Third party insurance? Role and alignment in interpreter and mediated primary care consultations

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COVER SHEET

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Third party insurance?: Interactional role alignment in family member mediated primary care consultations[i]

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Abstract

This paper deals with general practice consultations where there is a third party present, as a companion, to support the patient and act as a mediator between doctor and patient. Our study contrasts with most, but by no means all, of the studies on interpreting which (i) focus on a transmission of information model in professional interpreting; (ii) do not address monolingual mediated consultations where the third person is a carer and (iii) do not address issues of trust and feelings which can characterise consultations mediated by family members.

The data for this paper is drawn from a London-based project: Patients with Limited English and Doctors in General Practice: Educational Issues (PLEDGE). Using Goffman's participant framework and aspects of narrative performance, we propose a cline of mediation, which can be mapped on to the structure of the clinical consultation – as evidenced through two case studies. The analysis indicates that consultations with companions that act as lay interpreters have more in common with monolingual triadic consultations than with professionally interpreted consultations. The shifts in role-relationships and alignments between the three participants subvert their official position to produce a remarkable intimacy and collaboration, while often subduing, but sometimes amplifying the patient's voice. There are implications of our findings both for family carers as mediators and for primary care health providers.

Keywords: primary care consultation; lay interpreters; third party; mediation; participation frameworks; narrative performance; role relations.

1 Introduction

The insurance industry in most countries offers 'third party' insurance to protect those who are thought to be responsible if a claim is made against them. In healthcare encounters, the third party represents a rather different kind of insurance. Although family members may be seen as the relative outsider in a medical transaction, as the term 'third party' suggests, they help to mediate the encounter in highly significant ways. In this regard, the role-responsibilities of the doctor, the family member and the patient are likely to shift during the triadic encounter, producing more complex participant frameworks (Goffman 1981) which affect the communicative environment.

Intercultural healthcare encounters are a routine feature of healthcare delivery (Sarangi 2012; Schouten and Meeuwesen 2006), typical of the 'superdiversity' of globalised communities (Vertovec 2007, 2010). The extent to which trained interpreters can insure the consultation against misunderstandings and unspoken agendas has been the subject of much research and debate. Of equal interest, however, has been how a third party presence can lead to misunderstandings based on inaccurate relay of words and ideas. Most of the literature has assumed that triadic consultations are interpreter-mediated and the focus has been on linguistic aspects as well as interactional aspects of the encounter. However, mediated interactions with a third party non-interpreter presence are common in the healthcare setting. For instance, the parent in a paediatric encounter and a spouse or offspring in a geriatric encounter do not attend the clinic in the primary role as interpreter and/or mediator but as carer but they may be drawn into the communicative activities of mediation and interpretation in a given encounter.

In this paper we examine two encounters where family members are present. Both the encounters are mediated encounters in that the companion becomes involved in the interaction from an early stage and this leads to a three way conversation in which the third party takes on the role of making talk (more) understandable and of contributing to managing the doctor-patient relationship. While the literature on interpreting addresses a wide range of definitions for these triadic encounters, we will use the term companion for

the first case which is a monolingual encounter in English and the term lay interpreter (or family interpreter as they are widely known in the UK) for the second case where the daughter interprets for her Turkish speaking mother but has no training as an interpreter.

We proceed as follows. In section 2, we review relevant studies addressing the role of the interpreter. This is followed, in section 3, by an outlining of our data corpus and methodology, including the choice of analytical framework to engage with the empirical data. In section 4, we offer in-depth analysis of the two encounters. Section 5 provides a discussion of the key findings, where mediation in triadic settings is conceptualised on a continuum from the most institutionalised to the most familial and personal. Section 6 offers the conclusion.

2 Literature review

The literature on interpreting in healthcare journals tends to be structured around two debates. The first concerns whether the interpreter should be an impartial conduit through which two languages flow or, alternatively, act as an advocate who is on the patient's side, taking up a strategic position and arguing their case (Greenhalgh et al. 2006; Robb and Greenhalgh 2006). The second debate is around the issue of professional versus lay interpreters where the argument is as much about affordable financial resources for the recruitment of trained professional interpreters as about the quality of the interpreting activity itself.

The two debates are often conflated in the assumption that an ideal model of communication is an unproblematic transmission of a message and that professional interpreters are best placed to produce this. The argument about the interpreter as a neutral tool or 'walking bilingual dictionary' (Ebden et al. 1988) stems from a long history of research and training that relates to conference interpreting in which linguistic accuracy, completeness and objectivity are the trademarks of the profession. While acknowledging the necessity of these standards in community and public service interpreting, Corsellis (2008) and Hale (2004) recognise that interpreting in healthcare settings is not simply a matter of the impartial transmission of accurately translated

information (see also Angelelli 2005). In these settings, asymmetries of power and knowledge are compounded by complex socio-psychological dimensions such as differing cultural assumptions and trust (Robb and Greenhalgh 2006) that require a more active role of the interpreter as an advocate or ambassador representing the patient (Haffner 1992) or as intercultural mediator and co-therapist (Singy and Geux 2005). A number of studies (e.g. Baraldi and Gavioli 2012; Bolden 2000; Davidson 2000; Pöchhacker 2004; Raymond 2014a, 2014b; Li 2015; Wadensjö 1998) have focused on participant structure at the micro-interactional level without necessarily addressing issues of trust or advocacy.

The main concern in the healthcare sector in the UK has been the relative value of professional versus lay interpreters. Government and medical council policies on the use of professional interpreters vary across countries. In the UK, the official advice from the General Medical Council (GMC) is that every patient who is in need should have the right to a professional interpreter. But, increasingly, the cost of such provision is part of a wider, negative debate about immigration and its financial and social costs.

In reality, most interpreter-mediated consultations in the primary care setting are with lay interpreters, usually family members (and so are often referred to as family interpreters). The extent to which such triadic encounters are successful has not been widely researched (but see Cordella 2011; Meyer 2012). In the healthcare literature they are generally assumed to be problematic (Cohen et al. 1999; Putsch 1985). However, a few studies based on interviews and focus groups suggest that there are benefits to using family interpreters. The involvement of another family member – even if it is a child as in the case of Free et al.'s (2003) study – brings intimate knowledge of the patient and emotional and interactional support to counter feelings of mistrust towards the institution of medicine and, on occasions, the professional interpreter.

Just as there has been little research on family members as interpreters, there is also little attention paid to the role of the family member as mediator as well as companion in monolingual encounters. And, indeed, these two areas of interest have not been compared systematically. Studies of consultations with family members as third parties have looked at the elderly (e.g. Coupland and Coupland 2000, Tsai 2007) or at children

(e.g. Tannen and Wallat 1983) and adolescents (e.g. Silverman 1987). The issue of autonomy in both geriatric and paediatric settings comes to the fore in the interactional sense. In his seminal study, Silverman (1987) proposes the metaphor of 'chauffeuring' to describe parental involvement in the discussion and/or resolution of sensitive issues concerning diabetes management of adolescent children.

Rather than seeing interpreter-mediated consultations and non-interpreter mediated consultations as separate phenomena, it is possible to see a continuum of roles and relationships across a spectrum, with the professional interpreter as gatekeeper (Davidson 2000) at one extreme, orientating towards medical norms (Bolden 2000), and the more strategically positioned 'chauffeur' at the other, personally involved in driving the interaction to its destination. Real-life consultations, however, are always characterised by role shifts along this continuum, as we will show in the data analysis section.

3 Data and methodology

The data for this paper is drawn from a London-based project: Patients with Limited English and Doctors in General Practice: Educational Issues (PLEDGE) (Roberts and Moss 2003; Roberts, Sarangi ad Moss 2004). Although the focus of the PLEDGE project was on how patients and doctors manage the consultation in English, inevitably, the data included a sub-set of patients whose relatives or friends acted as mediators in either monolingual or multilingual encounters. Of the 232 videos recorded for the PLEDGE project, just under a quarter were with a third party. And this is certainly an underestimate, since encounters with professional interpreters or triadic encounters where virtually all the talk was not in English were not recorded. Half of the recorded triadic encounters were between parents and their babies/children and the general practitioner (GP), and most of the remainder were with elderly people who were accompanied by younger relatives as carers, mediators or 'chauffeurs'. So, although the consultation, certainly in the western world, is normally thought of as a two-party encounter, a three-way consultation is absolutely routine (Cordella 2011; Swinglehurst et al. 2014).

All video recordings were viewed independently, three times, by 2 discourse analysts in order to screen for language and communication issues such as apparent miscommunication, repositioning of interactional alignments, and so forth, and the GPs involved were asked for extended feedback on key video footage. Two pieces of data will be analysed in detail, one of a (non-interpreter) mediated consultation with an elderly Cypriot woman who is a fluent English speaker and her daughter. The other is with a middle-aged Turkish woman and her daughter who acts as a lay interpreter as the patient displays no knowledge of English.

3.1 Analytical framework

Our analytical framework is informed primarily by Goffman's (1983) notion of the interaction order, in particular the concepts of 'interactional frame', 'participant framework', and '(mis)alignment'. 'Frame' (Goffman 1974) is a set of understandings and assumptions about what is going on at any particular moment in talk – which relates to structure of participation. A 'participant framework' (Goffman 1981) is a multiplicity of speaking and listening roles which may be operative at any given point in a social encounter. 'Alignment' points to how an individual's contribution is in line with the other participants in the interaction. Misalignment comes about when there are discrepancies between 'what is actually taking place in a given situation and what is thought to be typical, normatively expected, probable, desirable or, in other respects, more in accord with what is culturally normal' (Stokes and Hewitt 1976: 841-842). During interactions, changes in alignment imply changes in frame, with speaker and listener roles being in constant flux. Especially in three-way communication, the roles of listener and speaker can become complicated: which hearer is the 'ratified' one; is the speaker 'animating' someone else's talk or are they, in Goffman's (1981) terms, the principal or author? Beyond the interaction order, these questions can have social and moral consequences, for example, when the family member is speaking to the doctor, turning the patient into a bystander or when the conversation between patient and mediator drives the interaction into a new and more emotional environment not routinely ratified in GP consultations.

Aspects of narrative theory are also drawn on in the analysis. All three participants are actively co-authoring the story of the patient but we look here particularly at the ways in which the patient and the third party co-narrate, drawing on elements of the classic Labovian fully-fledged story structure (Labov and Waletsky 1967) and on 'small stories' (Bamberg and Georgakopoulou 2007) the fleeting, interactionally acomplished fragments of a given story.

4 Data analysis

4.1 The mediated consultation in English

Mrs S is an elderly Greek Cypriot woman who has a history of heart problems (with pain in her chest) and has come to the surgery, accompanied by her middle-aged daughter. She had been admitted to hospital the previous week but tests showed that she had not had another heart attack. The doctor in the video is highly experienced and, anecdotally, popular with patients. He is not the one she usually sees, so he has to quickly familiarise himself with her history and home situation.

Data Example 1

D=Doctor, P = Patient, R = Patient's daughter

01 D: so how have you been
(1.0)
02 P: I've been (.) in hospital
03 D: mm
04 P: for (. .) Monday I went in on Monday and I came out
05 R: last Monday yeah sh- she
06 P: I came out Tuesday didn't I
07 R: she had chest pains an- and she came down here and they sent for an ambulance an-
08 P: and sent an ambulance from here an' [took me]
09 R: [took her]
10 P: to hospital
(. .)
11 P: then I had all these (.) tests
12 D: mm hm
13 P: injections (.) was (. .) [then they]

14 R: [and they said]
15 P: sent me home
16 R: the following day
17 P: and today I feel= =
18 R: = =she doesn't- she doesn't feel
19 P: no' alright today
20 D: what's- what's happened
21 P: s- since this morning y'know I feel my heart is (1.0) it's got this= =
22 R: = =it's not a chest pain it's like (.) it's like a murmur-y feeling

In this opening, symptom presentation and history taking phase, the daughter's role as co-narrator is established. The patient starts the story *in media res* in turn 3, 'I've been in hospital', taking the most dramatic moment, for her, of the events of the previous week. The daughter first clarifies the time reference in turn 6, 'last Monday yeah', and also in turn 19, 'the following day', and uses this first entry to put herself in the frame of co-narrator throughout this early stage of the consultation. She provides situational detail (turns 8-9) in the classic Labovian narrative style (Labov and Waletzky 1967) and she latches onto her mother's evaluation at turn 20 to reinforce the evaluative narrative stage of this 'small story' (Bamberg and Georgakopoulou 2007). She also tries to bring a more institutional perspective into the narrative when at turn 17 she overlaps with her mother's account which centres on what 'they' did to her. Here she tries to shoe-horn in a reference to the hospital's results, aligning herself to the GP and to a more doctorable narrative for the health professional (Bolden 2000). Again, in turn 25, she reformulates her mother's somewhat unspecific reference to her heart into a specific, doctorable symptom, 'not a chest pain' but a 'murmury feeling'. Although never invited, explicitly, to act as a mediator, she takes on the role of an interactional mediator. She fills in and expands information, disambiguates, makes vague accounts explicit and provides an evaluative gloss.

In the second example, about ten minutes into the consultation, the doctor is about to take the patient's blood pressure. In the later feedback session with the researcher , he explained that by this point, he was almost certain that the patient had not had another heart attack but was presenting with symptoms brought on by stress or anxiety. He elaborates this theme as follows.

Data Example 2

231 D: are you under <u>stress</u> at the moment
(1.0)
232 R: she does get a bit stressed because of my dad
233 P: hearing problem
234 R: oh he just he doesn't hear very [well]
235 P: [you-] you explain to him [things]
236 R: [she] gets very-
she gets frustrated with him and he- (.) it's just silly little things but she gets worked up yeah
237 D: is that getting more of a problem than it was
238 P: it's getting worse because he's- <u>he's</u> getting worse (.) deaf (.) [shouting an']
239 R: [he's getting]
forgetful as well
240 P: an' course shouting at him makes him cross (.) ((to daughter)) it's the truth innit
241 R: mm
(2.0)
242 D: is it getting too much for you
(1.0)
243 P: my daughter says not to take any notice (.) but what can you-
(5.0)
((GP taking pt's blood pressure; mother and daughter exchange a glance and smile))
244 P: ((well I came here to tell the [truth innit]))
((sotto voce))
245 R: [yeah you] <u>tell</u> the truth

The doctor's social-psychological theme is met by silence from the patient who may be co-opting her daughter to speak for her. Certainly, the daughter treats the 1 second pause as a possible turn offer. She provides a context for her mother's stress while still implicating herself in this joint story of family difficulties when she categorises the source of the difficulty as 'my dad' (turn 232). The daughter is thus presenting herself as a ratified speaker of the family story, somewhat in contrast to a typical professional interpreter's role as a ratified speaker in facilitating clearer information and negotiating more interactional space (Wadensjö 1998). Her mother's explanation of the 'hearing problem' (turn 233) is reformulated out of the more medical arena into an imaginable social scene in which the irritation of trying to communicate with an elderly hard of hearing person bubbles over. Again, while the mother tells the story from her perspective

of how cross her husband becomes, the daughter, antiphonally, provides a perspective on her mother: 'she gets frustrated with him' (turn 236), providing an evaluative thread to the mother's story, while also aligning to the doctor.

At this point, the alignment of the daughter as an interactional mediator changes as her mother draws her away from speaking *for* her to speaking *with* her and so re-frames the encounter. The mother draws her daughter into a micro conspiracy in which she reiterates her position that she came to tell the truth (turn 244). In the following turn, the daughter is emphatic in her encouragement and moves from animating her mother's words and implicit stance to actively reinforcing them. In both parts of the sequence, she is acting as a mediator but the shift towards the end makes her an advocate, an explicit champion of her mothers' concerns.

In Example 3, which occurs about two minutes after Example 2, the doctor is trying to persuade the patient that she does not have a heart problem:

Data Example 3

266 D: but it's- it's not your heart
(2.0)
267 P: uh why do they tell us different things
268 D: well [nobody's saying anything different]
269 R: [who s- who said different] thing- who said different things
270 D: [who's saying]
271 P: [the hospi-]
272 D: anything different
273 P: the hospital
(1.5)
274 D: [well]
275 R: [well] they didn't they kept you in [they did]
276 D: [they kept you-]
277 R: some tests and they sent you- [sent]
278 D: [yes]
279 R: you home
280 D: they s- they told you it wasn't your heart as well (.) cos that's what it says on the letter if they told you (.) it would have been (.) what they would have said at [this time]
281 P: [no I] mean this time when I went in the second time
282 D: yeah it wasn't your heart this time (1.0) all the heart tests are normal (0.5) that's what it says in the letter

283 P: did they sa- did that say
284 D: yes
285 P: they never said anything to me
286 D: mm (.) well (. .) do you believe me
((touches her knee))
287 P: of course I believe you
288 D: you looked a little uncertain there (.) we've just clarified that one (.) now if it's not your heart then we have to think it might be something else

As can be seen, the doctor meets with some resistance when he tells the patient she does not have a heart problem at the moment. Her lack of information, possible confusion and possible mix-up over the two different occasions when she has been in hospital with a suspected heart attack may all be summarised in her rebuttal: 'why do they tell us different things' (turn 267). Over the next few turns, the daughter aligns with the doctor in refuting her mother's claim. First, the daughter echoes the doctor and then he echoes her, both of them stating the facts in order to shift the patient's stance. In turns 280 and 282, the doctor then draws on the medical evidence and the authority of the hospital letter as persuasive devices and, at this point, the daughter takes a back seat. At this juncture she is not needed to do any institutional work; nor is she needed when the doctor, in turn 286, has a conspiratorial moment with his patient, 'Do you believe me?'. In the earlier example, a similar moment between the mother and the daughter was about truth-telling (Example 2, line 240); here it is a moment about belief/trust. In both cases, it restores the patient's position after a momentary relegation to third party, or even merely 'overhearer' in the interaction. And, arguably, this moment of intimacy may have been influenced by the doctor overhearing this previous conspiratorial chat between the mother and the daughter.

The daughter's role in the early part of this extract is less about co-narrating and more about managing a mismatch in framing. While the doctor is in the frame of reassurance (the patient has not had a heart attack, which is good news), the mother treats it negatively as yet another example of institutions out to confuse her. While earlier in the consultation, the daughter has skilfully inserted context and stance to amplify her mother's somewhat elliptical story, here she more forcefully challenges her mother three times (turns 270, 277 and 279). She seems to be taking on a gatekeeping role, aligning

with the doctor to reassure her mother that she has not had another heart attack. We may conclude that 'frame work' is harder than 'narrative work', especially when, as the mediating companion, the re-framing is coupled with co-narrating (275, 277).

In the final example from this particular consultation, we see the daughter's role change again

Data Example 4

409 D: well why don't you have a think talk about it between yourselves first because you're two of the key players and see because it sounds like you're getting to a stage where it's getting a bit too much
410 R: I mean Mum- I think Mum needs to try and not worry too much I know it's easier said than done though isn't it
411 D: yes
412 R: I mean I'm the same cos I'm a worrier and I know I mean like my mum and the slightest thing
413 D: but the problem is that erm it's coming to a bit of a head

This extract, nearing the end of the consultation, shifts the role of the daughter from mediator to carer, as the doctor implicates them both in the management plan. The daughter takes the lead in responding to it, using herself as an example, 'cos I'm a worrier' (turn 412), to involve the doctor in understanding the complexity of the situation and so relegating her mother, momentarily, to third party status. The three-way alignment that the daughter has shown, in different stages of the consultation, is summed up here. She speaks *to* the doctor, shaping the patient's problems to the institution – what has to be tackled is 'not worrying'; she speaks *for* her mother – what a high level of worrying her mother experiences; and she speaks *with* her mother, in aligning her own worrying nature to her mother's.

The daughter's work, is to make the implicit explicit, expanding on her mother's stance, to disambiguate and act as a mediator between the voice of medicine and the patient's lifeworld narrative voice (Mishler 1984) and in doing so take on an advocacy role. Often this means that she offers an explanation or clarification unasked, interactional work which would otherwise have been done by the doctor. She co-narrates with her mother

but also with the doctor. However, she goes much further than this conventional role in her interactional mediation and advocacy as she expands her mother's stance, commenting on her mother's perspective as well. And threaded through all this is the intimacy of their shared history and lives which only a relative or close partner or friend could bring to the consultation.

Much of the literature on triadic consultations is critical of this advocacy and interventionist role. The majority of critiques concern the role of the designated interpreter but there are also critiques of triadic consultations more generally (Beisecker 1989; Vickers et al. 2015). Beisecker labels the third party as 'watchdog', 'significant other' or 'surrogate patient' – all used as rather negative terms – and concludes, as do Vickers et al., that it is a matter of control. While the third party appears supportive, the patient's voice is suppressed and the relationship between doctor and patient muted. However, we have tried to show that it is not a matter of *appearing* supportive only, but of using the trust and intimacy between the mother and the daughter to produce a jointly constructed co-operative plan where the patient may sometimes be the overhearer, but can benefit from being in this role. Speaking *for* someone is not a simple matter of depriving them of their voice. Indeed the patient's voice may be amplified by the family member most concerned for their wellbeing – as appears to be the case here.

4.2 The interpreter-mediated consultation

This consultation is with a middle-aged Turkish woman and her daughter, probably in her early 20s, who acts as the lay interpreter. The doctor is a nationally recognised general practitioner. She also specialises in mental health issues. The following data extracts are taken from the same consultation. The Turkish expressions are marked in bold and the translated expressions are in italic. The extract begins after greetings and the doctor first addresses the daughter and turns to the mother.

Data Example 5

D = Doctor, P=patient, R= daughter

07 D: how can I help your mum
08 R: **agrin nedir** *(what is your pains)*
09 P: **karnim agriyor sirtim agriyor bacagim agriyor** ( )*(I have got stomach ache pain in my back and in my leg)*
10 R: she say she's got pains in her chest and on her back and then it's a different pain in her knee ( ) up there
11 D: okay does she want to tell me about the pain in her chest a little bit
12 R: **nasil bir karin agrisi** *(what kind of pain do you have)*
13 P: **karnim buradan agriyor birde karnimin ortasindan agriyor beraber tam ortasindan ( )** *(I have pain here in my stomach then just in the middle of my stomach and together ( ) in the middle)*
14 R: so it starts here and goes to the back of her back so it's like the pain is from there to the back of her back ((daughter indicates the location of the pain))

The mother, who does not speak English at all, has come to the clinic complaining about her painful stomach, back and knees. In addition to translating her mother's words, the daughter clarifies the symptoms, adding a layer of precision to the patient's story ('it's a different pain in her knee' 'up there' and 'so it starts here and goes to the back' (turns 11, 12, 18)). This filling in and expanding of information pre-empts possible follow-up questions by the doctor and is similar to the role taken on by Mrs S's daughter in the mediated consultation in English in making the story more doctorable. In both cases, the daughters as carers draw on their 'insider knowledge' of the patients' situation to assist the doctor in reaching a workable diagnosis. They both seem to be acting as gatekeepers but also as amplifiers of the patients' voice, drawing the patient's world into the gaze of the doctor.

After the history taking, the doctor turns to the daughter to ask about psychosocial symptoms.

Data Example 6

61 D: your mother doesn't drink or smoke =does she=
62 R: =no=
63 D: ((laughs)) unlike the next =generation presumably=
64 R: =((laughs))=
65 D: ((laughs)) where are you from from Turkey
66 R: yeah
67 D: your mother seems a bit down is this how she normally is

68 R: no she is just suffering cos just her knee is really hurting her
69 D: right cos she seems quite sad and quite
70 R: ((laughs))
71 P: **ne oluyor** *(what is happening)*
72 R: **pek mutlu degilsin diyor** *(she said you don't seem very happy)*
73 P: **mutluyum canim** *(I am happy my dear)*
74 D: her knee is hurting knee's been hurting her for a long time hasn't it
75 R: yeah
76 P: **dizimin agrisi cok fazla** *(I have got very strong pain in my knee)*
77 R: because they usually it's because of the weight but it's just
78 P: **( )**
((sounds of clothes shuffling))

At the start of this extract, in contrast to example 5, the doctor has co-opted the daughter into the interaction, ratifying her contribution not as a lay interpreter but as a full conversational partner when she comments about the strong possibility that the younger generation may smoke and drink. She then, at turn 67, introduces the theme of the patients' general wellbeing. As in the earlier case study discussed above (see Example 2), it is when psychosocial topics are introduced that the doctor talks directly to the interpreter or mediator. But, as with the earlier case, the patient intervenes in turn 71 so that she is not sidelined by the doctor-daughter discussion. This intervention seems to confirm the daughter's explanation that her mother is not sad but in pain. However, unlike with Mrs S whose comments are all hearable by the doctor, this remark 'I am happy dear' (turn 73) is not translated. At this point the formal (and seen as ideal) turn taking system in professional interpreter mediated consultations, in which each turn by patient and interpreter must be interpreted (Li 2015), is not present.[ii] However, the daughter's absence of a translation but insistence that the knee is hurting may imply that sadness is not the problem.

Data Example 7

79 D: she's keeping warm with (your long johns)
((D touches patient's knee))
80 R: ((laughs))
81 D: ((laughs))
82 P: **agriyor usumesin diye iste** *(it is painful I wear those to protect myself from cold)*
83 D: where =does it hurt=
84 R: (she only) put one layer on today ((laughs))

As with Mrs S's encounter, above, the doctor shifts from third to second person and back again quite routinely. In turn 79, the doctor switches from 'she ' to 'your' in mid-utterance and reinforces this shift in attention with her bodily conduct by touching the patient's knee. The patient responds in Turkish, showing her moral self to the doctor (turn 82), as someone who is sensible in looking after herself. The daughter does not translate this but aligns with the doctor, maintaining the theme ('she only put one layer on today', turn 84), sharing the humour of long johns with her. But, arguably, she is also defending her mother with this utterance: possibly indicating that her mother's one layer is to ease any physical examination or that her mother is sensible but not over-protective of herself. While a conventional analysis might simply critique the daughter's conduct, we can read it in a more sympathetic light. It indexes her janus like role in representing her mother and also sharing the humorous aspect of the underwear with the doctor, underscoring the importance of maintaining friendly relations with the doctor.

As well as moments when lifeworld and moral themes are not translated, there are also misalignments when different functions of the doctor's utterances are filtered out from the daughter's translation for her mother. For example, in Example 8 below, the doctor's diagnosis of the patient's knee is not translated.

Data Example 8

103 D: the other thing is she's got quite bad knee there when you feel it you feel it scrape has your mother had any x-rayed
104 R: erm **x-ray olmustu senin dizinde degil mi** *(you have had any x-ray)*
105 P: **belimden mi dizim mi dizimden olmustu** *(from my back or knee I have had from my knee)*
106 R: **x-ray olduydu** *(you have had x-ray)*
107 R: yeah she's had an x-ray on her

Here we may notice a misalignment: while the doctor wants to convey her hands-on diagnosis as well as discuss X–rays, the daughter orientates to the more factual aspects of the diagnosis. It is plausible that the daughter wants to protect her mother from this negative diagnosis, choosing protection over autonomy, or, as elsewhere, editing out those aspects which she may perceive as not strictly pertinent to driving

the management plan forward. Or it may be a matter of competence – she may not be able to make sense of or retain or translate the idea of the knee 'scraping'.

Given the potential for misalignments in multi-party talk in this kind of clinical setting, great communicative dexterity is required on the part of the doctor. In the final data example below we see how the doctor, while trying to attain the primary goal of the consultation, i.e. the discussion of treatment options, orients to the daughter (who we must remember is a third party in this encounter) as well as the patient, even to the extent of allowing the daughter as lay interpreter a momentary role as second patient in the room.

Prior to turn 120, the doctor has just told the daughter that her mother's knee is quite bad and that she is to be referred to a specialist. The daughter becomes quite tearful at this point. So sadness is an issue in this encounter.

Data Example 9

120 D: what's the matter
121 R: I don't know ((tearful))
122 D: what's the matter I'm gonna have to ask your mother now in Turkish why you're upset
123 R: ((sobbing))
124 P: **ne oldu** *(what happened)*
125 D: ((to patient)) why is she upset
126 P: ( )
127 D: ((to daughter)) why are you upset
128 R: I don't know I get ((tearful voice)) I don't like to see my mum upset like that ( ) her knee is really ( ) can't ( ) some place ( )=
129 D: =I know I'm sure she's in a lot of pain actually which is why I'm going to refer her to a specialist but is that why you're so upset
130 R: uhm
131 D: so both of you are looking sad I was right
132 P: **ne oldu kotu bir sey mi dedi** *(what happened did she say something bad)*
133 R: **yo** *(no)* ((tearful))
134 D: you've got other brothers and sisters
135 R: hmm two brothers and two sisters
136 D: are you the youngest
137 R: hmm
138 D: ((to patient)) the baby your daughter is the baby the youngest
139 P: **ne diyor** *(what she said)*

140 R: **bir sey yok** *(nothing)*
141 D: alright

As the daughter becomes increasingly tearful, the doctor's gaze turns to her. The interpreter becomes, for a moment, the patient and is addressed directly as such. With an uncomprehending legitimate patient and a tearful interpreter-patient, the doctor has a complicated emotional and moral landscape to deal with. She uses several strategies. Firstly, she tries to clarify the reasons why the daughter is upset (turn 120), then twice aligns with the mother, first to ask about, and then to comment on, the daughter (turns 122 and 125). This need to align sympathetically with the mother while her daughter seems the most needy of the two overrides the obvious language barrier between the mother and the doctor. Again, the daughter does not translate the doctor's attempts to seek ways of supporting the tearful young woman but seems to treat the information about her family as a side-sequence. The doctor's 'alright' (turn 141) closes this moment and the mother and the daughter return to their conventional roles, with no clear resolution for the mother about whether the doctor has 'said something bad' (turn 132).

5 Discussion: The role of the mediator/interpreter – a tripartite continuum

There are clearly differences in these two triadic consultations. However, a comparison suggests that the bilingual one where the daughter acts as interpreter and the monolingual one where the daughter is the companion have more in common than the literature on interpreting versus other triadic encounters implies. There is clearly some information loss in the lay interpreter-mediated consultation, which is not so evident in the monolingual encounter. However, in the latter case, the daughter frequently latches on to her mother's utterances or takes the unfilled pauses, thus possibly subduing her mother's voice and her agendas. There is also a difference in the age and status of the two third parties. Mrs S's daughter is middle-aged and displays confidence and experience in helping her mother. Mrs T's daughter is young and appears relatively inexperienced as a carer. She plays a much greater role in explicating her mothers' stance and in evaluating her situation at home. These differences may contribute to some of the differences in the two encounters.

Nevertheless, what is striking about these two encounters are the main similarities in role and interactional alignments. Both daughters act as mediators, particularly in the early stages of the consultation involving symptom presentation and history taking, and in the diagnostic phase. The conventional sequential structuring of doctor to interpreter to patient to interpreter to doctor (Li 2015) makes this obvious in the second case study, especially during the symptoms presentation and history taking phases (turns 7-77, not shown in the examples). But even in the first case, there are examples of the daughter clarifying, disambiguating and making information more expectable. Both daughters also fill in and extend their mothers' formulations and so both do co-narrating work, although as mentioned above, Mrs S's daughter does more of the evaluating stage of the narrative than the younger woman in Mrs T's case. We could argue that both do linguistic work and both do gatekeeping, advocacy and are involved in the interactional management of doctor-patient relations and their own relations with both the other two parties.

The daughter as companion, the daughter as lay interpreter and the two doctors, on occasions, give third party status to the patients. Again this can be seen in the sequential structuring at different moments, marked by third person referencing and tag questions. It is also evident in the shift to third person and in the ways in which psychosocial topics are maintained and developed between third parties and doctors (for example the brief discussion on whether young Turkish people smoke and drink). This sharing of themes between the doctors and the two daughters is one of the skilful ways in which both sides manage the complex and potentially face-threatening aspects of the triadic encounter, when any of the three can potentially become the third party. In both case studies, the shift to a psychosocial topic produces third party status for the two patients but both intervene to re-enter the interaction by commenting on their situation.

Both the lay interpreter and the companion align to the institutional aspects of the encounter, but in rather different ways. Mrs S's daughter uses her mediation role to make her mother's presentation of self, symptoms and wider context more doctorable. For example, she translates her mother's rather vague description about her heart into a specific metaphor, 'murmury feeling'. Mrs T's daughter also works to make her mother's talk more doctorable but tends to align to the institution in a more gatekeeping way

(Davidson 2000) by treating the lifeworld aspects as side sequences that do not need valorising through translation.

Both daughters are carers as well as having a mediating role. Their presence in the consulting room establishes this, but it is also clear in the remarkable intimate, emotional and off-stage work they both do in disclosing their feelings and anxieties about their mothers. Mrs S confides, sotto voce, to her daughter that they had agreed that she would tell the truth and in the final stages of the consultation, the daughter discloses her own worried self in commenting on her mother's home situation. The young daughter's emotional labour as a carer is expressed more directly when she bursts into tears and her role as interpreter is temporarily suspended. In all these instances the supportive, collaborative and intimate relations between mother and daughter suggest a level of trust, unlikely to be found in consultations with professional interpreters (although for a counter example see Wadensjö (this issue) where the professional interpreter seems to build trust between patient and doctor). Both examples are notable for the display of feelings and the close and loving relationships between mother and daughter, punctuated by moments of frustration, and the caring respect tempered by glimpses of humour shown by each doctor to both patients and the daughters who accompany them.

Finally, all three parties attend to the complex participation frameworks in which three people manoeuvre around what is traditionally a two-way interaction. All three find intimate moments, local confederations, with one another when the main track of the consultation is subverted. This is done through sotto voce talk, talk in a language incomprehensible to the other which yet draws them in, and in non-verbal moments of touch to counterpoint other moments when the patient has been constructed as a third party.

5.1 Interpreter as social and linguistic intermediary

While the health care literature has been largely concerned with issues of provision and accuracy, the sociolinguistic literature has focused on the social and interactional aspects of the mediated encounter. The latter studies present the interpreter as a full participant with social agency and interactional rights and not a mere conduit (Ebden et al. 1988). In

much of this literature where the interpreter sits in relation to the continuum (see figure 1) is less important than how the conversational flow is framed and managed (Coupland and Coupland 2000; Li et al. 2017; Roy 1999; Wadenjö 1998). Sociolinguistic analysis has also examined how professional interpreters employed by the institution, such as a hospital, can act as gatekeepers. They manage the interaction, actively evaluating the patient's discourse to save the doctor's, and therefore the institution's, time (Davidson 2000).

The social and interactional lens transforms the mediated consultation into a complex negotiation of talk and social relations and provides analytic frameworks that allow interesting insights into the various roles called up in mediated encounters, from institutional gatekeeping to the intimate advocacy of a family member, as discussed here. Unlike previous studies, we have looked beyond the mechanisms of interaction to how trust, confidence and feelings are threaded through the family mediating and interpreting work.

The data analytical findings lead us to propose a role continuum to capture the dynamics of mediation as in Figure 1. Although these might appear as discreet roles, with professional/paid interpreters on the left and family interpreters and mediators on the right, there are elements of all of these interactional roles in the data discussed above. There is evidence of: gatekeeping and more impartial interpretation and re-wording, elloboration and expansion to make patient's utterances more doctorable, advocacy, mediation of the more emotional and intimate aspects of the mother/daughter relationships and some 'chauffering' work, driving the consultation towards the daughters' goals.

Figure 1: The role continuum

Professional Interpreter (gatekeeper)	Professional interpreter (impartial)	Cultural mediator (advocate)	Lay/family interpreter	Companion mediator	Chauffeur

6 Conclusion

In this paper we have explored the dynamics of triadic interaction in the primary care setting, where the co-present third-party positions herself either as a companion or as a mediator, the latter being the case when the patient has a low level of proficiency in the language of the clinic. Our findings show that such positioning cannot be simplistically framed in either-or terms, as shifts in interactional footing are routinely identifiable.

Family interpreters and mediators, who are also carers, have three different footings which continuously re-frame the triadic consultation. They speak *for* patients, in a representative role as ambassadors. They speak *with* the patients, as advocates of the patients' view and often echoing their stances and emotions. They also speak *to* the doctor, both directly and when the doctor is an overhearer. They mediate between the relative and the institution in making the patients' story more doctorable, summarising or eliminating aspects of the talk which they do not see as salient for the doctor, in a gatekeeping role. But this role is also subverted when they implicate themselves personally in the patient's world, living the patient's worries as in the first case study, or weeping for their mother, as in the second case study.

In many respects the lay or family interpreter has more in common with the companion in a monolingual setting than with the professional interpreter. Both family interpreters and companions take on partisan roles, becoming spokespeople or even 'authors' in their own right, or indeed in the suppression of information, in order to accomplish tasks that they deem to be necessary, orientating to both doctor and patient. In so doing they mediate not only the interaction but also the consultation process, and the feelings it elicits, and by implication the outcome of a consultation.

Most of the interpreting research literature only attends to the differences between professional and lay interpreters to air the problems with the latter and the need to replace them with professionals. It rarely looks at some of the valuable work done by lay interpreters and does not consider the triadic consultations where carers become mediators and take on linguistic and advocacy work. This study has outlined some of the

commonalities between family members as monolingual carers and as lay interpreters in multilingual encounters. The social and interactional work of the companion-mediators in representing and advocating on behalf of a relative is not questioned. But a similar task undertaken by lay or family interpreters is often criticised for not being sufficiently impartial and for depriving the patient of their voice and of control in the consultation (Beisecker 1989; Vickers et al. 2015).

Although information loss, inaccuracies and an undermining of patient control remain potential problems in family interpreting, the value of family interpreter's understanding and commitment to the patient, who is also their relative, may bring advantages which are not widely voiced, in particular to the opportunities in such encounters for feelings to be surfaced and attended to. Some patients seem to prefer a family interpreter to a professional one and more research comparing the two will help to establish whether they are justified in their preference. Similarly, more research on the role of the carer as an active mediator will help to bring this kind of triadic consultation into focus so that its significance in producing the best outcomes for patients can also be considered.

Appendix (transcription conventions)

The following transcription conventions are adapted from Psathas 1995.

[Overlap e.g.

] T: I used to smoke [a lot
B: he th]inks he's real tough

= Latching i.e. where the next speakers turn follows on without any pause
A: I used to smoke a lot= =
B: = =He thinks he's real tough

(.) Untimed brief pauses

(1) Timed pauses in seconds

(s'pose so)	Unclear talk / possible hearings indicated by stretch of talk in parentheses
( )	Unrecognisable talk, empty brackets
((bell sounds))	Description of conversational scene
((whispered))	Description of characterisations of talk

References

Angelelli, C. (2005) *Medical Interpreting and Cross-Cultural Communication*. Cambridge: Cambridge University Press.

Bamberg, M. and Georgakopoulou, A. (2008) Small stories as a new perspective in narrative and identity analysis. *Text & Talk* 28 (3): 377–396.

Baraldi, C. and Gavioli, L. 2012 (eds) *Coordinating Participation in Dialogue Interpreting*. Amsterdam: John Benjamins.

Beisecker, A. 1989 The influence of a companion on the doctor-elderly patient interaction. *Health and Communication* 1 (1): 55 – 70.

Bolden, G. B. (2000) Toward understanding practices of medical interpreting: Interpreters' involvement in history taking. *Discourse Studies* 2 (4): 387-419.

Cohen, S., Moran-Ellis, J. and Smaje, C. (1999) Children as informal interpreters in GP consultations: pragmatics and ideology. *Sociology of Health & Illness* 21 (2): 163-186.

Cordella, M. (2011) A triangle that may work well: Looking through the angles of a three-way exchange in cancer medical encounters. *Discourse and Communication* 5 4: 337-353. doi:10.1177/1750481311418100

Corsellis, A. (2008) *Public Service Interpreting: The First Steps*. London: Palgrave Macmillan.

Coupland, N. and Coupland, J. (2000) Relational frames and pronominal address reference: The discourse of geriatric medical triads. In S. Sarangi and M. Coulthard (eds) *Discourse and Social Life*, 207–229. Harlow, Essex: Pearson Education.

Davidson, B. (2000) The interpreter as institutional gatekeeper: The socio-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics* 4 (3): 379-405.

Davidson, B. (2002) A model for the construction of conversational common ground in interpreted discourse. *Journal of Pragmatics* 34: 1273-1300.

Goffman, E. (1974) *Frame Analysis: An Essay on the Organisation of Experience*. New York: Harper & Row.

Goffman, E. (1981) *Forms of Talk*. Oxford: Blackwell.

Goffman, E. (1983) The interaction order. *American Sociological Review* 48: 1-17.

Greenhalgh, T., Robb, N., Scambler, G. (2006) Communicative and strategic action in interpreted consultations in primary healthcare: A Habermassian perspective. *Social Science & Medicine* 63: 1170-1187.

Haffner, L. (1987) Translation is not enough: Interpreting in a medical setting. *Western Journal of Medicine* 157: 255-259.

Hale, S. (2004) *The Discourse of Course Interpreting: Discourse Practices of the Law, the Witness and the Interpreter*. Amsterdam: John Benjamins.

Labov, W. and Waletzky, J. (1967) Narrative analysis: Oral versions of personal experience. In J. Helms (ed.) *Essays on the Verbal and Visual Arts*, 12-44. Seattle: University of Washington Press.

Li, S. (2015) Nine types of turn-taking in interpreter-mediated GP consultations. *Applied Linguistics Review* 6 (1): 73-96.

Li, S., Gerwing, J., Krystallidou, D., Rowlands, A., Cox, A., and Pype, P. (2017) Interaction—A missing piece of the jigsaw in interpreter-mediated medical consultation models. *Patient Education and Counseling* 100 (9): 1769-1771.

Meyer, B. (2012). Ad hoc interpreting for partially language-proficient patients: Participation in multilingual constellations. In C. Baraldi and L. Gavioli (Eds.) *Coordinating Participation in Dialogue Interpreting*, 99-113. Amsterdam: John Benjamins.

Mishler, E. G. (1984) *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, N.J.: Ablex.

Pöchhacker, F. (2004) *Introducing Interpreting Studies*. London: Routledge.

Psathas, G. (1995) 'Talk and social structure' and 'studies of work'. *Human Studies* 18: 139-155.

Putsch, R. W. III (1985) Cross-cultural communication: The special case of interpreters in health care. *The Journal of the American Medical Association (JAMA)* 254 (23): 3344-3348.

Raymond, C. W. (2014a) Conveying information in the interpreter-mediated medical visit: The case of epistemic brokering. *Patient Education and Counseling* 97 (1): 38-46.

Raymond, C. W. (2014b) Epistemic brokering in the interpreter-mediated medical visit: Negotiating "patient's side" and "doctor's side" knowledge. *Research on Language and Social Interaction* 47 (4): 426-446.

Robb, N. and Greenhalgh, T. (2006) `You have to cover up the words of the doctor': The mediation of trust in interpreted consultations in primary healthcare. *Journal of Healthcare Organisation and Management* 20 (5): 434-455.

Roberts, C., Sarangi, S., and Moss, R. (2004) 'Presentation of self and symptom in primary care consultations involving patients from non-English speaking backgrounds. *Communication & Medicine* 1 (2): 159-169.

Roberts, C. and Moss, R. (2005) Explanations, Explanations, Explanations: How do patients with limited English construct narrative accounts in multi-lingual, multi-ethnic settings and how can GPs interpret them? *Family Practice* May: 1-7.

Roy, C. B. (1999) *Interpreting as a Discourse Process*. New York: Oxford University Press.

Sarangi, S. (2012) The intercultural complex in healthcare encounters: A discourse analytical perspective. In N. G. Patil and C. L. K. Lam (eds) *Making Sense in Communication*, 13-24. Hong Kong: IMHSE Publication.

Schouten, B. and Meeuwesen, L. (2006) Cultural differences in medical communication: A review of the literature. *Patient Education & Counselling* 64: 21-34.

Silverman, D. (1987) *Communication and Medical Practice: Social Relations in the Clinic*. London: Sage.

Singy, P. and Guex, P. (2005) The interpreter's role with immigrant patients: Contrasted points of view. *Communication & Medicine* 2 (1): 45-51.

Stokes, R. and Hewitt, J. P. (1976) Aligning actions. *American Sociological Review* 41: 838-849.

Swinglehurst, D., Roberts, C., Li, S., Weber, O. and Singy, P. (2014) Beyond the 'dyad': A qualitative re-evaluation of the changing clinical consultation. *BMJ Open* 2014;4:e006017.doi:10.1136/bmjopen-2014-006017

Vickers, C. Goble, R and Deckert, S. (2015) Third party interaction in the medical context: Code-switching and control. *Journal of Pragmatics* 84: 154-171.

Tannen, D. and Wallat, C. (1983) Doctor/mother/child communication: Linguistic analysis of a paediatric interaction. In S. Fisher and A. D. Todd (eds) *The Social Organisation*

of Doctor-Patient Communication, 203-219. Washington DC: Centre for Applied Linguistics.

Tsai, M. (2007) Who gets to talk?: An interactive framework evaluating companion effects in geriatric triads. *Communication & Medicine* 4 (1): 37-49.

Vertovec, S. (2007) Super-diversity and its implications. *Ethnic and Racial Studies* 30 (6): 1024-1054.

Vertovec, S. (2010) Towards post-multilingualism? Changing communities, conditions and contexts of diversity. *International Science Journal* 199: 83-95.

Wadensjö, C. (1998) *Interpreting as Interaction*. London: Longman.

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[ii] Out of the total of 177 turns in this three-party consultation, the doctor takes 68 turns, the daughter takes 80 turns and the patient takes only 29 turns.