions, for example, physicians may discover lifestyle issues that reveal underlying causes of physical complaints (Frankel, 1984, 1990). In a 1987 study, the use of open-

ended, patient-centered questions elicited twice the amount of clinically relevant information as closed-ended questions (Roter & Hall, 1987). Indeed, "by feeling that they are listened to, understood and cared for… patients may feel that the consultation is a safe place to share their personal and sometimes difficult stories, which in turn may enhance the medical outcome" (Cordella, 2004, p. 147). Research has also shown that physicians' patient-centered behavior leads to increased patient satisfaction and therefore, adherence (Hall, Roter, & Katz, 1988; Roter, Hall, & Katz, 1987; Stewart, 1984).

The growing interest in patient-centered care has engendered a corresponding interest in the therapeutic importance of the doctor-patient relationship itself. In the early 1990s, the Pew-Fetzer Task Force on Advancing Psychosocial Health Education created the term "relationship-centered care" (Roter & Hall, 2006, p. 36). They affirmed that more than a simple transaction takes place in the doctor-patient meeting; rather, a relationship with therapeutic power is formed (Tresolini, 1994). The relationship-centered care model focuses on the dimension of personhood and the value of forming doctor-patient relationships through dialogue and mutual expression (Beach & Inui, 2006). In fact, the formation of a positive interpersonal relationship has been identified as the first goal in doctor-patient communication (Ong, de Haes, Hoos, & Lammes, 1995).

Despite the increased emphasis on patient-centered and relationship-centered care, as well as great scientific and technological advances, modern medical interviews still do not fulfill their therapeutic potential due to deficiencies in doctor-patient communication (Roter & Hall, 2006, p. 6). In fact, recent years have seen an increased focus on the quality and improvement of doctor-patient communication, contrary to the

past perspective: "In the past, good bedside manner was seen as a desirable, but essentially unmodifiable, physician communication trait" (Frankel, 2004, p. 1163). However, current research into health services has shown that communication skills often can be taught, internalized, and put into practice (Beckman, Frankel, Kihm, Kulesza, & Geheb, 1990; Roter et al., 1995; Smith et al., 1998). For example, the Accreditation Council for Graduate Medical Education (ACGME) now requires all trainees to demonstrate competence in six areas of practice, among them communication and relationship building (Swing, 2007). Other testing organizations have adopted and now test for these competencies, including the American Board of Internal Medicine (ABIM), American Board of Medical Specialties (ABMS), and the Educational Commission for Foreign Medical Graduates (ECFMG) (Frankel, 2004).

The importance of doctor-patient communication cannot be overstated. Indeed, "patients often remember, word for word, their exchanges with their doctors, and these exchanges are frequently recited for family members and friends and played back over and over in the patient's mind" (Roter & Hall, 2006, p. xv). The remembered dialogue may provide comfort or may recreate anguish in each repetition (Roter & Hall, 2006, p. xv). Furthermore, when a physician communicates medical information to a patient, the patient's impressions of the doctor (based on caring, competence, and taking the patient seriously) "may be more important even than the information itself" (Roter & Hall, 2006, p. 17). Additionally, in cross-cultural medical exchanges, differences in conversational style have the power to cause even more problems than grammatical errors (Gumperz & Cook-Gumperz, 1981).

Many studies reflect the relationship between effective doctor-patient communication and medical outcomes, such as patient satisfaction, adherence, recall, and understanding of medical information (Bensing, 1991; Ong et al., 1995). Good communication, as part of the patient-centered approach, "is the key to compliance and effective health management" (Cordella, 2004, p. 29). On the other hand, "unsuccessful history taking leads to delayed diagnosis or unnecessary tests" (Henry et al., 2013, p. 398). Because patients sometimes come to the doctor with "hidden" non-palliative concerns such as informational needs, social isolation, psychiatric disorders or life stresses, they may wait until the last minute of the medical interview to blurt out sensitive concerns (Barsky, 1981). By facilitating patient disclosure at the beginning of the visit, doctors help diminish delayed problem presentation and subsequent lengthening of the interview (Roter & Hall, 2006, p. 115). Furthermore, communication difficulties, though not often identified as the precipitating cause in malpractice suits, are "widely believed to be a predisposing cause" (Roter & Hall, 2006, p. 37).

In addition, if there are problems in treatment, the impressions formed during the medical consultation play a critical role in the patient's ensuing reactions. In one study, physicians with a history of malpractice used less humor, spent less time with patients, and were less likely to check for patient comprehension or to seek patient input compared to physicians who had never been sued (Levinson, Roter, Mullooly, Dull, & Frankel, 1997). Similarly, patients of physicians with prior malpractice claims reported twice as many complaints about their care than patients of doctors without malpractice claims (Hickson, Clayton, & Entman, 1994). Their complaints included feeling ignored, rushed, receiving inadequate explanations for tests, and other communication-related problems

(Hickson et al. 1994). Furthermore, communication problems such as devaluing the patient's views, delivering information inadequately, and failing to understand the patient's perspective were present in more than 70% of the reviewed cases of complaints appearing in malpractice depositions (Beckman, Markakis, Suchman, & Frankel, 1994). Other communicative issues such as the absence of friendliness and warmth, the failure to fulfill patient expectations, and the use of confusing terminology and instructions also contribute to patient dissatisfaction (Cordella, 2004, p. 28). Because of the disparity between doctor and patient medical knowledge, as well as knowledge of the medical institution and system, doctor-patient interactions are inherently asymmetrical (Cordella, 2004, p. 21). However, mutuality in the interaction can be achieved by establishing an atmosphere conducive to patient participation, by demonstrating to the patient that his or her contributions are appreciated and appropriate, by confirming patients' goals and expectations, and by eliciting the patient's informed preferences and suggestions (Brody, 1980).

In general, improved communication leads to improved patient-provider relationships. According to Vuori, Aaku, Aine, Erkko and Johansson (1972), communication is one of the three main functions of the patient-provider relationship, in addition to application of the physician's knowledge and skills to the condition and addressing the emotional aspects of the condition and its treatment. When doctors and patients engage in behaviors that foster a positive relationship, they form a team with the shared goal of addressing the patient's health concern(s). Additionally, it is likely that "the majority of malpractice claims would not be pursued if the patient, or the patient's

family, were not angered over failures or disappointments in the patient's relationship with the physician" (Roter & Hall, 2006, p. 38).

Interpreted Medical Interviews

Medical interpretation occurs during real time interactions (as opposed to written translation, for example) and involves misunderstandings, conflicts, interpersonal factors, and errors that characterize the oral communication process (Dysart-Gale, 2007, p. 238). Before the 1960's, interpretation in medical settings was often provided by friends, family members (including young children) and bilingual clinic employees (Dysart-Gale, 2007, p. 238). However, awareness has grown of the practical and ethical difficulties engendered by nonprofessionals serving as interpreters, as well as awareness of the clinical cost of the language gap: "compromised health status, increased interview times, duplication of ordered tests, exacerbation of symptoms due to undertreatment or inappropriate treatment, and other unsatisfactory outcomes" (Dysart-Gale, 2007, p. 238). Title VI of the Civil Rights Acts of 1964 requires health facilities receiving federal funds to provide all patients with linguistic access, including translated health education materials and interpretation services, at no cost to the patient (Putsch, 1985).

Ideally, all patients would receive care from physicians who speak their language (Rivadeneyra et al., 2000). However, as the number of immigrants to the United States continues to rise, the number of non-English speaking patients has consequently risen in outpatient, primary care settings (Aranguri, Davidson, & Ramirez, 2006). In the 2011 American Community Survey, more than 25 million people (above the age of five) living in the United States claimed to speak English less than "very well" (U.S. Census Bureau, 2011). This population considered to have limited English proficiency (LEP) comprised

approximately 8% of the United States population above the age of five and faces significant language barriers in obtaining healthcare (U.S. Census Bureau, 2011). Therefore, many medical institutions provide interpreters to bridge the gap between patient and physician in face-to-face interactions.

In 2004, the National Council on Interpreting in Health Care (NCIHC) published their "National Standards of Practice for Interpreters in Health Care" to clarify basic expectations and to provide greater consistency in medical interpreting at a national level (NCIHC, 2005). The eight standards include accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development, and advocacy. Each standard is defined and elaborated upon in the publication. The present study particularly concerns the standard of accuracy, whose objective is "to enable other parties to know precisely what each speaker has said" so that all messages are rendered accurately and fully without revision or omission (NCIHC, 2005, p. 5). Furthermore, the NCIHC prescribes that the interpreter replicate the tone, register, and style of the speaker (p. 5). For instance, a friendly and enthusiastic greeting such as "Hello! How are y'all doin' today?" may be best interpreted in a similarly casual and warm rendering in Spanish rather than a formal, rigid interpretation.

The presence of an interpreter challenges the traditional patient-practitioner dyadic model of same-language communication. For various institutions, the preferred role of the interpreter is that of a neutral conduit who facilitates communication in patient-practitioner interactions (as prescribed by the NCIHC). For instance, in order to save time and minimize the interpreter's impact on the practitioner-patient dyad, interpreters are encouraged to preserve first person pronouns in their interpretations and

to avoid reported speech (i.e., by stating "I am writing you a prescription" instead of "He says he is writing you a prescription.") (Dysart-Gale, 2007, p. 239). However, some researchers claim that full neutrality is impossible and have acknowledged interpreters as active participants in clinical interactions (Davidson, 2002; Putsch, 1985). Other proposed interpreter roles include that of clarifier, culture broker, and patient advocate (Dysart-Gale, 2007, p. 239). Clarifying occurs when interpreters interject helpful information when cultural differences create difficulty in interpreting a message (Dysart-Gale, 2007, p. 239). The role of culture broker defines the interpreter as "a necessary cultural framework for understanding the message being interpreted" (Dysart-Gale, 2007, p. 239). The patient advocate role anticipates the interpreter working on behalf of the patient, outside of the bounds of an interpreted interview, to provide quality care as well as quality communication (Dysart-Gale, 2007, p. 240). Davidson (2001) has called the interpreter an “institutional gatekeeper” and a “covert co-diagnostician," echoing Candlin’s (1998) statement that interpreters are placed in a "contested area between being providers of a service and being agents of authority and control” (p. xvii).

The increased need for interpreters in recent years has piqued interest in the physician-interpreter relationship. To provide quality care, trust is critical to the provider-interpreter relationship (Hseih, Ju, & Kong, 2010). This relationship is unique to other professional relationships in healthcare settings, and physicians must “believe that interpreters can provide services without distorting their voice or compromising the quality of care” (Hseih et al., 2010, p. 171). In forming an empirically-based framework of provider-interpreter trust, Hseih et al. (2010) identified four dimensions of provider-interpreter trust: interpreter competence, shared goals, professional boundaries, and

established patterns of collaboration. Through in-depth interviews conducted with 32 physicians who worked regularly with interpreters, the researchers found that physicians emphasized "literal, neutral, faithful relay of information" as a basic expectation for interpreters (p. 173). Furthermore, the authors proposed that shared goals as a healthcare team increased provider-interpreter trust: many providers did not mind interpreters providing emotional support for patients or modifying the information in culturally appropriate ways to facilitate patient-provider communication (p. 175). Interpreters and providers must communicate clearly so that the team's shared health goals can be understood by both members.

In recent years, increased research has emerged on the impact of language barriers and interpreted language on medical interactions and outcomes. For instance, Aranguri et al. (2006) analyzed transcripts of 16 interactions between Spanish-speaking patients and English-speaking physicians (13 with a bilingual interpreter and 3 with only the patient and a bilingual physician). They hypothesized that the interpreter's speaking time should constitute approximately 50% of the speaking time (i.e., if the interpreter repeats everything the doctor and the patient say, the interpreter's speech will simply double that of doctor and patient). Instead, they found that the tendency of interpreters was to reduce, sometimes to a drastic degree, what was said: "Physicians spoke 49% of the words spoken in the visit, patients spoke 24%, and interpreters spoke 27%" (Aranguri et al., 2006, p. 625). The researchers then divided interpreting errors into three main (non-mutually exclusive) categories: content omissions (leaving out significant information), content revisions (altering significant content); and content reductions. One of the most salient observations relates directly to the present study: much of the speech omitted by

interpreters was “small talk,” or “socially oriented talk that is designed to further relationships rather than establish medical facts” (Aranguri et al., 2006, p. 626). The interpretation process equated to “a complete absence of almost any form of purely social interaction” (Aranguri et al., 2006, p. 627). The lack of small talk seemed to render the discourse “facts-only” and less personal, and the researchers noted that such facts consequently become less reliable (Aranguri et al., 2006, p. 627). Without friendly small talk to help build a relationship, patients may feel less comfortable asking questions about their illness or telling the physician sensitive details through an interpreter (Aranguri et al., 2006, p. 627).

In another study, Rivadeneyra et al. (2000) compared 19 interpreted medical interviews of Spanish-speaking patients with 19 interviews of English-speaking patients. They found that Spanish-speaking patients using an interpreter made markedly fewer comments than patients speaking directly to the doctor. They postulated that Spanish-speaking patients may have had less time to ask questions and raise concerns due to the time consumed by interpretation. Furthermore, in the interpreted consultations, physician-patient rapport became more difficult to achieve because of the reduction of “direct verbal communication and nonverbal reciprocity between the patient and the physician” (Rivadeneyra et al., 2000, p. 470). For instance, the nature of consecutive turns in the interpretation process eliminates conversational cooperation markers that help build rapport, such as “duetting” (making similar statements simultaneously), collaborative sentence building, smooth transitions in speaking turns, and receiving confirmatory utterances to summary statements (Cordella, 2004; Tannen, 2005). Various

other studies have detailed errors and miscommunications that occur in interpreted medical interviews (Flores et al., 2003; Li & Wilson, 2004).

Despite the many challenges of interpreted consultations, establishing rapport with language-discordant patients is essential. In a 1998 survey of 457 patients seen in a public hospital emergency department, patients who required an interpreter perceived their examiner as "less friendly, less respectful, and less concerned for them as a person" as compared to patients without interpreters (Baker, Hayes, & Fortier, 1998, p. 1465). Such patients are less likely to return to the same doctor to establish a trusting professional relationship (Rivadeneyra et al., 2000, p. 473). In a 1988 study of 96 Spanish-speaking patients, those treated by language-discordant physicians were more likely to make emergency room visits than those who spoke the same language as their physician (Manson, 1988). Non-English speaking patients may wait until a health problem becomes severe rather than attempting to explain mild or subtle physiological symptoms through an interpreter (Rivadeneyra et al., 2000, p. 473).

In conclusion, quality medical interpretation is increasingly necessary as the number of Limited English Proficiency patients in the United States continues to increase. The presence of an interpreter in a medical consultation offers unique challenges related to the interpreter's role as a participant in the conversation, as well as to accurate and precise interpretation of participants' messages. Training interpreters and medical staff to work together is essential for accurate interpretation, increased patient satisfaction, and establishment of patient-physician rapport.

Rapport

The concept of rapport is central to the present study. Many definitions of rapport have been offered. Tannen (1994) defined rapport as a sense of mutual understanding between people that does not require explicit statements to be realized (p. 178). Aston (1988) defined rapport as the establishment and maintenance of friendly relations. Norfolk, Birdi and Walsh (2007) offered a specifically medical definition of rapport, interpreting it as a therapeutic relationship and as the provider's understanding the patient's perception of his or her problem. In addition, Spencer-Oatey (2008) studied rapport through the framework of applied linguistics and politeness theory. The present study utilizes her definition of rapport management as "the management of harmony-disharmony among people" (Spencer-Oatey, 2008, p.13), or the use of language to promote, maintain, or threaten harmonious social relationships.

Hall, Roter, Blanch, and Frankel (2009) performed a study of observer-rated rapport between medical students and standardized patients, coding rapport on a scale of 1 (no rapport) to 9 (high rapport). They defined rapport as a relationship that is "pleasant and engaging, a high degree of liking or positive affect, mutual attention, harmonious relation, easy/ smooth communication, and/ or symmetry and synchrony in the interaction" (Hall et al., 2009, p. 324). The researchers noted a correlation between observed rapport and the positive statements and rated warmth, interest, and interactivity of both the medical student and the standardized patient. Unlike the Hall et al. (2009) rapport study, the present study will examine rapport-building in a triadic context (between doctor, patient, and interpreter). In addition, while acknowledging the

interactional nature of communication between multiple participants, the present study limits its scope of analysis to physician rapport efforts that are not interpreted.

Politeness/ Face Theory

Politeness is another pragmalinguistic concept related to rapport whose theoretical framework will be examined briefly. Face, or "the positive social value a person effectively claims for himself " (Goffman, 1967, p. 5), is a motivating force for politeness. In their fundamental work on politeness, Brown and Levinson (1987) argued that politeness may intend to enhance positive or negative face, or public image. Negative face is one's desire for autonomy (i.e., to act freely and to not be impeded or imposed upon by others), whereas positive face is one's desire for approval and appreciation. Each person presumably has face wants, or the desire for face to be respected (Brown & Levinson, 1987, p. 62). Furthermore, when certain speech acts present a threat to one's face, politeness is a linguistic strategy used to avoid or soften such face-threatening acts (FTA's) that appear in dialogue. In managing "facework," or "language addressed to the face-wants of others," (Grundy, 2008, p. 299), the weight of a particular face-threatening act can be determined by the following formula: social distance (D) between speaker and hearer + social power (P) that hearer has over speaker + culturally rated degree of imposition (R) of the face-threatening act (Brown & Levinson, 1987, p. 76). That is, if one or more of these social components are increased, the greater the threat to face will be and consequently the need for linguistic redress of the threat. Politeness, according to this model, is "the use of redressive language designed to compensate for face-threatening behaviour" (Grundy, 2008, p. 195). Brown

and Levinson (1987) proposed various strategies for positive and negative politeness, as summarized in Table 1.

Table 1. Positive and Negative Politeness Strategies

Positive Politeness Strategies	Negative Politeness Strategies
Notice/ attend to hearer's wants	Be conventionally indirect
Exaggerate interest/ approval	Question, hedge
Intensify interest	Be pessimistic
Use in-group identity markers	Minimize imposition
Seek agreement	Give deference
Avoid disagreement	Apologize
Presuppose/ assert common ground	Impersonalize
Joke	State the impositions as a general rule
Assert knowledge of hearer's wants	Nominalize
Offer, promise	Go on record as incurring a debt
Be optimistic	
Include speaker and hearer in the activity	
Give (or ask for) reasons	
Assume/ assert reciprocity	
Give gifts to hearer (goods, sympathy, etc.)	

Adapted from Brown and Levinson, 1987, pp. 102, 231.

Building upon the previously held redress functions of politeness (that is, mitigation and reparation), Hernández-Flores (2004) included face *enhancement*, which affirms the good working of social interaction even when no threat to face is present. Regarding the relationship of politeness to rapport, Spencer-Oatey (2008) included face management in her list of components of rapport management (in addition to interactional goals, fairness, consideration of the hearer, and behavioral appropriateness) (Spencer-Oatey, 2008, pp. 13-14).

So far this chapter has examined the history and dynamic of the doctor-patient relationship, as well as the importance of patient-centered care and improvement of

doctor-patient communication. The need for medical interpretation, the role of the medical interpreter, and the theoretical framework of politeness and face have also been discussed. In the present study, specific rapport-building strategies are examined in the context of interpreted clinical consultations. These strategies include affiliative humor, mitigation of directives, inclusive pronouns used for solidarity, words of empathy, apologies, compliments, and ritual greeting and leave-taking. In the following section, each category is examined as it pertains to rapport and to the politeness framework previously discussed. The next chapter will discuss how these strategies were determined and counted in the transcripts.

Rapport Categories

Affiliative Humor

Brown and Levinson (1987) list joking as a "basic positive politeness technique" (p. 124) that functions to put the hearer at ease and stresses shared values and background knowledge. For instance, in one of the transcripts from the present study, female camaraderie and rapport were built through affiliative humor: after a pregnant patient had jokingly called her husband a coward for staying home during her medical appointment, the physician joked amid the patient's laughter, "Sometimes it's hard to decide whether they're a supporter or a pain" (211-4). Humor in healthcare interactions can perform face-saving functions for the patient, diminish psychological stress, and may lead to increased quality of patient care (Coombs & Goldman, 1973; Ragan, 2000). DuPré (1998) also analyzed the role of humor in establishing rapport between radiology technicians and female patients undergoing routine mammograms. The use of humor

helped mitigate anxiety about an uncomfortable and often fear-producing procedure and enhanced patient cooperation with the exam process. In addition, affiliative humor or joking may be used to mitigate directives or redress a face-threatening act (Brown & Levinson, 1987, p. 124).

Mitigation of Directives

Speech acts are "the performative, or action accomplishing, aspect of language use" (Grundy, 2008, p. 301). Directives (Searle, 1976) are speech acts where the speaker wants the hearer to perform some action. Suggestions, recommendations, requests, commands, and advice are examples of directives. Because directives threaten autonomy, or negative face, by obliging the hearer to act, they are naturally face-threatening. Thus, directives may be softened or mitigated by indirectness. Indirect speech acts are those in which the form and function are not directly related; that is, when the message the speaker intends to communicate is different from the words uttered (Searle, 1976). For example, a physician's question to patient, "Would you mind sitting up here real quick?" is really a request expressed in interrogative form. Within English, indirect speech acts are "so much associated with politeness that directives are more often expressed as interrogatives than imperatives" (Cutting, 2008, p. 18), especially between people who are not familiar with one another.

Directives are also mitigated in other ways. Changing the perspective away from the hearer and making it inclusive ('Let's take a look at your throat'), speaker-oriented ('I need to look at your throat'), or impersonal ('Your throat needs to be looked at') mitigates threats to face (Blum-Kulka, House, & Kasper, 1989a, p. 19). Also, downgraders such as consultative devices ("*Do you think* I could look at your throat quickly?") and

understaters ("You need to exercise *a bit* more") mitigate directives (Blum-Kulka et al., 1989a, p. 19). Mitigating directives through questions, hedges (a form of downgrader), minimizing imposition, and conventional indirectness are negative politeness strategies proposed by Brown and Levinson (1987) that will be examined in the present study.

Inclusive Pronouns for Solidarity

Another strategy listed by Brown and Levinson (1987) to redress face-threatening speech is to include the speaker and hearer in the activity with an inclusive pronoun such as 'us' or 'we,' although the speaker literally only means 'you' or 'me' (p. 127). Such usage communicates solidarity between the hearer and the speaker and may function to protect positive face, especially if the speaker is in a position of authority (such as a physician). An example of a greeting a clinician may use with a patient upon beginning a consultation is "How are *we* doing today?" Furthermore, inclusive pronouns may also be used to mitigate directives (as discussed in the previous paragraph), such as "*We* need to get our blood sugar down," when clearly, the only person literally implicated is the hearer.

Empathy

Empathy also relates to rapport. Clinical empathy is "the ability to understand the patient's situation, perspective, and feelings," without the physician losing his or her own clinical perspective, "and to communicate that understanding to the patient" (Coulehan et al., 2001, p. 221). An important part of demonstrating clinical empathy to the patient is checking for feedback with phrases like “Let me see if I have this right,” or “I want to make sure I really understand what you're telling me” (Coulehan et al., 2001, p. 225).

These prompts for patient feedback express “the physician’s desire to listen deeply, thereby reinforcing a bond or connection between clinician and patient” (Coulehan et al., 2001, p. 221). Norfolk et al. (2007) divided clinical empathy into four stages: empathetic motivation (the physician’s commitment to understand the patient’s perspective), empathetic skills (internal diagnostic skills, or the ability to understand), communication skills, and empathetic understanding (which, the authors argue, contributes to establishing rapport with the patient). Communication skills related to empathy may be verbal, such as eliciting information with open-ended questions, clarifying, and summarizing, or non-verbal, such as "warmth of voice, appropriate use of silence, smiling, nodding, mirroring of posture" (Norfolk et al., 2007, p. 693).

The importance of empathy in the medical consultation cannot be overstated. The economic pressures of managed care constrain physician’s time with patients, and “one of the most widespread and persistent complaints of patients today is that their physicians don’t listen” (Coulehan et al., 2001, p. 221). However, many doctors acknowledge that personal interactions with patients compose “the most satisfying aspect of their professional lives,”(Coulehan et al., 2001, p. 221) and that the ability make a connection with patients lies at the heart of medical practice. Researchers have demonstrated the impact of empathy in the medical encounter: when used effectively, empathy fosters patient adherence, enhanced quality of clinical data, and produces a more therapeutic physician-patient relationship (Bertakis, Roter, & Putnam, 1991; Kim, Kaplowitz, & Johnston, 2004). Additionally, patients reported greater trust and satisfaction when their doctors expressed empathy in response to their concerns (Epstein et al., 2007).

Of course, like other communicative skills, making patients feel respected and understood requires practice. Recently, a new emphasis on communication skills has appeared in the medical curriculum, and educators have conceptualized empathy as a set of teachable and learnable skills (Coulehan & Block, 2005; Platt & Keller, 1994). Empathetic communication includes the following components: active listening, identifying emotion and content of patient's discourse, and requesting or accepting correction upon reflecting summaries of patients' stories back to them: "So, if I'm hearing you right…" or "…Anything I left out?" (Coulehan et al., 2001, pp. 222-223). Furthermore, it has been suggested that practitioners' queries such as "Tell me more" and statements such as "I can't imagine how difficult this is" elicit more information from patients, and that more information may lead to a clearer understanding of patients' emotions and perspectives (Coulehan et al., 2001, p. 222). Effectively eliciting and responding to patient emotions is a critical communication skill for physicians (Roter and Hall, 2006, p. 180). Relating to Brown and Levinson's (1987) politeness framework, words of empathy fulfill a patient's positive face needs, including "the wants to be liked, admired, cared about, understood, listened to, and so on" (p. 129). In addition to verbal expressions of empathy, physicians may employ various non-verbal displays of empathy such leaning forward toward the patient, using a sympathetic tone of voice, displaying a concerned facial expression, or physical contact such as patting an arm (though not all patients are comfortable with physical contact) (Roter & Hall, 2006, p. 181). However, the analysis of non-verbal expressions of empathy is beyond the scope of the present study.

Apologies

By apologizing, the speaker admits that some violation of a social norm has occurred and that he or she is at least partially responsible (Blum-Kulka et al., 1989a, p. 12). Such recognition of one's fault is inherently face-threatening to the speaker and thus "hearer-supportive" (p. 12). In a clinical context, physicians apologize to patients for a variety of reasons, ranging from causing discomfort during an exam to committing a *faux pas* such as referring to a patient's female baby as a boy. Apologies may be considered a realization of deference, a negative politeness strategy in which the speaker humbles his or herself, thus defusing potential threats to face (Brown & Levinson, 1987, p. 178).

Compliments

Another linguistic realization of positive politeness is compliments, which may be categorized in Brown and Levinson's (1987) model as noticing/ attending to the hearer or as giving goods (such as admiration and approval) to the hearer. Compliments function to consolidate or increase solidarity between the speaker and the addressee (Holmes, 1986, p. 486). Furthermore, compliments are social tools that serve to create or maintain rapport (Wolfson, 1983, p. 86). In a clinical context, a physician may compliment a patient in order to build rapport or to put the patient more at ease. In one transcription, a physician complimented a patient by saying "I like your shoes... They look really comfortable" (116-1).

Ritual Greeting and Leave-taking

Interpersonal ritual offerings, such as greetings, occur when an individual conveys a sign of involvement and connectedness (Goffman, 1971, p. 63). Linguistic

routines are important in negotiating social relationships, as they serve as tools of polite behavior which reduce the risk of face threats and show acknowledgment of the hearer (Laver, 1981, pp. 289-296). Often, greeting behavior includes "some show of pleasure in the company of the other" (Goffman, 1971, p. 74). In clinical encounters, physicians will often enter a patient's room saying "Good to see you again!" Such greeting rituals show acceptance and affirm the social relationship between the speaker and hearer (Firth, 1972; Goffman, 1971). Furthermore, farewell rituals during leave-taking recognize the establishment of relationship and often refer to continuation (Firth, 1972, p. 16). For instance, at the end of a medical encounter, physicians may tell patients "It was great to see you again; I will see you in two weeks." Greetings and leave-takings, though highly conventionalized, are neither empty nor trivial and may have an important impact on the hearer (Firth, 1972; Goffman, 1971).

This chapter has considered previous literature on doctor-patient communication in medical consultations, as well as the increasing emphasis on patient-centered care. The nature and challenges of medical interpretation have also been examined. Finally, principles of rapport and politeness have been discussed, along with specific rapport-building strategies such as affiliative humor, mitigation of directives, inclusive pronouns for solidarity, words of empathy, apologies, compliments, and ritual greeting and leave-taking. The following chapter will outline the method and procedures used in the current study's analysis of interpreted medical conversations.

CHAPTER THREE

Procedure and Method

Rationale

The following chapter describes the procedure for collecting and analyzing data in the present study. The study benefits from conversational analysis, a formalized method for studying structural features of discourse such as participant turn-taking and question-and-answer sequences (Roter and Hall, 2006, p. 49). Data for this research came from already transcribed interpreted medical consultations at a community health center in Central Texas.

After conducting a pilot reading of several transcripts, I noted recurring instances where physicians' spoken attempts at building rapport with patients were not interpreted by the interpreter. I then documented specific instances of omission observed in the pilot study that seemed to be frequent or important in the transcripts, and from that initial observation, formulated a system for categorizing such repeatedly un-interpreted discourse. Written comments by four transcribers denoting items of interest in the transcripts also informed the pilot reading and subsequent study. Additionally, in the fall of 2015, I completed a Spanish Semantics and Pragmatics course at Baylor University in which I analyzed more than 13 hours of previously obtained video recordings involving interpreted medical consultations conducted at the same clinic as the transcripts used in this study. Although the recordings were different interviews from the medical transcripts analyzed here, the information drawn from that project contributed to the formation of the present study.

Procedure

The data consisted of 43 transcripts of medical consultations recorded with Institutional Review Board (IRB) approval and permission from all participants in a separate study in January and February of 2013 at a family medicine clinic in Central Texas. As selection criteria, I studied 43 out of 75 available transcripts that were interpreted (i.e., they included a clinician, an interpreter, and one or more Spanish-speaking patients) and totaled more than three pages. Transcripts shorter than three pages were excluded because they only contained small fragments of conversations, whereas the majority of transcripts analyzed portrayed complete clinic visits and contributed a more representative sampling of rapport attempts to the study.

The transcripts analyzed came from a pool of 52 clinicians (16 faculty physicians/ mid-level clinicians and 36 residents), approximately 40 lay interpreters who were dual role employees serving as nurses, receptionists, and in other clerical roles, and an undetermined number of patients who had indicated a preference for Spanish in their clinic visits. The transcripts ranged from 4 to 14 pages in length of video recordings that had been transcribed in a 2013 research study of medical consultations. I documented in an Excel spreadsheet the non-interpretation of rapport attempts offered by physicians to patients in the transcripts. Tokens of omission in each category were documented, counted, and later analyzed.

Research Questions

The key qualitative and quantitative research questions were:

(1) How frequently do the specified variables occur yet are not interpreted in the selected transcripts?

(2) What effect does the omission of each variable in interpretation have with respect to the intended message?

(3) What is the overall effect of non-interpretation of rapport attempts in the analyzed consultations?

Regarding Question (1), I hypothesized that each of the variables defined below would occur yet not be interpreted in a majority (i.e., more than half) of the analyzed transcripts. For the qualitative Questions (2) and (3), based on previous rapport studies from Chapter Two, I hypothesized that the variables listed below contribute to doctor-patient rapport and therefore that non-interpretation of these variables constitutes missed opportunities for establishing rapport. Consequently, doctor-patient rapport would likely be improved if these specific variables were interpreted.

In this study, instances were counted when clinicians' rapport attempts were not interpreted to Spanish-speaking patients. More specifically, these missed rapport attempts were categorized as affiliative humor, mitigation of directives, inclusive pronouns used for solidarity, words of empathy, apologies, compliments, and ritual greeting and leave-taking.

Definition of Terms

Affiliative Humor

Categorization of affiliative humor followed Miczo and Welter's (2006) definition as "humor that is intended to elicit laughter and/or other forms of amusement in targets" (p. 63) in order to reduce tension and/or strengthen social bonds. An example of affiliative humor coded in the transcripts was a physician's advice to a patient with high

blood sugar. The patient was told to avoid "sodas, candy, cake, ((laughs)) all the good stuff ((chuckles))." (114-1). In the transcripts, affiliative humor was often marked by laughter after the humorous remark.

Mitigation of Directives

In this study, mitigation of directives were categorized as preparators, politeness markers ('please'), downtoners ('possibly,' 'just,' 'perhaps'), understaters ('a bit,' 'real quick'), hedges ('somehow,' 'kind of'), and appealers ('for me,' 'you know,' 'okay?') (Faerch & Kasper, 1989, p. 224; Blum-Kulka et al., 1989b). Preparators are phrases where "the speaker prepares his or her hearer for the ensuing request by announcing that he or she will make a request" (Blum-Kulka et al., 1989b, p. 287) without explicitly stating the request's content . In one transcript, a physician mitigated his directive with the preparator, "*And what I'd like for you to do*/ get your batteries changed/ and then just start checking your blood sugar just once when she wakes up, okay?" (117-1). Understaters are "adverbial modifiers which the speaker uses to under-represent the state of affairs denoted in the proposition" (Blum-Kulka et al., 1989b, p. 283). Hedges are used by the speaker when he or she "wishes to avoid a precise propositional specification" (Blum-Kulka et al., 1989b, p. 284) and appealers, which occur in a syntactically final position, are used to appeal to the hearer's "benevolent understanding" and usually to elicit a response from the hearer (Blum-Kulka et al., 1989b, p. 285). In addition, as mentioned in Chapter Two, mitigation may be realized through conventionally indirect strategies "containing reference to preparatory conditions (i.e., ability, willingness)" (Blum-Kulka et al., 1989a, p. 18). For example, in one transcript, a physician obliged his patient to sit down with the mitigated directive, "If you could just

sit here" (128-2). "If you could" is a conventionally indirect strategy referring to patient ability with the syntactically modified conditional "could," with "just" functioning as a downtoner to mitigate the force of the request. In the transcripts, tokens were counted where these mitigation strategies appeared but were not interpreted.

Inclusive Pronouns

Physicians use the inclusive pronoun 'we' to include patients (meaning 'you and I'), to exclude them (meaning 'we doctors'), or to mean "all of us human beings" (Skelton, Wearn, & Hobbs, 2002, p. 484). In this study, inclusive pronouns used to build solidarity were categorized as instances of the subject pronoun 'we,' the object pronoun 'us,' and/or the possessive pronoun 'our,' which included both doctor and patient or all of mankind (universal 'we'). The contracted form 'let's' was also counted. In addition, inclusive pronouns that were used literally to include the patient and physician and not in a solidarity-building sense were not counted. For example, in a consultation in which a pregnant woman expressed her struggle with mobility, the "we" in the physician's following utterance was coded as an inclusive pronoun used to build solidarity: "*We*'ll work on that, okay?" (117-2). The physician then added, "I am going to give her some exercises like we talked about." The first utterance expressed the physician's solidarity with the patient because of their shared goal of decreasing the patient's discomfort. Of course, the patient herself was the only one who would be performing the exercises, so the "we" in this instance was coded as an inclusive pronoun for solidarity, unlike the "we" in the follow-up statement "like we talked about." In this statement, the "we" was literal (i.e., the patient and the doctor both participated in talking about the exercises) and not counted in this study.

Words of Empathy

As outlined in the previous chapter, empathy plays an essential role in physician-patient interactions. Following Decety's (2012) definition of empathy as "the natural capacity to share, understand, and respond with care to the affective states of others" (p. vii), physician's utterances were coded as empathy which acknowledged or expressed understanding of the patient's experience or perspective. For instance, any utterance that acknowledged the patient's difficult situation was coded as empathy, such as the physician's "Yeah, this is a tough time of pregnancy" (117-2). Furthermore, the words 'I'm sorry' were coded as empathy when used to express empathy rather than to apologize, such as when a physician said "Oh, I'm sorry" upon hearing that the patient's child had been hospitalized for pneumonia (116-2).

Apologies

In this study, "routinized, formulaic expressions of regret such as: (be) sorry, apologize, regret" (Blum-Kulka et al., 1989a, p. 20) were categorized as apologies. For example, while examining a pregnant woman, a physician apologized, "I'm sorry my hands are really cold" (116-1). Note that this category does not include the word 'sorry' when it appears as a form of empathy (see above paragraph for a definition and examples of empathy).

Compliments

A compliment is "a speech act which explicitly or implicitly attributes credit to someone other than the speaker, usually the person addressed, for some ‘good’ (possession, characteristic, skill, etc.) which is positively valued by the speaker and the

hearer" (Holmes, 1986, p. 485). In one transcript, for example, the physician told the patient that she liked her shoes, and then added "They look really comfortable" (116-1).

Ritual Greeting and Leave-taking

This study follows Goffman's (1971) definition of ritual greeting as when "one individual provides a sign of involvement in and connectedness to another" (p. 63). In the present study, greetings were categorized by 'Hello' or its equivalents 'Hi' or 'Hey,' affirmations such as 'Good morning,' inquiries about the hearer such as 'How are you feeling?,' and affiliative words of pleasure in the hearer's company such as 'Good to see you' or 'Nice to meet you.'

During farewell rituals, consolidatory comments "addressed to the positive aspect of face" often occur (Laver, 1981, p. 303). The comments documented as ritual leave-taking included those which showed esteem for the hearer such as 'Nice meeting you,' benevolent admonitions such as 'Y'all take care,' and arrangements for the continuation of the relationship such as "We'll see you in *dos semanas*" (213-2).

This study's categorization of missed rapport opportunities contains some linguistic overlap. For instance, inclusive pronouns and/or affiliative humor may be used to mitigate directives, and the phrase 'I'm sorry' may appear to be an apology but really may be an offering of empathy. Nevertheless, each un-interpreted token was categorized without overlap. In other words, in order to achieve a more precise analysis, tokens were not "double counted" in multiple categories. Items which pertained to more than one rapport-building category were classified according to the more specific category they pertained to. For instance, a physician's instruction about alcohol intake, "We've gotta slowly cut back" (122-1) was coded as an inclusive pronoun, even though it is also an

example of a mitigated directive. If any token proved doubtful or ambiguous as to which category it pertained to, it was not categorized in order to avoid basing data on guesswork. This presentation of rapport-building categories is far from exhaustive. For example, the present study does not analyze certain forms of conversational rapport-building and politeness strategies, including those that are non-verbal (gestures, eye contact, facial expressions) and verbal (affirmative feedback, tone of voice, cooperative overlap, duetting) (Tannen, 2005, p. 41).

This chapter has provided an outline of the procedure in which medical transcripts were analyzed. Definitions have also been provided for each variable to be studied. The following chapter includes analyses and results from the transcripts.

CHAPTER FOUR

Data Analysis and Results

The following chapter discusses the analysis and results of the research questions outlined in the previous chapter:

(1) How frequently do the specified variables (listed in the previous chapter) occur yet are not interpreted in the selected transcripts?

(2) What effect does omission of each variable in interpretation have with respect to the intended message?

(3) What is the overall effect of non-interpretation of rapport attempts in the analyzed consultations?

As discussed in Chapter Three, the variables selected from the transcripts were affiliative humor, mitigation of directives, inclusive pronouns used for solidarity, words of empathy, apologies, compliments, and ritual greeting and leave-taking. Regarding Question (1), it was hypothesized that each variable would occur yet not be interpreted at least once in a majority (i.e., more than half) of the 43 analyzed transcripts. Analysis indeed showed that the following categories occurred but were not interpreted in over half of the transcripts: mitigation of directives, inclusive pronouns used for solidarity, words of empathy, and ritual greeting and leave-taking. Affiliative humor, apologies, and compliments were not as frequent in the data. Table 2 (below) shows a summary of the results for each variable:

Table 2. Results of Analysis by Variable

Variable	Number of Transcripts*	Percentage of Total Transcripts (%)
Mitigation of directives	30	69.8
Greeting and/or leave-taking	25	58.1
Inclusive pronouns for solidarity	23	53.5
Words of empathy	23	53.5
Apologies	12	27.9
Affiliative humor	8	18.6
Compliments	2	4.7

* (Transcripts in which the variable occurred but was not interpreted)

Analysis Procedures

In order to quantify data consistently, several guidelines determined the documentation of the above variables. Recall that only transcripts involving an employee-interpreter were examined in the study (i.e., transcripts were excluded when family members interpreted for patients or when no interpreter was used). Further steps were taken to avoid distortion of data. For instance, in the transcripts, the symbol (()) signified that the speaker's utterance was inaudible or unintelligible to the transcriptionist. When a physician's utterance included one or more of the above rapport-building variables, yet the (()) symbol appeared in the interpreter's speech, the item was not counted due to the possibility that the variable was actually interpreted but not transcribed.

In addition, in the few transcripts where patients seemed to speak some English and even responded at times in English, non-interpretation of examined variables produced by the physician were still documented. This included four transcripts in which the patients were bilingual children brought to the clinic by a primarily Spanish-speaking parent. The reason was that all utterances should have been interpreted for any patient

who indicated a preference for Spanish interpretation. Much of the conversations between bilingual children and the physician were not interpreted to the Spanish-speaking parent present; therefore variables were counted that occurred in these encounters but were not interpreted.

As discussed in Chapter Three, the rapport-building categories examined in this study may overlap linguistically. To ensure that data was not distorted and that items found in the transcripts were not assigned to multiple categories, items pertaining to more than one rapport-building category were classified according to the more specific category they pertained to. For instance, in various conversations physicians used inclusive pronouns to include themselves in a directive toward patients; thus, the directive was mitigated by inclusive pronouns. The physician softened his orders to the patient in the following example.

(1) C: So just what *we'*ll do is try to avoid eating a lot of bread,
I: *Lo que debe hacer es evitar comer mucho pan, cosas altas en carbohidratos y azúcar.*
What you should do is avoid eating a lot of bread, things high in carbohydrates and sugar. (114-1)
Key: Hereafter, C = physician; P = patient; I = interpreter.

Because mitigation of directives includes a wide variety of linguistic strategies, it is a broader category than inclusive pronouns, which can only be expressed in the words 'we,' 'us,' and 'our' (although these may also function to mitigate directives). Thus, example (1) above was classified as a non-interpreted inclusive pronoun for solidarity, not as a mitigation of directive.

Furthermore, in one transcript, affiliative humor was used by the physician to mitigate a directive toward a female patient preceding a pelvic examination.

(2) C: Alright, let your legs fall open as much as possible. Help you rela::x.[1] Let 'em fall ou::t. She's not letting them fall out.
I: *Baje las piernas todo lo que pueda.*
Drop your legs as much as you can.
C: Yeah. *Go loose. Like noodles. Loosey goosey*. Does that translate? Any of that?
I: No. No idea what loosey goosey is (C and I laugh). (213-9)

Affiliative humor is a more specific category than mitigation of directives. Therefore, although the above item functioned here to mitigate a directive, it was categorized as non-interpretation of affiliative humor.

Finally, rapport-building variables that occurred and were not interpreted immediately by the interpreter, but were indeed interpreted several speaking turns later, were not counted in this analysis.

Results of the analysis are discussed below regarding each variable analyzed, in order of most relative frequency.

Results

Mitigation of Directives

In this study, mitigation of directives was most likely to remain un-interpreted, occurring in 69.8% of transcripts. Directives are mitigated through a variety of strategies, as previously discussed. Table 3 (below) provides a representative outline of mitigated directives. Additionally, illustrative examples from the transcripts are outlined and discussed below.

Table 3. Mitigation of Directives in Transcripts

Mitigation Type	Expression	Examples from Transcripts
External Mitigation	Preparators, Disarmers	"Okay, so what she can do that will help..." (114-2) "I know that sounds kinda weird" (213-8)
Perspective Mitigation	Speaker-oriented directive	"*I would* have her be seen..." (211-2)
Conventionally indirect strategy	'can,' 'could,' 'want'	"Mama *can* you help me hold her head?" (215-3) "If you *could* just sit here" (128-2) "You *want* to have a seat up here?" (22-1)
Lexical/ phrasal downgraders	Politeness markers	"I want her to go up to 25 units... *please*" (117-1)
	Downtoners	"Okay, *just* relax" (24-2) "...you *probably* need to go to the hospital..." (28-1) "... *maybe* on a weekend" (213-8)
	Understaters	"... go to the lab *real quick*" (27-2)
	Hedges	"... *kind of...*" (213-8) "... and *whatever* make phone calls and *whatever*" (212-6)
	Appealers	"... look here *for me*" (27-4) "... when he's at home with you, *okay*?" (213-8)
	Cajolers	"... be sure that she knows that you guys *you know*, love her..." (212-6) "*Go ahead and* put your feet together" (28-2)

Adapted from Blum-Kulka, House, & Kasper, 1989b

Preparators. Examples of preparators that occurred but were not interpreted are listed below. In example (3), "what she can do that will help is" served as a preparator (which was not interpreted) to mitigate the physician's directive.

(3) C: Okay, so *what she can do that will help is* uhm after every ounce that she feeds him? stop and burp and make sure that he really gets a good burp coming in so he's not taking in as much gas.
I: *Dice de* [sic] *que cada onza que termina/=*
He says that every ounce that he finishes
P: =uh-huh=
I: *=le saques el gas para que no esté observando mucho:: gases*
=burp him so that you are not seeing him with a lot of gas. (114-2)

In example (4), the mitigatory force of the preparator "what I'd like for you to do" was lost and the directive was interpreted without mitigation. The physician's preparator itself

was conventionally indirect and speaker-oriented, which imposed less on the patient's negative face (or desire for autonomy) than hearer-oriented strategies would have (as discussed in Chapter Two).

(4) C: And *what I'd like for you to do*/ get your batteries changed/ and then just start checking your blood sugar just once when she wakes up, okay? She doesn't need to check it twice...
I: *...Dice que cambie la pila para estarse checando, nada más tiene que checar una vez al día en la mañana.*
He says for you to change the battery in order to be checking yourself, you just have to check once a day in the morning. (117-1)

In example (5), "Do me a favor" served to mitigate the physician's directive by preparing her for the subsequent commands "prop that wrist up" and "Hold strong."

(5) C: Okay, okay. *Do me a favor*, prop that wrist up/. Hold strong/
I: *Hágalo fuerte que no se lo baje.* ((C is pushing against her arm))
Make it strong so that he does not lower it.

In (6), the phrase "a couple of other things that we tell everybody" served as a preparator to soften the force of the physician's directive. The physician impersonalized his directive by communicating to the patient that she was not being singled out by the doctor, a strategy for avoiding threats to negative face (Brown & Levinson, 1987).

(6) C: ...Okay, so *a couple of other things that we tell everybody*, ahm, don't use any of those walkers once he gets old enough, like the ones they kind of stand in so they're able to walk around before they walk, those can be very dangerous
I: Okay*, que dice que no use los andadores, que porque son muy peligrosos* [P: Oh okay] *que todavía no es* (())
Okay, he says do not use the walkers, because they are very dangerous [P: Oh okay] that he is still not (()). (128-1)

Conventional indirectness. Although mitigation and indirectness are considered separate linguistic entities, they were analyzed together as they both function to soften the often face-threatening force of directives. Recall that conventionally indirect strategies

include references to the hearer's ability or willingness to comply with the speaker's directive (Blum-Kulka et al., 1989a, p. 18), often expressed in English with verb 'can.' Directives realized with 'can' are considered indirect because the speaker is usually not inquiring about the hearer's literal ability to fulfill the directive; rather, 'can' softens the force of the directive. Some examples from the transcripts are listed below. Note the difference in pragmatic force between the mitigated English version with 'can' and the Spanish version without.

(7) a. C: Okay. Ahm but you don't- it's not a full visit. You *can* just come in and do the stress test and go home.
I: *No va a ser una visita completa para ver el doctor. Solamente va a venir para ver la enfermera y ponerla en el monitor.*
It will not be a complete visit to see the doctor. You are only going to come to see the nurse and put you on the monitor. (116-1)

b. C: ((examines baby)) You *can* sit him up/
I: *Siéntelo*/ ((baby starts crying))
Sit him up. (116-2)

c. C: ... Mama *can* you help me hold her head/?
I: *La cabecita*
Her little head. (215-3)

Similarly, directives were mitigated syntactically with the conditional form 'could,' which was not interpreted.

(8) C: ((looks at computer)) Okay. If you *could* just sit here,
I: Okay*, dice que Ud. tome un asiento*
Okay, he says for you to take a seat. (128-2)

Furthermore, the verb 'want' was used as a conventionally indirect strategy appearing to refer to the patient's willingness but was not interpreted. In example (9), P2 (the second patient in the consultation) is an energetic child whom the physician directs with mitigation which the interpreted message does not reflect. The child's energy and unruly

behavior may have influenced the interpreter's more stern interpretation of the doctor's directive.

(9) C: Okay. You *want* to have a seat up here/? I'm not done with you P2[2]
I: *P2 ven. Siéntate aquí.*
P2 come. Sit here. (22-1)

Also, some physicians used a combination of syntactic mitigation (the conditional form 'would') and a speaker-oriented perspective to mitigate directives. Thus, they avoided threatening patients' negative face by orienting their directives toward themselves, telling patients what they *would* do. Such mitigation was not interpreted.

(10) a. C: [Yeah.] What *I would do* is where ever she goes, whether it's here or somewhere else if she has those bumps *I would* have her be seen for them at that time to see if we can see what they are just to see what they look like
I: Um. *Su esposa necesita ver a su doctor en cuanto le salgan esos uhm barros que tiene*
Um. Your wife needs to see her doctor as soon as those uhm pimples that she has come up. (211-2)

b. C: (regarding a patient's future medical appointment) Okay. Yeah*, I'd definitely keep that* then. ((looking at computer)) Uhm:: ((clicks fingers)) and you say it's been going on for months?
I: Uhm, three months. *Esto ha pasado por 3 meses?*
This has happened for 3 months? (214-1)

Additionally, an interesting mitigation strategy appeared in physicians' directives: the use of future or present tense combined with the verb 'have' (expressed colloquially in one transcript as "get"). It seemed that physicians' directives were softened by stating what they and/or the clinical staff were *going to have* the patient do. This mitigation was not interpreted.

(11) a. C: (sound of door opening) Okay, *we'll* pull this out and *have you lie down*
I: *Acuéstese*.
Lay down. (28-2)

b. C: Alright mom *I'm going to have you* hold her.
I: ((Sosténgala))
Hold her. (215-3)

Directives also may be mitigated internally through lexical or phrasal downgraders, which were defined in Chapter Three. The following are examples of lexical and phrasal downgraders which were not interpreted.

Politeness markers. The word 'please' is a very common politeness marker, or "optional element added to a request to bid for cooperative behavior" (Blum-Kulka et al., 1989b, p. 283).

(12) C: And I want her to go up to 25 units/ [Once a day]
I: *Y quiere que se esté poniendo 25 [al día], una vez al día.*
And he wants you to be giving yourself 25 a day, once a day
C: [*please*]
P: Mmm-hmm. *La insulina?*
Mmm-hmm. The insulin? (117-1)

Appealers. The appealer 'for me' was used below but not interpreted.

(13) C: (examining patient) OK (...) Can you take off your jacket *for me*?
I: *Puede removerse la chaqueta?*
Can you take off your jacket? (114-1)

Downtoners. The downtowner 'just' was used to moderate the force of the directive but was not interpreted.

(14) a. C: Okay, *just* relax. Let me look.
I: *Relájese.*
Relax. (24-2)

b. C: Okay, *just* look here for me::
I: *Mire donde ella apunte*
Look where she points. (25-1)

c. C: *Just* squeeze my fingers as tight as you can
I: *Aprete* [sic] *los dedos lo más que se pueda*
Squeeze the fingers as much as you can. (27-4)

Understaters. The understater "real quick" occurred in multiple transcripts but was not interpreted.

(15) C: ...you can go to the lab *real quick*
I: *Vaya al laboratorio,*
Go to the lab,
C: And then come back and I'll have that written for you
I: *Y luego venga para atrás*
And later come back. (27-2)

Cajolers. Cajolers are "conventionalized speech items whose semantic content is of little transparent relevance to their discourse meaning" (Blum-Kulka et al., 1989b, p. 284). In this study, the phrasal downgrader/ downtoner 'go ahead and...' was classified as a cajoler, because it served as internal mitigation that softened the force of the directive but contributed no real semantic content. Examples that were not interpreted are included below.

(16) a. C: ...Okay, *go ahead and* follow my finger with your eyes.
I: Ah, *siga su dedo con sus ojos/*
Ah, follow his finger with your eyes. (25-1)

b. C: Okay. *Go ahead and* put your feet together/
I: *Póngalos juntos/*
Put them together. (28-2)

Hedges. Hedges are generally adverbial phrases that are used when a speaker wishes "to avoid a precise propositional specification" (Blum-Kulka et al., 1989b, p. 284). 'Kind of,' and 'somehow' are common hedges. An example of a hedge, 'kind of,' is shown in example (18) below.

Combination of strategies. In many transcripts, a combination of the above mitigation strategies were used by the physician but were not interpreted. In (17), the conventionally indirect preparatory strategy "if you can" was used in combination with the cajoler "go ahead and."

(17) C: But before we do that *if you can go ahead and* lay down here
I: *Acuéstese primero*
Lay down first. (24-2)

In (18), the physician's directive was mitigated with several different strategies: The preparator "It would help me if," which was softened syntactically with the conditional verb form and was speaker-oriented, minimized the imposition by appealing to the patient's benevolent understanding (as if adherence were for the physician's sake and not for the patient's). Next, the physician mitigated with an inclusive perspective as well as the conventionally indirect conditional 'could': "if we could keep..." Similar to a preparator, a disarmer is an external supportive move in which "the speaker tries to remove any potential objections the hearer might raise upon being confronted with the request" (Blum-Kulka et al., 1989b, p. 287). The physician immediately followed his request with the disarmer "I know that sounds kinda weird," as if anticipating the patient's potential objection due to the oddness of the request. Furthermore, the downtoner "maybe" and the hedge "kind of" were uttered for additional mitigation, completed with the appealer "okay?"

(18) C: ... *It would help me*:: *if we could* keep a voiding journal/ for a few days::/ *I know that sounds kinda weird*, uhm but that he:: *kind of* (.) *maybe* on a weekend or ((to M)) when he's at home with you, *okay*? Is there any [period of time for a couple of days] that that's gonna happen?
P: [(())]
I: *Entonces dice que quiere que anote cuántas veces va al baño/ que si es- qué es lo que hace, un periodo de tiempo cuando Ud. lo ((tenga)) con Ud.*

So he says that he wants you to make a note of how many times he goes to the bathroom/ that if it is- what is it that he is doing, a period of time when you have him with you. (213-8)

Furthermore, instances were counted in which an *entire mitigated directive* was omitted by the interpreter instead of just unmitigated in interpretation. Several illustrative examples are listed below:

(19) a. C: Okay. *Just put your feet in there for me*. Good.
I: You let me know what you want to do first-
C: We'll do this fir::st
I: Okay. (114-1)

b. C: *She can sit right down there*. Has she, has she been under a lot of pressure or stre:ss or anything recently?
I: *Ultimamente ha estado teniendo mucho estrés*?
Lately have you been having a lot of stress? (116-4)

c. C: ((washing hands)) Okay. *If she wants to go ahead and sit up there* I'm going to measure her.
I: *Nomás la va a medir*
He is just going to measure you. (123-1)

Interpreted mitigation. In a few transcripts, mitigated directives were interpreted with different mitigation strategies. Such instances were not counted but provide interesting examples of pragmatic correspondence in interpretation. In (20b), the physician's mitigation was interpreted differently although the directly corresponding '*por favor*' exists in Spanish. Although it was not a word-for-word interpretation, it showed politeness. Especially when word-for-word renderings of mitigation do not exist in Spanish, changing the interpretation to increase pragmalinguistic appropriateness is likely the best option.

(20) a. C: Take deep breaths *for me.*
I: *Se puede respirar/* ((P breathes deeply))
Can you breathe/ (121-1)

b. C: Okay. Sit up here *please*/
I: *Puede subir allí*/
Can you get up there/ (27-4)

Ritual Greeting and Leave-taking

Words of ritual greeting and/or leave-taking occurred but were not interpreted in 58.1% of transcripts. As outlined in the previous chapter, greetings were categorized by 'Hello' or its equivalents 'Hi' and 'Hey' as in (21), affirmations such as 'Good morning' as in (22), inquiries about the hearer such as 'How are you?' as in (23), and affiliative words of pleasure in the hearer's company such as 'Nice to meet you' as in (24). In various transcripts, a combination of the above greetings were stated by the physician but not interpreted, as in (25). Illustrative examples are outlined below.

(21) a. C: Oh, *hi*. I'm Dr. X (shakes hands with P)
I: *Ella es la Dra. X*
She is Doctor X. (116-1)

b. C: *Hello*! X, right? Have a seat right there.
I: *Siéntate.*
Sit down. (213-1)

(22) C: (to married couple): *Good morning*. [PM & PF Good morning.] *How are y'all*?
PF: Not too good. (122-1)

(23) a. C: This is doctor Z Ms. Y
C2: *How are you*
C: I wanted him to take a look at your hands (26-2)

b. C: *Hey, how are you doing*? I'm Dr. X ((shakes hands)
I: *Ella es la Dra. X.*
She is Doctor X. (215-4)

(24) C: *Hola, cómo está? Me llamo* Dra. X. *Good to meet you*. She's going to be translating for me.
Hello, how are you? My name is Dra. X...
I: *Voy a estar traduciendo para ella.*
I am going to be translating for her. (129-1)

(25) C: *Hello* (shakes hands) *HI/! Good to see ya*. How are you doin' today?
I: *ºCómo está?º*
How are you?
P: *Bien*
Good
C: Good. *It's good to see you again*. How's things goin' with your pregnancy?
I: *Cómo está yendo todo para el embarazo?*
How is everything going for the pregnancy? (117-2)

Leave-taking was categorized into consolidatory comments showing esteem for the hearer, as in (26), benevolent admonitions, as in (27), and arrangements for the continuation of the relationship, as in (28). Illustrative examples are listed below. Example (28a) was counted as un-interpreted because the physician only partly stated his leave-taking in Spanish. The Spanish-speaking patient likely only understood "two weeks," which was an incomplete form of the warmer, more polite statement, "We'll see you in two weeks." In (28b), the lengthy leave-taking sequence about the next appointment was not interpreted and likely not understood by the patient.

(26) a. C: Okay. *Good to [see you*]
I: *[Si necesita algo más] nos habla okay?*
If you need anything else talk to us, okay? (114-1)

b. C: Okay? *It was nice meeting you*:: ((shakes hands))
P: *Sí*:: ((smiles)) ((holds out hand))
Yes. (24-7)

(27) C: *Y'all take care* do you have any other questions?
I: *¿Tiene otra pregunta?*
Do you have another question? (116-2)

(28) a. C: All right. ((shakes hand)) We'll see you in *dos semanas*.
All right. ((shakes hand)) We'll see you in two weeks.
P: OK. *Gracias*.
OK. Thank you. (213-2)

b. C: Okay. ((Looks at her directly)) I'm glad. ((Places hand on her shoulder)) *Thanks for coming to see me*, okay? I'm gonna see you again in one week, [okay] uh:: maybe it might be two depending on the schedule but if you

feel like uh you need to come see me sooner than that, we'll force the issue but *over the next one or two weeks I'll see you*, okay?
P: [Ok.] OK. (124-2)

If utterances were made by the physician at the opening or closing of the conversation but not interpreted, they were not counted unless they fit into one of the greeting or leave-taking categories specified above. In one transcript the physician signaled that the interview was over with an statement that did not directly correspond with any of the leave-taking categories specified and thus was not counted in the analysis. The non-interpretation of "Come on out" led the patient to ask for clarification.

(29) C: Okay. *Come on out*. ((C leaves room))
P: *Es todo entonces, verdad?*
That's all then, right? (211-2)

Similarly, some temporary leave-takings occurred but were not counted because of their temporary nature (i.e., they were not addressed to patients' positive face to close the interaction). These un-interpreted utterances indicated that the doctor was temporarily stepping out of the room.

(30) C: And *we'll be right back*/
((C & I leave room)) (24-2)

Although not counted in the analysis, such tokens may be considered missed politeness or rapport-building opportunities. The patient in the above example may have been confused when the physician and interpreter left abruptly without an interpreted explanation.

Inclusive Pronouns for Solidarity

Inclusive pronouns used for solidarity occurred but were not interpreted in 53.5% of transcripts.

(31) C: And the insulina. And *we'*ve gone up on *our* insulin to 25 units, okay?
I: *Y no se olvide de que es- subió a 25.*
And do not forget that it is- it went up to 25. (117-1)

(32) C: Okay. Alright. Um. Tell me what *we*'ve tried to do as far as helping with the peeing at night.
I: *Qué es lo que ha hecho usted para ayudarle a no mojar la cama.*
What is it that you have done to help him not wet the bed? (213-8)

When counting un-interpreted inclusive pronouns used for solidarity, tokens with the words 'we,' 'us,' 'our,' and 'let's' were not counted when they obviously excluded the patient. For instance, while explaining the clinic's requirements for completing paperwork, a physician said to a patient, "...we do it every year for a well-child visit" (214-3). This was not counted as an inclusive pronoun used for solidarity because it was assumed the "we" in his statement included himself and the clinic staff but not the patient. Additionally, if these inclusive pronouns were used literally to include the doctor and the patient rather than used non-literally to imply solidarity, the instance was not counted in the analysis. For example, in an examination of a pregnant woman, the physician said, "Let's try and listen to the baby real quick" (215-4). It was assumed that "let's" was meant literally: both the physician and the patient intended to listen to the baby's heartbeat. However, though these instances were not counted in this study, un-interpreted inclusive pronouns used in a literal sense may have still constituted missed opportunities for establishing solidarity with patients. Note the difference conveyed by a patient-inclusive versus patient-exclusive subject pronoun.

(33) C: ... *Let's* try and listen to the baby real quick.
I: *Acuéstese primero, va a ver si puede escuchar el corazón.*
Lay down first, he is going to see if he can listen to the heart. (215-4)

Furthermore, when the use of inclusive pronouns was ambiguous as to literal or non-literal inclusion, the instance was not counted in the analysis to avoid basing data on

guesswork. For example, a physician said to a parent regarding his child's low weight, "It's something that we will continue to watch," (214-3). It is impossible to deduce whether the use of "we" meant to exclude the parent (implying that the doctor and his staff would be monitoring the child's weight), to include the parent in a literal sense (both the doctor and the parent would be monitoring the child's weight), or if the pronoun was simply used to express solidarity with the patient but did not imply that both parties would be monitoring the child's weight. Thus, the item was not counted. Additionally, inclusive pronouns signifying 'universal we' or humankind were counted in the analysis. Such usage occurred but was not interpreted in only one transcript.

(34) C: Yeah it is very normal. So in *our* vaginas we have bacteria in there normally every woman does/
I: Mmm-hmm. *La área vaginal adentro de la vagina en una mujer siempre tiene bacteria*
Mmm-hmm. The vaginal area inside the vagina in a woman always has bacteria. (114-1)

As previously mentioned, the use of inclusive pronouns may be used to mitigate directives by appealing to positive face (i.e., by showing solidarity with the hearer). Inclusive pronouns functioned to mitigate directives in 30.2% of the analyzed transcripts.

Words of Empathy

Words of empathy occurred but were not interpreted in 53.5% of the transcripts. Recall that empathy is "the natural capacity to share, understand, and respond with care to the affective states of others" (Decety, 2012, p. vii). In the present study, utterances that acknowledged or expressed understanding of the patients' difficulty were coded as empathy. These utterances often began with "I know that...," as in (35b). Furthermore, the words "I'm sorry" were coded as empathy when used to respond with care (as the

above definition suggests) to a patient's situation rather than to apologize, as in (36). In general, any occurrence of the physician's words "I'm sorry" in which the physician had no responsibility for any violation were counted as words of empathy. Additionally, one instance of a physician asking his patient for feedback and correction with "Do I understand that correctly?" was not interpreted (124-2). Because Coulehan et al. (2001) defined asking for patient correction as an essential part of clinical empathy, this item was counted in the analysis. Finally, following the first part of Decety's (2012) definition of empathy as the "ability to share in... the affective states of others" (p. vii), two instances were counted as empathy in which the physician expressed empathetic solidarity with/ concern for the patient, as in (37). In (37), the word "unfortunately" conveyed emotional understanding of the patient's situation (i.e., that physician understood that the patient's symptoms are normal, yet difficult, effects of pregnancy), and thus conveyed empathy.

(35) a. C: Yeah, *this is a tough time of pregnancy*. A ton of forward heavy, so you're havin' to use your back muscles a lot more to keep [upright]
I: *[dice que tiene que] usar los músculos más durante el embarazo dice.*
She says that you have to use your muscles more during pregnancy. (117-1)

b. C: You're doing very good here (..) *I know it's uncomfortable*, I'm sorry. (.) (()) (.) ((you can)) (.) Thank you
I: °What is this one for?° that's just for clean? (26-2)

(36) a. C: (touching P's arm) *I'm so sorry that you're having to worry about this*.
I: And she says she doesn't have any family here. (114-1)

b. I: She says when she's walking and she feels like instead of going forward, she's going backwards.
C: (laughs) Oh, *I'm sorry*. Has baby been moving good for ya?
I: *Está moviendo bien el bebé?*
Is the baby moving well? (211-4)

(37) C: Okay. *Unfortunately* those are all things that are happening because of your pregnancy.
I: *Todo eso es a causa del embarazo.*
All of that is because of the pregnancy. (128-2)

Apologies

Apologies were un-interpreted in only 27.9% of transcripts. Apologies are linguistic devices that signal regret on behalf of the speaker, who asks forgiveness for a violation and thereby appeases the hearer (Blum-Kulka et al., 1989a). By apologizing, the speaker "admits to the fact that he or she is at least partly involved in its cause" (p. 12). In the present study, an apology was only counted if it the physician who uttered it was at least partially at fault for the violation prompting the apology. Recall that not all instances of the phrase 'I'm sorry' constituted apologies; rather, some constituted words of empathy. For example, a physician said to a parent who was irritated with the large amount of paperwork to fill out for his children, "Yes, there's a lot, I know I'm sorry" (212-6), which was not interpreted. This item was categorized as empathy instead of as an apology because the physician was not directly responsible for the patient's paperwork obligations. In the transcripts, un-interpreted apologies were divided into categories of violations: causing the patient physical discomfort as in (38), impinging on the patient's time as in (39), violating a social norm of politeness as in (40), and miscellaneous violations such as (41).

(38) a. C: º*I'm sorry*º I'm gonna put some gloves on since my hands are cold ((laughs))
I: *Están bien frías*
They are very cold. (116-1)

b. C: (During eye exam): *I'm sorry*. I know this is tough. You need a second?
I: *Ella sabe que sí le duele pero uhm necesita verlo atrás.*

She knows that yes it hurts you but uhm she needs to look back there. (121-1)

(39) a. C: *Sorry*. It's hard transferring weeks into months for us, so hold on just a second.
M: (patient's husband): *Yo pues más o menos tengo que salirme a mediado de abril.*
I well more or less have to leave in the middle of April. (117-2)

b. C: Okay. *Sorry*, lots of questions. We're wearing her out, I think. Alright umm, how much did you weigh before you got pregnant?
I: *Cuánto pesaba antes de embarazarse?*
How much did you weigh before getting pregnant? (213-9)

(40) C: (referring to baby): I got my he-shes wrong. *Sorry about that*. I should've asked, so
P: ((unclear))
I: She says he's real hairy, so (121-1)

(41) C: *Sorry for* my pronunciation, very bad
I: *Es muy mal la pronunciación*
His pronunciation is very bad. (212-3)

Affiliative Humor

Affiliative humor occurred but was not interpreted in 18.6% of transcripts. Affiliative humor is "humor that is intended to elicit laughter and/or other forms of amusement in targets" (Miczo & Welter, 2006, p. 63). In the transcripts, affiliative humor was often marked by laughter after a humorous remark. In example (42), the physician added "all the good stuff" to the list of foods the patient with high blood sugar was told to avoid. This served to mitigate his directive through humor. In (43), after greeting the patient in Spanish, the physician made a self-deprecating humorous comment about her low Spanish-speaking ability, which was laughed at by other participants but not interpreted to the patient. In (44), after the doctor told a diabetic patient that he could drink no more than one beer a day, the patient jokingly asked what size and indicated a

large can of beer with his hands. Although the patient appeared to understand some English (as he replied correctly in Spanish to the physician's comment), the physician's lengthy affiliative banter toward the patient, including "You joker," was not interpreted. Finally, in (45), female camaraderie and rapport were established through affiliative humor. In a previous consultation, the patient's husband had been difficult and uncooperative. The physician's humorous offer, "Sometimes it's hard to decide whether they're a supporter or a pain," was not interpreted.

(42) C: So just what we'll do is try to avoid eating a lot of bread,

I: *lo que debe hacer es evitar comer mucho pan, cosas altas en carbohidratos y azúcar*
What you should do is avoid eating a lot of bread, things high en carbohydrates and sugar.

C: Sodas, candy, cake, ((laughs)) *all the good stuff*. ((chuckles)) Okay. I'm thinking- I'm trying to decide if we're going to do the 8-month labs today.

I: How many weeks is she? (114-1)

(43) C: *Hola*
Hello.

P: *Hola*
Hello.

C: *And we have now exhausted all of my Spanish* ((I laughs)) Tell her I'm sorry about the wait today. I apologize, [I know y'all have been waiting for a] while.

I: *[Que disculpa por] por la tardancia* [sic] *dice*
Sorry for the delay he says. (116-2)

(44) C: Oh, the REgular ((indicates small size)) (()) a can. ((everyone laughs)) Not the big one. *You joker*. ((laughs)) Hop up here, let me listen to your heart and lungs. ((examines PM)) Good. Okay, respire. Good. Well, I am very proud of you for changing your diet and not drinking so much. That's fantastic. You should be proud of yourself. ((pats PM's knee)) That's hard o do. ((Facing PM, about 1 ft between them))

PM: *Así es*.
Yes it is. (122-1)

(45) C: You left your husband at home today, huh?

I: *dejó a su esposo en la casa hoy?*
You left your husband at home today?

P: *Sí*. (all three women laugh) (()) *por cobarde*
Yes. For being a coward.
C: *Sometimes it's hard to decide whether they're a supporter or a pain*. (P is still laughing) Okay. All right. [Well, that was]
P: *[Tengo una pregunta] esta parte de aquí ...*
I have a question this part here... (211-4)

Compliments

Compliments occurred but were not interpreted in only 4.7% of transcripts. Recall that a compliment is "a speech act which explicitly or implicitly attributes credit to someone other than the speaker, usually the person addressed, for some 'good' (possession, characteristic, skill, etc.) which is positively valued by the speaker and the hearer" (Holmes, 1986, p. 485). In (46), the physician's addition to her initial compliment, "They look really comfortable," was not interpreted. In (47), the physician gave his depressed patient multiple compliments referring to the quality of her character ("You're a good person") and to her quality as a mother, none of which were interpreted.

(46) C: Excuse me. I like your shoes. (chuckles)
I: *Le gustan sus zapatos*
She likes your shoes.
C: *They look really comfortable*. Okay. (measuring patient) I'm sorry my hands are really cold.
P: *Cuánto mide el bebito*?
How much does the little baby measure? (116-1)

(47) C: *You're a good person. You're a great mother*. I know that you- I've seen you with your daughter, okay? I know that you love her and I know that she loves you, and *you are a good person*, okay? This is- this is a normal- it's normal, okay?
P: OK (124-2)

In several transcripts, physicians affirmed or encouraged patients for various reasons. During a pelvic examination, the affirmation "You're doing very good here" was not interpreted to the patient.

(48) C: *You're doing very good here* (..) I know it's uncomfortable, I'm sorry. (.) (()) (.) ((you can)) (.) Thank you
I: °What is this one for?° that's just for clean? (26-2).

Such instances were not counted as compliments since they were not addressed to a positive characteristic, skill, or possession of the patient following Holmes' (1986) definition above.

Discussion

The second and third research questions were:

(2) What effect does omission of each variable in interpretation have with respect to the intended message?

(3) What is the overall effect of non-interpretation of rapport attempts in the analyzed consultations?

It was hypothesized that the variables analyzed contribute to doctor-patient rapport and that non-interpretation of these variables constitutes missed opportunities for building rapport. Consequently, doctor-patient rapport would likely be improved if these variables were interpreted.

The most prominent rapport-building variables that occurred but were un-interpreted in the transcripts were mitigation of directives, greeting and leave-taking, inclusive pronouns for solidarity, and words of empathy. However, what was the overall effect of the non-interpretation of these variables, and is it important in the interaction between physician and Spanish-speaking patient?

In very general terms, cross-cultural comparative studies over the last few decades have indicated that in realizing directive speech acts, native English-speakers tend to use more indirect strategies than native Spanish speakers (Ballesteros Martín, 2001; Blum-

Kulka, 1989; Pinto & Raschio, 2007). These studies have included comparisons of English and Spanish from a wide variety of regions and from an array of social situations and contexts. For instance, in a study of Spanish request strategies in various contexts, the use of direct strategies grew significantly in situations of closeness or small social distance, whereas no direct requests were used in situations of increased social distance (Ballesteros Martín, 2001).

Furthermore, Spanish-speakers tend to use differing levels of directness in realizing directive speech acts, often influenced by country or region. For example, indirect strategies are more prominent in Ecuadorian Spanish than in Spain (Placencia, 1996). Similar to studies on directness, comparative studies on mitigation of directives have found that in general, Spanish speakers opt for less mitigation than English speakers (Ballesteros Martín, 2001; Pinto, 2005). The difference in directness in Spanish compared to English has been explained by the generalization that Spanish-speaking societies tend to be more oriented toward positive politeness (i.e., inclusion and acceptance of the hearer), whereas English-speaking societies are more characterized by negative politeness (i.e., avoiding imposing on the hearer, respecting autonomy) (Pinto & Pablos-Ortega, 2014).

Furthermore, Spaniards are the most direct Spanish-speakers in terms of direct speech act realizations, lack of mitigation, and reduced use of politeness forms (Pinto & Pablos-Ortega, 2014, p. 182). In a comparative study of Mexican versus Spanish perceptions of imperatives, Mexicans rated imperatives without mitigation as far less polite than did Spaniards (Curcó & Fina, 2002). Of course, these generalizations depend on a host of variables such as register, social distance, and situational formality. In

interactions between peers or "social equals," speakers of Mexican Spanish tend to use more direct strategies just as Spaniards or even English-speakers do.

For the present study, one may argue that in direct varieties of Spanish, indirect and/or mitigated speech acts may be perceived as false, insincere, sarcastic, or as an attempt to create social distance between speakers (Pinto & Pablos-Ortega, 2014, p. 215). However, because of the prominence of Mexican Spanish spoken by patients, this study assumes that mitigation and/or indirectness would not be perceived in any of these negative ways. Furthermore, in a situation of inherent social distance it is unlikely that mitigation of directives would cause any offense, even among the speakers of the most direct varieties of Spanish.

In a study of request strategies in Mexican Spanish, indirectness was the norm for showing respect and distance between speakers. In interactions among peers and close friends, solidarity and politeness were expressed through direct strategies modified by some form of mitigation (Félix-Brasdefer, 2005). Due to the location of the present study's interactions at a clinic in Central Texas, the majority of patients in the transcripts spoke a variety of Mexican Spanish. Furthermore, it is assumed that the medical consultation is an interaction of social distance (i.e., that the physician and the patient are not peers and that the physician is in an intrinsic position of authority). Thus, in spite of these studies' findings that mitigation and/or indirect strategies are more prominent in English than in Spanish, they are still important politeness strategies to be interpreted. Recall that that this analysis counted un-interpreted mitigation of directives; that is, when directives were interpreted to the patient in a direct, un-mitigated form. The message that reached the patient's ears may have been perceived as too direct, rude, or impolite.

Moreover, interpretation of mitigation/ indirectness with directives is especially important in light of the social distance inherent in the consultation and the general norm of indirectness in Mexican Spanish.

Additionally, choice of perspective (speaker-oriented, hearer-oriented, inclusive, or impersonal) used to realize directive speech acts has been compared in Spanish versus English. In general, Spanish speakers orient their directives toward the hearer, whereas English speakers tend to produce speaker-oriented directives (Blum-Kulka, 1989; Pinto, 2005). Again, this pattern may follow Spanish's tendency toward positive politeness and English's tendency toward negative politeness (avoiding imposing on the hearer, respecting autonomy). That is, making the directive speaker-oriented may help to diminish the threat to negative face in English, whereas the hearer-oriented perspective focuses on the hearer's participation needed to fulfill the desired directive (Pinto & Pablos-Ortega, 2014, p. 206). In general, people in collectivist societies tend to value maintaining social harmony and a sense of belonging to a group, as well as an inclusive, community-oriented perception of the world (Pinto & Pablos-Ortega, 2014, p. 191). On a scale of 78 countries ranked in order of individualism, Spain occupied the most individualistic position of all the Spanish speaking countries (32), while the most collectivistic were Panama, Ecuador, and Guatemala (Hofstede, Hofstede, & Minkov, 2010). Mexico was listed as 48th, more on the collectivistic side of the spectrum (Hofstede et al., 2010).

In light of Spanish-speakers' general tendency toward positive politeness and hearer-oriented directive strategies, opportunities for building rapport were missed when mitigation with inclusive pronouns for mitigation was un-interpreted. That is, the

Spanish-speaking patient would have likely resonated with the inclusive nature of physician's directives such as "So just what *we'*ll do is try to avoid eating a lot of bread" (114-1). Similarly, example (49) below shows a use of the inclusive pronoun "our":

(49) C: Yeah it is very normal. So in *our* vaginas we have bacteria in there normally every woman does/
I: Mmm-hmm. *La área vaginal adentro de la vagina en una mujer siempre tiene bacteria*
Mmm-hmm. The vaginal area inside the vagina in a woman always has bacteria. (114-1)

By saying "our vaginas," the female physician presumably intended to show solidarity with the patient by referring to a universal female norm. Granted, in the Spanish language, body parts are generally not modified by possessive adjectives, so that interpreting word-for-word with *en nuestras vaginas* would likely be pragmatically odd. However, possession in this context is expressed in Spanish through other grammatical indicators such as reflexive pronouns or by the subject of the verb (Butt & Benjamin, 2011). For instance, one interpreter translated well the inclusive possessive pronoun 'our,' capturing the solidarity of the statement without violating Spanish linguistic norms. Similar interpretations occurred in transcripts with physicians who were native speakers of Spanish.

(50) C: I think your blood pressure is fine today. It's normal for *our* blood pressure to uhm be higher when *we*'re in pain, just like *our* heart rate goes up when *we*'re in pain ((looks at I as if to tell her to translate))
I: So *dice que es normal que a veces la presión suba cuando tenemos dolor porque el corazón va latiendo más rápido.*
So he says that it is normal that sometimes the blood pressure goes up when *we* have pain because the heart is beating more quickly. (121-1)

Closely tied to the notion of rapport in this study, *personalismo,* respect, and *simpatía* are Latino cultural values that have been explored in the context of medical encounters. These values reinforce the importance of interpreting words of empathy, as

well as greeting and leave-taking, to the Spanish-speaking patient. *Personalismo* has been listed as one of the fundamental cultural values for Latino people (that is, people of Latin American origin) (Chong, 2002, p. 24). *Personalismo* is "the human quality of being able to relate on a personal level, regardless of social or financial standing" (Chong, 2002, p. 24). Included in the concept of *personalismo* is the knowledge of an individual's personal qualities acquired over years of relationship and sharing (Chong, 2002, p. 25). Another fundamental cultural value for Latino societies is respect. Initiating a relationship with a stranger, such as a healthcare provider, is often based on whether or not respect is perceived in the initial interaction (Chong, 2002, p. 26). A third concept of *simpatía* is also highly valued in Latino cultures. *Simpatía*, which is not equivalent to the English 'sympathy,' implies people-oriented skills and "the ability to develop a harmonious relationship that expresses a warm and caring attitude" (Chong, 2002, p. 27). Latino patients will likely view the physician as an authority while simultaneously expecting personal warmth (Erzinger, 1991, p. 92). Hence, words of empathy demonstrate "the natural capacity to share, understand, and respond with care to the affective states of others," (Decety, 2012, p. vii). In light of the cultural importance of *simpatía* and *personalismo*, interpretation of words of empathy such as "I'm so sorry that you're having to worry about this" (114-1) is crucial.

Furthermore, the demonstration of *simpatía*, respect, and *personalismo* to the Spanish-speaking patient entails interpretation of greetings and leave-takings. Greetings and leave-takings are far from empty conventions. They stress the positive aspect of participants' relationship by showing mutual respect and esteem for the other and by acknowledging and including the other as a member of the social scheme (Firth, 1972;

Goffman, 1971; Laver, 1981). Imagine attending a medical consultation in which the physician began without polite ritual greetings such as 'Hello' or 'How are you doing?' and immediately began the next phase of the interview. Such an interaction might have a negative effect, leaving a patient feeling confused (because the expectation for polite behavior was not met) and even rushed, ignored, or not cared about by the physician. A similar reaction would follow if the physician left without saying 'Take care, goodbye' or 'See you in two weeks.' This departure would likely be perceived as uncaring, impolite, and even disrespectful. Such situations may have been the reality for many patients in the analyzed transcripts who did not receive interpretations of physicians' greetings and leave-takings, especially in the case of patients with virtually no English proficiency. Interpreters may have assumed that Spanish-speaking patients had lived in the United States for enough time to have learned basic English greetings and leave-takings. However, if patients request an interpreter, assumptions must not be made regarding which English utterances they might understand. Following the NCIHC's standard of accuracy (discussed in Chapter Two), participants in an interpreted conversation have a right to know the *precise* message intended for them; that is, all messages must be rendered accurately and fully without revision or omission (NCIHC, 2005, p. 5).

In one transcript, the medical resident had memorized beforehand some common Spanish greetings and leave-takings with which he opened and closed the consultation. This method seemed particularly effective for establishing rapport and showing warmth and politeness to the Spanish-speaking patient. First, the use of greeting and leave-taking in the patient's own language negated the need for warmth and politeness to be communicated by the interpreter. Second, by taking a small amount of time and effort to

memorize the Spanish phrases, the resident validated the patient as a person and showed that he and his language were important to the resident. The resident closed the medical interview with "*Que Dios lo bendiga*" (God bless you), and the patient responded with "*Igualmente*" (you too) (214-1). Rapport was established merely through the resident's use of Spanish in greeting and leave-taking. Such a strategy likely would be beneficial for application in future interpreted medical interviews.

The rapport attempts that occurred but were not interpreted in less than half of the transcripts were apologies, affiliative humor, and compliments. Because apologies are caused by situational and often accidental infringements, it is not surprising that they did not occur as frequently as a conversational norm such as ritualized greeting and leave-taking. Furthermore, the use of affiliative humor depends on the physician's personality and is situationally determined (i.e., it would not be appropriate to use humor with many patients in this study, such as with a depressed patient). Similarly, compliments are situationally provoked and likely dependent on the physician's personality as well. However, just because these items were not documented in a majority of transcripts does not mean they were not important in the given situations.

Real-time, consecutive turn-taking medical interpretation is indescribably difficult. Often, interpreters may preference one part of the physician's utterance due to perceived time constraints or the perception that a politeness strategy such as mitigation is less important than the directive itself. Other times, messages may not be interpreted because the patient interrupts the interpreter or the patient seems to understand without interpretation. Such was the case in the example below, in which none of the physician's reassuring words were interpreted to the patient with depression:

(51) C: You're a good person. You're a great mother. I know that you- I've seen you with your daughter, okay? I know that you love her and I know that she loves you, and you are a good person, okay? This is- this is a normal- it's normal, okay?
P: OK
C: Do you understand?
I: ((*entiende)) bien?*
Do you understand well?
P: ((nods)) (124-2)

Although she nodded her head when asked if she had understood the doctor's statements, his words still should have been interpreted. Again, the importance of doctors and interpreters working together as a team to build rapport and solidarity with the Spanish-speaking patient during the medical consultation cannot be overstated. The interpreter can work toward this goal by communicating the physician's rapport-building attempts (such as mitigation of directives, inclusive pronouns for solidarity, words of empathy, and greetings and leave-takings) so that they reach the patient's ears. Interpretation of these items likely enhances rapport-building during the consultation, which leads to future success in the future doctor-patient relationship.

In conclusion, this chapter has discussed the analysis and results from 43 transcripts of interpreted medical interviews. The variables that occurred but were not interpreted, from most to least frequent, were mitigation of directives, greeting and/or leave-taking, inclusive pronouns for solidarity, words of empathy, apologies, affiliative humor, and compliments. Additionally, the practical importance of interpretation of these variables has been reviewed with studies on regional Spanish pragmatics and cultural values. The next chapter provides a summary of the present study, limitations, applications, and topics for future investigation.

CHAPTER FIVE

Conclusions and Implications

In the previous chapter, results from the transcript analysis were outlined and discussed. This chapter addresses the research questions posed at the beginning of the study and summarizes conclusions. Limitations of the research are also discussed, as well as application of the study's findings and suggestions for future research.

Research Questions

Initially, it was hypothesized that affiliative humor, mitigation of directives, inclusive pronouns for solidarity, words of empathy, apologies, compliments, and ritual greeting and leave-taking would each occur but not be interpreted in a majority of transcripts. Additionally, these variables were viewed as contributing to doctor-patient rapport and therefore that non-interpretation of these variables would constitute missed opportunities for building rapport. Consequently, doctor-patient rapport likely would be improved if these variables were interpreted.

The study began with three research questions (one quantitative and two qualitative). Each question is listed below along with a summary of the results.

(1) How frequently do the specified variables occur yet are not interpreted in the selected transcripts?

The most prominent rapport-building variables that occurred but were un-interpreted included, in order of frequency, mitigation of directives, greeting and leave-taking, inclusive pronouns for solidarity, and words of empathy. Apologies, affiliative

humor, and compliments were less important, occurring in less than half of the transcripts.

(2) What effect does the omission of each variable in interpretation have with respect to the intended message?

Non-interpretation of each variable often had a slightly different effect, depending on context and on the variable itself. First, un-interpreted mitigation of directives (that is, directives that were expressed by interpreters as direct imperatives) may be perceived as blunt and impolite, especially to speakers of more indirect dialects such as Mexican Spanish (Curcó & Fina, 2002; Félix-Brasdefer, 2005). Also, Spanish-speaking societies are generally collectivistic, community-oriented, and characterized by positive politeness and group inclusion (Hofstede et al., 2010). Therefore, when inclusive pronouns showing solidarity are not interpreted, opportunities are missed to establish rapport and show solidarity with Spanish-speaking patients. Thirdly, non-interpretation of empathy may convey, albeit unintentionally, that the physician does not understand or respond with care to the patient's perspective, affective state, or experienced difficulties (Decety, 2012). This perception may leave the patient feeling emotionally isolated from the physician and unwilling to continue a future professional relationship, especially if words of empathy are not interpreted after a particularly vulnerable or painful divulgence by the patient. Finally, when greetings are not interpreted, the patient may feel unacknowledged and confused (because the expectation for polite behavior was not met) or even rushed, ignored, or unvalued by the physician. Non-interpretation of leave-takings has a similar effect. A physician who closes the consultation by simply leaving the room likely is perceived as uncaring, impolite, or even disrespectful. Spanish-speaking patients in the

analyzed transcripts (especially those with no English proficiency), who did not receive interpretations of the physician's greeting and leave-taking, may have experienced these negative effects.

(3) What is the overall effect of non-interpretation of rapport attempts in the analyzed consultations?

Following Brown and Levinson's (1987) model of politeness, all of the variables analyzed contribute to negative and/or positive politeness in some way. Politeness is closely related to and involved in rapport management, or the use of language to promote or maintain harmonious social relationships (Spencer-Oatey, 2008). Consequently, the importance of rapport (which entails trust, good communication, and relationship-building) between physicians and patients cannot be overstated. That is, lack of rapport between physicians and patients leads to decreased patient satisfaction and adherence and may prevent patients from returning to the same doctor to establish a trusting professional relationship (Rivadeneyra et al., 2000). It is likely that "the majority of malpractice claims would not be pursued if the patient, or the patient's family, were not angered over failures or disappointments in the patient's relationship with the physician" (Roter & Hall, 2006, p. 38). In general, an absence of physician friendliness and warmth contributes to patient dissatisfaction (Cordella, 2004, p. 28). On the other hand, when doctors and interpreters engage in rapport-building communication that fosters a positive relationship, they form a team with the shared goal of effectively addressing patients' health concerns. Interpretation of all rapport-building speech is crucial to this process.

Furthermore, following Chong's (2002) outline of fundamental Latino cultural values, all of the analyzed rapport-building variables correspond to the notions of

personalismo, *simpatía*, and respect. The importance Spanish-speakers assign to these values reinforces the need to interpret mitigation, words of empathy, greeting and leave-taking, and inclusive pronouns to the Spanish-speaking patient. In sum, physician's attempts at rapport are rendered ineffective when left un-interpreted; instead, the perception of social distance or impoliteness may be the unintended consequences.

Limitations

Certain limitations exist within the present study that may have affected the results. These limitations mainly pertain to the use of transcripts as the data source. Prior to this study, four transcriptionists had viewed videos of the conversations and typed them into Word documents. Given the enormous quantity of information to transcribe (75 consultations) and the challenging nature of precise transcription, some spelling errors occurred in the transcripts. Also, it is possible that some words or phrases were accidentally overlooked or not transcribed that would have affected the data. The impact of human error in transcription on the results, however, is likely slight. Frequent background noises and/or participants speaking inaudibly in the videos also prevented transcription of certain words and phrases that may have slightly affected the data. An additional (and perhaps the most important) limitation regarding the transcripts is the lack of visual context in understanding the conversation. In instances where the physician used an inclusive pronoun whose referents were ambiguous, the item was not counted in this study. Access to a video of the conversation might have clarified whether or not the physician meant to include or exclude the patient through context clues such as whom he or she indicated or made eye contact with during the statement.

Furthermore, reliability would have been increased with an additional data analysis. However, time limitations and the scope of the study did not allow for an additional researcher.

Applications

The study yielded results that support previous studies on cross-cultural medical interpretation. For instance, a transcript analysis of interpreted medical encounters found that interpreters often reduced or omitted what was said, especially small talk between physicians and patients (Aranguri et al., 2006). The researchers noted that with almost all purely social interaction omitted, the conversation was rendered "facts-only" and seemed less personal (Aranguri et al., 2006, p. 627).

Regarding implications for interpreters to put into practice, this study reinforces the National Council on Interpreting in Health Care's (NCIHC) proposed national standards, specifically the standard of accuracy. This standard obliges the interpreter to render "all messages accurately and completely, without adding, omitting, or substituting" and to replicate "the register, style, and tone of the speaker" as much as possible (NCIHC, 2005, p. 5). The present research suggests that interpreters should particularly interpret rapport-building attempts including mitigation of directives, inclusive pronouns for solidarity, words of empathy, greetings, and leave-takings.

Regarding the interpretation of mitigation of directives, recall that this study only documented instances when mitigation occurred but was not interpreted *at all* to the patient (i.e., either the entire mitigated directive was not interpreted or only a non-mitigated imperative was used). Furthermore, recall that some English mitigatory words and phrases, such as 'go ahead and,' may not be easily translated word-for-word into

Spanish. Therefore, interpretation of mitigated directives that resembles the original message as closely as possible is better than not interpreting mitigation at all. The goal of interpretation is not necessarily perfection, but the conscious awareness of rapport-building attempts and the effort to interpret them to the patient. Although direct, word-for-word interpretation of the possessive pronoun 'our' is not an ideal option in Spanish, other ways of conveying the same sense of solidarity exist in Spanish. Interpreting the sense of inclusion and solidarity to the Spanish-speaking patient is particularly valuable.

Future Research

In future research, the study could be replicated by first providing lay interpreters with professional training in interpretation and then analyzing videos or *post-training* transcripts to see if more rapport-building attempts had been interpreted. Future studies could also encompass patient satisfaction surveys for Spanish-speaking patients, comparing survey results before and after interpreter training to see if patient satisfaction increased.

Additionally, during the transcript analysis, I noted other areas related to rapport-building for future analysis. These areas included high amounts of positive feedback and reassurance that physicians offered throughout the medical consultation. For example, when patients described their health routines or which medications they had been taking, physicians often indicated approval or encouragement using phrases such as '(Very) good,' 'That's fine,' 'That's fantastic,' and 'Perfect!' These phrases occurred but were not interpreted in 74.4% of the transcripts. One example appears below, in which the physician praised a patient's positive dietary changes.

(52) C: ...*Well good*. So it sounds like you're feeling motivated and you're making a lot of changes already. *That's fantastic.*

I: *Suena como que está motivado y que está haciendo cambios todavía*
Sounds like you are motivated and that you are making changes already. (122-1)

Such positive feedback or reassurance was not counted as a compliment because the physician was generally praising physical progress or adherence to instructions, rather than a characteristic or possession (following the definition of compliments previously outlined). Other times, the physician simply exclaimed "Good!" during a physical examination or upon seeing a patient's lowered blood sugar numbers, for example. Perhaps because the interpreter assumed that the patient understood basic words like 'good' and 'perfect,' such utterances were not interpreted. Other common rapport-building words that were not interpreted included 'thank you' and 'congratulations.'

As mentioned in Chapter Three, for a class project at Baylor University, I analyzed videos of consultations recorded at the same clinic where this study's interactions took place. A possible rapport-related topic for future study is the positioning of the patient, physician and interpreter in those videos. Often, physicians sat close to the patients (and to the computer), while the interpreters stood in the doorway on the other side of the room. This prompted the patients, if they wanted to make eye contact with both the interpreter and the physician when each spoke, to constantly turn their heads from one side to another depending on who was speaking. Some patients opted to simply not look at the physician and maintained their gaze toward the interpreters. Similarly, physicians often spent a significant amount of time looking at the computer screen as they entered data and reviewed patient histories. This lack of eye

contact between physician and patient detracts from rapport that could potentially be established.

Another productive area for future investigation would be the interpretation of small talk or "non-obligatory talk in terms of task requirements" (McCarthy, 2000, p. 84). Small talk, such as a physician asking a child patient about his or her friends at school, may be considered a strategy for positive politeness, as it intensifies or exaggerates interest in the hearer (Brown & Levinson, 1987). Small talk between the interpreter and patient should always be interpreted to the physician, not only in case it reveals pertinent information but also to avoid excluding the physician. To illustrate, a distressed pregnant patient in one transcript gave a lengthy explanation of her difficult personal situation to the interpreter, who did not interpret it to the doctor. The patient had explained how her abusive husband had left her and how she was worried about who would care for her children while she was in the hospital. The physician, completely unaware of the topic of conversation, interrupted her narrative with a friendly rapport-building attempt at small talk, "Did y'all have a good Christmas?" (114-1). The blunder of attempting light-hearted small talk in the midst of the patient's painful narrative would have been avoided if her story had been interpreted to the physician. Furthermore, when physicians made rapport-building small talk with the bilingual children of Spanish-speaking patients, this small talk should have been interpreted to the parents even though it was not directed to them. Merely knowing physicians' interest in and friendly banter with their children would presumably establish rapport between parents and physicians.

In summary, this study found that mitigation of directives, inclusive pronouns for solidarity, words of empathy, and greeting and leave-taking were the most representative

variables of missed rapport-building attempts. Affiliative humor, apologies, and compliments were not representative in the data but constituted missed rapport opportunities in their individual contexts. In order to improve the rapport-building process between physicians and Spanish-speaking patients, these variables must be interpreted and not omitted for time's sake or considered extraneous to the interpretation. These variables are not secondary to "more important" information communicated by the doctor; if anything, the patient's impressions of the doctor (based on caring, competence, and taking the patient seriously), "may be more important even than the information itself" (Roter & Hall, 2006, p. 17). A message consists of not only of *what* is said, but more importantly *how* it is said. The examples containing variables analyzed in this study illustrate that interpreted physician-patient communication often misses this crucial ingredient, bypassing the personal connection that could have been established and, worse yet, possibly leading to impoliteness and misunderstanding.

Notes

[1]Symbols for conversational analysis:

[	Beginning of overlap
]	End of overlap
=	Latching (continued utterance between two speakers with no pause in between or continued utterance by the same speaker)
(.) (..)	Pauses.
((cough))	Researcher's comments about actions; e.g., (sigh) or (laugh)
(( ))	Unclear or unintelligible utterance
? or /	Rising intonation
. or \	Falling intonation
,	Continuing intonation
::	Lengthened or prolonged sound (e.g., ri::ght)
—	Hyphen indicates utterance that is cut off or interrupted.
WO	Increased loudness.
º	Markedly quiet or soft.

[2]All names in examples from transcripts are omitted for anonymity. Thus, "Dr. X," "Ms. Y," etc.

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