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Constructing Language Normativity through the Animation of Stance in Spanish Language Medical Consultations

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Abstract

The purpose of this study is to examine the construction of language normativity as medical providers interact with patients and animate stance within Spanish language medical consultations. The context of the study is a clinic in which providers use Spanish to communicate with monolingual Spanish-speaking patients. This clinic is in the United States, an English-speaking macro-societal context. Findings indicate that providers who are second language users of Spanish animate stance and interact with patients in ways that English is constructed as normative and Spanish as marked. Implications include the need to consider how the construction of language normativity within medical consultations affects health outcomes.

Scholarship has addressed the asymmetrical power relationship between the relatively powerful medical practitioner and the relatively powerless patient in the medical consultation (Maynard, 1991; Mishler, 1984; Peräkylä, 2002; Sarangi, 2001). However, fewer studies have discussed ways that second language use in the medical consultation further exacerbates this already asymmetrical relationship with the exception of Roberts et al. (2004) and Martinez, (2008). Moreover, Martinez's work did not set out to look at face-to-face interactions within consultations, and though identity was of concern to Roberts et al., implications for understandings of power relations were not overtly the focus of their work. In this paper, we examine medical consultations between Spanish-English bilingual providers and Spanish monolingual patients. In these consultations, providers at times code-switch to English during these otherwise Spanish language medical consultations to animate administrative and authoritative stances. While these stances typically index power differences, we argue that the use of English to animate these stances indexes additional power constructions. It indexes English as normative and Spanish, the language the patients use, as marked within the consultations, creating further distance between the provider and the monolingual Spanish-speaking patient.

The purpose of this paper, then, is to examine through the analysis of discourse whether such English use indexes cultural assumptions about language superiority (and inferiority). We will also assess through the analysis of discourse the interactional effects of the providers' use of English to animate administrative and authoritative stances. Additionally, we will examine whether English-speaking dominant or Spanish-speaking dominant providers are more likely to use English to animate these stances. We address two specific research questions as follows:

1. What are the interactional effects of the providers' use of English to animate administrative and authoritative stances in the medical consultation?
2. Are English-speaking dominant or Spanish-speaking dominant providers more likely to use English to animate these stances?

Identity, Indexing and Stance

Identity is a notion that is constructed and performed in the process of interaction and much of this interaction is language based (e.g., Austin, 1975; Butler, 1997; Ochs, 1993). Moreover, identity constitutes a complex construct in that it is not monolithic but multi-aspected (Bailey, 2001). For example, people orient to different aspects of identity depending on the situation. In some instances, a woman may orient to a wife identity, in others a professional identity, and in others an athletic identity, etc. We define identity as flexible, fluid, and multi-aspected and as co-constructed in ongoing interactions in relation to specific contexts (Deckert & Vickers, 2011). One way to consider the processes of identity construction is in terms of how stances index multiple aspects of identity (Cutler, 2007) as people interact within specific contexts. We define stance as "social position ... invoking broad categories of participation in social life, such as class or ethnicity" (Cutler, 2007, p. 10).

Ochs (1992) pointed out that while linguistic forms are used to signal socially relevant information, there is not necessarily a direct correlation between particular linguistic forms and the social element being indexed. Ochs (1992) observed:

Rather, such knowledge entails tacit understandings of (1) how particular linguistic forms can be used to perform particular pragmatic work (such as conveying stance and social action) and (2) norms, preferences, and expectations regarding the distribution of this work *vis-à-vis* particular social identities of speakers, referents, and addressees (p. 341).

In other words, linguistic forms index stances, acts, and social meanings. The particular stances, acts, and social meanings, then, index particular aspects of identity. In the case of Ochs' study, she demonstrated that particular ways of using language index particular kinds of stances, acts, and social meanings that indirectly index gender. This social construction of gender through language, of course, varies according to social context and the communicative repertoire and competence of the interactants.

One important aspect of the performance of social identity is the way that individuals linguistically achieve stances. Dubois (2007, p. 163) defined stance as follows:

“a public act by a social actor, achieved dialogically through overt communicative means (language, gesture, and other symbolic forms) through which social actors simultaneously *evaluate objects*, *position subjects* (themselves and other), and *align with other subjects*, with respect to any salient dimension of value in the sociocultural field.” (italics added)

The notion of stance, then, is a useful one for an examination of how people position themselves in the world through language.

If we consider Ochs’s (1993) notion of indexing in conjunction with DuBois’ (2007) notion of stance, we gain a clearer picture of how the linguistic form that stances take indexes particular social identities within particular kinds of social context. Figure 1, which combines DuBois’s (2007) model of stance and Ochs’ (1993) model of indexing allows us to consider the important role of stance in indexical processes that contribute to the construction of social identities.

The triangle to the left represents DuBois’ notion of stance. As DuBois (2007) stated, “key to this configuration is a set of three entities (first subject, second subject, stance object) and a set of three actions (evaluation, positioning, alignment)” (p. 163). This configuration represents the fact that, when two people talk, they index stance in terms of the way they form utterances with regard to each other and to any other object in the world. As they formulate stance, they evaluate each other and any other object; they position each other and any other object; and they align with particular objects, people, and ideas. This can include, of course, the possibility that in relation to a certain object, Subject 1 and 2 can create a stance in which they align or do not align with one another. As they formulate stance, then, they co-construct identity as they use particular linguistic forms and languages to perform particular pragmatic acts.

Code-Switching and Stance

Scholars have discussed code-switching in a number of ways. For example, Arnfast and Jorgensen (2003) pointed out at least two types of code-switching when they argue that second language users code-switch to fill “gaps in the L2 learner’s vocabulary” and for “social negotiation purposes” (p. 50). They note that while code-switching used to fill gaps in L2 vocabulary is often “flagged” by hesitations or pauses, code-switching for social negotiation purposes flows smoothly with no such flagging. In the medical consultations that we examine here, providers code-switch in the way that many bilinguals do (Grosjean, 1982), for social negotiation purposes. Code-switching can act as a strategy for second language users to enhance meaning making potential.

The interpretation of code-switching as indicative of stance and as indexing particular kinds of social identities is complex. For example, in a study of code-switching in a Corsican classroom, Jaffe (2007) examined the stances that teachers take when they communicate with students in Corsican and French. Jaffe argues that evaluation on the part of teachers indexes an authoritative stance. In looking closely at evaluation on the part of teachers, specifically instances when they evaluated student contributions, she found that teachers used both Corsican and French, which positioned both languages “as equally important and

powerful” (p. 75). One language or the other may of course take on more power in specific kinds of evaluative usages in subtle ways.

A speaker’s choice to use a particular language in taking a particular stance, then, may reflect ideological notions about that particular language and by extension, it may reflect ideological notions of any other language being used. In Goffman’s (1981) terms, the choice of language to animate an utterance is important in terms of the construction of social identity. Similar to Jaffe (2007), we find that animating particular stances in English reflects ideological notions about the normativity of English.

Data

Study Context

The research site is a small community clinic located in an urban, low-income, largely Spanish-speaking neighborhood in California. Frequent use of Spanish on store signs and advertisements constructs a Spanish-speaking gestalt. However, it is important to keep in mind that a larger English dominant context in which English is the language of power surrounds this largely Spanish-speaking neighborhood. The clinic itself represents a bilingual context. For instance, the clinic provides all signs and brochures in Spanish and English and employs all bilingual staff. As stated in the clinic mission statement and service materials in clinic brochures, this clinic works to provide culturally sensitive, affordable care to patients. The mission of the clinic includes the employment of bilingual staff and that the clinic works toward shared decision making between provider and patient.

Data Collection

The current analysis derives from a corpus of audio-recorded medical consultations as well as written field notes of interactions that took place within the clinic. We collected the corpus over a period of nine months from October 2009 to July 2010, and includes +/- 100,000 words. We gained informed consent of all patients and providers who participated in the research. Audio-recording equipment was set up in each consultation room in the clinic for the purpose of recording the consultations. The data included a variety of participation frameworks (Goffman, 1981) in the consultations, which included one-on-one interactions between bilingual providers and monolingual Spanish-speaking patients, one-on-one interactions between bilingual providers and bilingual patients, and consultations in which a family member accompanied the patient. The participation frameworks also included various combinations of monolingual Spanish-speaking and bilingual patients and monolingual Spanish-speaking and bilingual third parties interacting with bilingual providers (triadic interaction). A researcher attended each medical consultation conducting participant observation and taking field notes. For this particular paper, we focus on interactions between bilingual providers and monolingual Spanish-speaking patients. The particular uses of code-switching that we will detail later in this paper are unique to the participation framework in which the provider is bilingual and the patient is monolingual, and the provider is aware of the patient’s monolingual status. All of the consultations that we analyze in this paper have such a participation framework.

The clinic staff included two bilingual nurses (Carrie and Laura¹), a bilingual medical doctor (Dr. Thomas), and one bilingual medical assistant (Maria) who was responsible for triaging patients. Interactions in the clinic, then, included patients and Spanish-English bilingual providers. We analyze consultations with Carrie, Laura, and Dr. Thomas in the present paper. Laura was Spanish dominant but spoke English as a second language, while Carrie and Dr. Thomas were English dominant but spoke Spanish as a second language. All patients self-identified as monolingual, Spanish-speaking in interviews with the research team. The data that we analyze in the present paper include Carrie's interaction with 20 monolingual Spanish-speaking patients, Laura's interaction with 14 monolingual Spanish-speaking patients, and Dr. Thomas's interaction with two monolingual Spanish-speaking patients. The consultations that we will analyze were the same in terms of both participation framework and speech event structure.

Transcription

We transcribed audio-recordings using the *Express Scribe* computer program. The transcriptions constituted the corpus from which we coded and tagged discourse. The transcriptions allowed us to examine a written and linguistically coded corpus of the interactions within the medical consultations. Transcripts of audio-recordings allowed for the fine-grained discourse analysis of the recorded consultations.

Data Coding

Once the two data coders had coded their data separately, they discussed any individual instances of apparent difference in coding and came to a negotiated conclusion to resolve any ambiguities or perceived differences. For example, the coders negotiated instances for which it was difficult to determine whether a participant's use of English was an example of self-talk or an example of interacting with a computer. In this example, we used additional information such as the clicking of a computer mouse or sounds of typing when they were present to determine that the interaction was an interaction with a computer rather than an instance of self-talk. However, since the two coders developed the coding rubric together as they conducted a preliminary analysis of the data and then participated in a pre-coding training session in which they reviewed each of the major codes in the coding rubric that they developed together, very few differences appeared in the two data coders' original sets of coding, and when differences did appear, the coders came to a mutually negotiated agreement about the proper code. Moreover, the coding rubric became open to categories that were not originally created when the coders developed the rubric. The coders then defined and refined these categories in the rubric and reviewed the rubric prior to each coding session, resulting in robust categories that were generated out of the data set. Moreover, to further test coding reliability, two trained coders conducted separate coding sessions for 20% of the data. Reliability of coding ranged from 95% to 100% between these two coders.

¹All names are pseudonyms.

Data Analysis

Data Analysis involved discourse analysis to analyze the micro-interactional moments in which particular stances were animated (DuBois 2007, Jaffe, 2007) in English and Spanish. Our approach to analysis is similar to that taken by Schiffrin (2006) who points out that speakers have linguistic choices about how to express themselves. Given these different linguistic choices, a particular linguistic choice implies a particular identity construction.

In our data, we focused on the forms of talk that are instantiated through particular lexical choices and grammatical forms. We categorized and coded these particular forms of talk. Much like Jaffe (2007), we then considered how the forms of talk we identified animated particular stances.

Having identified various forms of talk in the data, we then approached the analysis using methods associated with corpus linguistics (Biber, Conrad, & Reppen, 1998). Corpus linguistics is a field that examines large systematically gathered collections, or corpora, of language. As McCarthy and Carter (2004) define a corpus, it is constituted by “a collection of texts, whether spoken or written, typically stored in computer-readable form and usually with some organizing or uniting feature” (p. 147). Corpus linguistics provides a framework for considering the frequency of occurrence of linguistic features in a given corpus. Methods most typically employed include quantitative analysis, though qualitative analytic techniques are also important to the framework (Biber, Conrad & Reppen, 1998).

Though the focus of corpus linguistics is often particular grammatical features or lexical items, or three or four word lexical bundles (Biber, 2004), we argue that in line with a corpus approach, it is also possible to conduct frequency counts to examine the distribution of particular forms of talk. Such an analysis is somewhat different from a traditional corpus approach because it is not feasible for a computer program to search for particular forms of talk in the same way that one can search for linguistic items because as Ochs (1999) points out, forms of talk do not always share the same linguistic features at the level of the lexical item or the syntactic class.

By beginning with a discourse analysis in which particular forms of talk are categorized and coded, it is possible to conduct a computer analysis to count identified forms of talk by programming the computer to search for and count particular codes. This method of coding and counting allowed us to quantify the usage of each of the identified forms of talk in both Spanish and English.

Findings

As we present the findings, we first define administrative and authoritative stances and then present discourse analysis of particular instances of these forms of talk in interaction. We then move to quantitative analysis to demonstrate frequencies of usage of English and Spanish in our corpus. We have provided these descriptive frequencies to demonstrate that the English dominant providers have a different pattern of English usage while animating authoritative and administrative stances than the Spanish dominant provider does. It is

important to note that all of the providers were engaged in the same type of speech event, the medical consultation.

Two Types of Stances: Administrative and Authoritative

In analyzing the language forms used by the providers in this clinic, we found that they animated several types of stances. In the current section, we will focus on two of those stances and discuss how their use often normalizes English and marks Spanish. The two stances that we will examine are an *administrative stance* and an *authoritative stance*. We focus on these stances because they index power in terms of the clinic as an institution (administrative stance) and the authority of the provider (authoritative stance). Animating these particularly powerful stances in English constructs English as normative.

Administrative Stance

In the data that we will present, an *administrative stance* is demonstrated by at least two forms of talk: *bureaucratic side talk* and *think aloud*. We define *bureaucratic side talk* as the provider engagement in side talk (Goffman, 1981) related to aspects of clinic bureaucracy aside from interaction with the patient when the patient is present in the room. These examples include side talk related to doing the business of being a medical practitioner. They can include, but are not limited to, side talk with other practitioners about bringing in equipment to draw blood; a fellow practitioner sticking his/her head in to ask a question; or practitioners doing side talk as they work with computers on bureaucratic matters while the patient is in the room. As these examples indicate, we are using the term *bureaucratic side talk* to define any talk that had to do with matters of running the clinic and that did not directly engage the patient. Such side talk does not include the patient as a ratified participant but rather includes other clinic staff members or the computer as ratified participants. Due to the nature of the bureaucratic side talk as we have defined it, we argue that its use indexes an administrative stance.

Another of these forms of talk that indexes administrative stance occurs when providers *think aloud*. We define *think aloud* as instances when providers do not engage the patient as a ratified participant but rather engage in monologic formulations of their next move. Because the think aloud instances in these data were related to the ritual of doing the business of being medical practitioner, such as a provider trying to determine what medicine to give or providers talking to themselves about patient records, we argue that these think aloud instances also index an administrative stance.

Authoritative stance

Providers animate an *authoritative stance* when they engage in *evaluation* of patient stories and question responses. *Evaluation* is not, of course, the only way that people enact an authoritative stance in interactions. For instance, in our data, the providers animate an authoritative stance when they direct patients to make lifestyle changes or take particular medicines. However, we will limit our focus to *evaluation* in this paper since *evaluation* is the only animation of authoritative stance that occurred in English in our data and our focus is the effect of the use of English in these otherwise Spanish-language medical consultations. Providers engage in *evaluating* patient contributions during direct interactions

with the patient. Examples include when a provider says “good” in response to a patient’s explanation of a beneficial dietary change or the practitioner says something like “oh geez” when patients provide alarming records of their blood glucose levels. Such evaluations index an authoritative stance because they index the practitioner’s authority to evaluate patients’ medical situations.

Other interactions may index an administrative stance, an authoritative stance, or other stances. However, there is not one form of talk in particular that we see having as patterned a use of code-switching to English in the data as we do with *bureaucratic side talk*, *think aloud*, and *evaluation*. Therefore, here we focus on these three categories of forms of talk that involve indexing two main stances.

Discourse Analysis

Administrative Stance: Bureaucratic Side Talk

Since patients in this clinic are essentially monolingual, as they self-defined in their interviews, it is important to note in relation to the points we will articulate below, that these medical consultations are essentially recognized by the patients as Spanish-Spanish consultations. Once it is recognized that patients consider Spanish the normative language of these interactions, then the practitioner’s choice to use English becomes open for analysis. Consider, for example, what happens when bureaucratic side talk occurs in English.

Excerpt 1² involves Carrie and Rosana, a monolingual Spanish-speaking patient. Rosana has high blood pressure, and in lines 1 and 2, Carrie queries Rosana about the last time she had blood drawn. In line 4, Carrie then begins to review Rosana’s electronic medical record on the computer to determine if or when Rosana had blood drawn previously. Beginning at line 4, Carrie interacts with the computer as she reads Rosana’s medical record, which was recorded in English. Arrows indicate instances of bureaucratic side talk throughout the transcript.

Carrie’s code-switching from Spanish to English when she interacts with the computer adds another layer to the effect of the administrative stance. In lines 4–5, for example, Carrie code-switches back to whispered English as she engages with the computer to find Rosana’s blood results. Even though Rosana’s response in line 6, “no tengo memoria de esto” (I don’t have a memory of this), is in Spanish, Carrie’s “yes” overlaps in English with Rosana in line 7, and it is not a response to Rosana’s statement, but an utterance in response to the information she has found on the computer. In lines 9 and 10, Carrie briefly mentions to Rosana in Spanish that she did have blood drawn in February. However, to review the blood results, Carrie resumes her English interaction with the computer in lines 11–13 and 15–18 as indicated by her low volume and audible mouse clicking in the background. Ultimately, Carrie resumes her interaction with Rosana in lines 19 and 20 as she code-switches back to Spanish to reveal that Rosana does not have high cholesterol and to discuss the itching that Rosana had been experiencing on her neck.

²Transcription conventions are available from the corresponding author.

As Carrie engages in bureaucratic side talk, she indexes an administrative stance. The fact that the provider animates the administrative stance in English has additional consequences for the construction of the relative values of English and Spanish in the clinic context, which is partially because it indexes the fact that records are kept in English and by extension that English is the normative language of the extended social context outside this clinic. In other words, the use of English is marked in this Spanish-Spanish immediate context, and that markedness brings to the front that English is the language of the bureaucratic system and the normative language of larger context. Moreover, Carrie's animating an administrative stance in English exacerbates the already asymmetrical power relationship between patient and provider by creating another layer of distance.

Administrative Stance: Think Aloud

Think alouds, about scheduling, prescriptions, and dosages of medicine, among other bureaucratic topics, demonstrate administrative stances. When administrative work is done in English it displays the relative value of English and Spanish for administrative work.

The point here is not that the providers are speaking to themselves in English, It is also not that the providers are speaking English in front of monolingual speakers of Spanish, although this is a somewhat questionable act in terms of communication. The point is that administrative work is being done in English reinforcing that fact that English is the norm for administration in the extended social context.

Not only is the normativity of English re-constructed in such situations, but again the asymmetrical power relationship between provider and patient is re-constructed and reinforced by this added linguistic distance.

In Excerpt 2, Dr. Thomas consults with Arturo, a monolingual Spanish-speaking patient with diabetes. In the excerpt, Dr. Thomas is trying to schedule a follow-up appointment with Arturo, but she hesitates because of her uncertainty about her available dates.

As she considers when she can schedule the follow-up, she thinks aloud in English. Such thinking aloud is indicative of an administrative stance. Arrows indicate instances of thinking aloud in the transcript.

Throughout the excerpt, Dr. Thomas defaults to English to think aloud. In lines 1 and 2, Dr. Thomas is looking at a calendar to determine when Arturo should schedule his follow-up consultation as she had an upcoming trip to Guatemala planned: "oh that's February okay where's..where is it? (2.3) I can do this (2.5)." After she determines that she will be California in two weeks, she code-switches to Spanish in lines 3 and 4 to inform Arturo when he should schedule his appointment: "okay <L2> este es hoy (3.0) ah: no en realidad...en dos semanas estoy aqui" (okay <L2> this is today (3.0) ah: no actually...in two weeks I'm here). Dr. Thomas and Arturo continue to negotiate the date of the follow-up appointment in Spanish for the remainder of the excerpt.

While it would seem intuitive that thinking aloud would reflect language usage that is most natural and comfortable for an English dominant user and that *think alouds* are typically

monologic and internalized, it does not mean that such usage is also inherently neutral in the clinic context. In the Spanish-Spanish context in which power is unequally distributed, usage of English is not a neutral act, even if the provider is unaware of this lack of neutrality. The fact that we see a *think aloud* animated in English demonstrates, at its most neutral, that the bilingual provider identifies as an English user. Moreover, she identifies as an English user in a context in which English is normative in the macro-societal context.

In excerpt 2, the normativity of English is directly contrasted with the fact that Arturo is a monolingual Spanish speaker, so he does not have access to Dr. Thomas's *think aloud* as an English user would, which creates distance between him and his provider.

Authoritative Stance: Evaluation

Authoritative stances also demonstrate the power that one individual has relative to another in medical contexts. Authoritative stances are not neutral but are displays of the provider-patient power differential. When these displays occur in English, they involve other layers of power, particularly those related to language values in the extended context. Excerpt 3 involves Carrie and Cynthia, a monolingual Spanish-speaker who has experienced an injury to her knee. In the excerpt, Carrie evaluates Cynthia's movement of her knee as she aims to diagnose the pain that Cynthia had experienced. As Cynthia and Carrie co-construct the nature of Cynthia's pain, Carrie evaluates Cynthia's response in line 5 as indicated by an arrow. The evaluation, which indexes Carrie's authoritative stance, occurs in English.

After Carrie has Cynthia stretch out her knee, Carrie and Cynthia co-construct that idea that Cynthia's pain occurs when her knee is stretched (lines 1–4). In line 5, after Cynthia has followed Carrie's command, Carrie code-switches to English to quietly evaluate Cynthia's movement, "mkey that's good." In line 6, Carrie code-switches back to Spanish to continue her physical examination.

It is interesting in this example, that the provider uses the command form, *suéltelo*, with its inherent provider/patient power structure in Spanish. The use of *suéltelo* is of course necessary to communicate effectively with the patient to get her to move her knee. Conversely, the provider's evaluation of the move also animates the provider/patient power structure in a different way. Evaluations indicate that the provider has the interactional right to evaluate as the person in the interaction with interactional authority and, therefore, it indexes an authoritative stance. The fact that this evaluation happens in English indexes both the practitioner's stance, one of authority, and the practitioner's connection of this authoritative stance with English. The occurrence of evaluations in English is important especially when one considers Jaffe's (2007) claim that the code-switch to a particular language to animate an authoritative stance elevates that language, in this case English, as the more dominant and powerful language.

As noted, not all of the providers' administrative and authoritative stances were animated in English, and their choices to animate these stances in Spanish indicate a different construction of the relative values of the two languages. Laura, for example, was a provider who identified as a Spanish dominant bilingual. She was born in Peru and immigrated to the United States when she was 13 years old. In the following example, Excerpt 4, we can see

how the choice of Spanish to animate an authoritative stance through the use of evaluation in line 10 provides a more consistent interaction in Spanish and does not introduce notions of English language dominance into the context of the interactional event. In excerpt 4, Maria has already explained that she has experienced pain in her back. In the interaction, we can see that Laura, the provider, is entering data in the computer as she updates the patient's file.

A number of interesting interactions occur in excerpt 4. First, Laura is interacting with the computer and the patient while maintaining her interaction consistently in Spanish with a focus on the patient. We should note here that "Okay" occurs commonly in Spanish and can be considered a Spanish word. Second, the evaluation that occurs in this interaction is in Spanish. In line 10, when Laura responds to Maria's agreement that she had a tubal ligation in 2006 indicating that the records are correct, she uses the Spanish "excelente."

The evaluation indexes an authoritative stance and in engaging in that stance, the provider indexes the power differential between the provider and the patient. However, in the case of excerpt 4, the fact that Laura animates the powerful stance in Spanish does not add the additional layer of indexing the power of English in the way that we have seen in previous examples. In fact, it could be argued that the use of Spanish here aligns the provider with the patient as a fellow Spanish speaker and thus reinforces the solidarity between the provider and the patient, creating a more cohesive interaction and indexing Spanish as important.

Quantitative Analysis

Quantitative analysis demonstrates differences in the number of uses of the two types of stances. Though the percentage of English may not seem frequent, even the small pattern of use has important interactional consequences as we have seen in the discourse analysis. The purpose of demonstrating the frequency with which English occurs as providers engage in authoritative and administrative stances is not to argue that these uses of English happen enough to matter. Rather what is important is that switches to English while engaged in powerful stances happen in various ways, and that even one occurrence would index ideological assumptions about language superiority. The quantitative analysis most importantly demonstrates the fact that the English dominant providers tend to use English to engage in these stances, while the Spanish dominant provider does not.

Quantitative data demonstrate that the use of English is more pronounced with some providers than with others. We can see this partly in the amount of Spanish and English that each provider uses in these Spanish language consultations. Laura, for example, is a first language user of Spanish, and she almost always uses Spanish (98.83% Spanish and 1.17% English); Dr. Thomas, a second language user of Spanish, uses Spanish 93.61% and English 6.39%. Carrie is second language user of Spanish and, out of this group, she uses the least Spanish (84.63%) and the most English (15.37%). It seems, then, that some providers are more apt to use English than others. See Table 1.

In Table 2, we display the quantification of the *administrative stance* (which includes *bureaucratic side talk* and *think aloud*) and *authoritative stance* (which includes *evaluation*). We show how often these forms of talk occur as a percentage of each provider's total words spoken in the corpus. We then calculate the percentages that each of the providers used the

particular forms of talk in English and Spanish as a percentage of total use of each form of talk.

As shown in Table 2, these forms of talk occur repeatedly in the data. Carrie (5.10%) uses bureaucratic side talk more frequently than Dr. Thomas (2.4%) and Laura (.97%). Moreover, when Carrie and Dr. Thomas engage in bureaucratic side talk, they almost always use English. Conversely, Laura's bureaucratic side talk occurs in English 45.45% and in Spanish 54.55%.

Carrie and Dr. Thomas engage in think aloud at similar frequencies (3.47% and 3.07% respectively), while Laura does not often engage in think aloud (.26%). Carrie often uses English to think aloud (95.29%); Dr. Thomas uses mostly English (58.33%); and Laura's instances of think aloud are mostly in Spanish (84.75%). The second language users of Spanish think aloud more often than the first language user of Spanish, and they tend to think aloud in English.

Carrie evaluates 1.28%, Dr. Thomas .18%, and Laura .21%. Moreover, Carrie's evaluations are mostly in English (67.59%), while Laura and Dr. Thomas tend to use Spanish to evaluate. The quantitative analysis utilizes descriptive percentages to demonstrate that providers who are English dominant, second language users of Spanish tend to use English more often to engage in side talk, think aloud, and evaluation than the provider who is Spanish-dominant and a first language user of Spanish.

Conclusion

The data presented here demonstrate that different providers within the same clinic animate stances in ways that are not all neutral in relation to cultural constructions of the relative value of Spanish and English. We see this in particular as Carrie and Dr. Thomas seem to have a greater tendency to animate administrative stances and authoritative stances in English.

Although we do not have the data to comment on how provider styles contribute to health outcomes, we encourage further research that assesses how the use of a dominant language, in this case English, within a local language minority context may affect health outcomes. In light of Martinez (2008), it seems that language minority patients may be less willing to participate in a healthcare context in which their language is constructed as marked, and the dominant language is constructed as normative. In a context such as a medical consultation, it seems impossible for relations between providers and patients to be power neutral as powerful stances are inherent in medical interaction. However, it is important to consider how a choice of language exacerbates this power differential creating further distance between the patient and the provider.

Another important point here is that both Carrie and Dr. Thomas are second language users of Spanish. Though their styles of language use are different, we should consider how language competence plays into their patterns of language usage that contribute to the construction of English as normative. We need to consider whether these providers realize what their language use is like and explore their attitudes toward such usage.

As we have demonstrated, English is constructed quite often as normative within consultations with Carrie and Dr. Thomas as they animate powerful stances. In Jaffe's (2007) terms, these providers construct English as "important and powerful" (p. 75) and Spanish as marginal and subordinate. Laura, on the other hand, uses English infrequently. English is normative in the macro-societal context within which the clinic we studied is embedded, but the clinic is supposed to be a context in which language minority Spanish-speaking patients can find a haven of Spanish normativity. Laura's use of Spanish is much more aligned with this type of context. The status of Spanish depends on provider style and possibly language competence. Long-term ethnographic studies that follow minority language patients whose providers consistently maintain the use of the minority language with their patients even during powerful stances in contrast to patients whose providers code-switch during powerful stances would be beneficial in obtaining health outcomes data.

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Figure 1.
Indexing and Stance

Table 1

Corpus Quantification (English and Spanish)

	Laura	Carrie	Dr. Thomas
Total Words	22707	22609	5088
Total Words in English	265	3475	325
Percentage of English	1.17%	15.37%	6.39%
Total Words in Spanish	22442	19134	4763
Percentage of Spanish	98.83%	84.63%	93.61%

Table 2

Administrative and Authoritative Stances

	Laura		Carrie		Dr. Thomas	
	#Words	%	#Words	%	#Words	%
Administrative Stances						
Bureaucratic Side Talk						
<i>Total out of Entire Corpus</i>	220/22707	0.97%	1,152/22609	5.10%	122/5088	2.40%
<i>Total English in Form</i>	100/220	45.45%	1,089/1,152	94.53%	122/122	100.00%
<i>Total English in Form</i>	120/220	54.55%	63/1,152	5.47%	0/122	0.00%
Think Aloud						
<i>Total out of Entire Corpus</i>	59/22707	0.26%	785/22609	3.47%	156/5088	3.07%
<i>Total English in Form</i>	9/59	15.25%	748/745	95.29%	91/156	58.33%
<i>Total English in Form</i>	50/59	84.75%	37/785	4.71%	65/156	41.67%
Authoritative Stance						
Evaluation						
<i>Total out of Entire Corpus</i>	47/22707	0.21%	290/22609	1.28%	9	0.18%
<i>Total English in Form</i>	1/47	2.13%	196	67.59%	0	0.00%
<i>Total English in Form</i>	46/46	97.87%	94	32.41%	9	100.00%

Table 3

Anomalous Spanish

	Laura	Carrie	Dr. Thomas
Total Words	22707	22609	5088
Words in Spanish	22442	19134	4763
Ungrammatical Spanish (Words)	0	229	578
Ungrammatical Spanish (%)	0.00%	1.20%	12.14%

Excerpt 1

Bureaucratic Side Talk

1	C: sacábamos sangre? (1.0) hace	<i>did we draw blood?(1.0) has it been a</i>
2	mucho?	<i>long time?</i>
3	R: m: :=	
4 →	C: <L1> =oh it looks like it (2 CLICKS)	
5 →	((whispers)) let me see	
6	R: no [tengo memoria] de esto	<i>I don't [have a memory] of this</i>
7	C: [yes]	
8	R: ((xxx))	
9	C: <L2> hace: hac— <L1> yeah <L2>—	<i>it's has been has</i>
10	en febrero ... sacábamos <L1> ((to	<i>in February ... we drew</i>
11 →	computer)) let's see. how'd that looked	
12 →	(CLICK) (5.5, CLICKING) oh... @that's	
13 →	@okay @@@ okay:: <L2> bien bien	<i>good good</i>
14	(1.0) mira muy bien todo (1.0) okay <L1>	<i>everything looks good</i>
15 →	good (CLICK) other test? ((whispers)) and	
16 →	what was that ... we did (2 CLICKS)	
17 →	<TSK> two five (CLICK) two five (2	
18 →	CLICKS) it's that one (1.0) same thing	
19	(2.0, CLICKING) ((to R)) no tiene	<i>you don't have</i>
20	colesterol ni nada	<i>cholesterol or anything</i>
21	R: no (CLEARS THROAT)	
22	C: <L1> nope <L2> mira muy bien <TSK>	<i>it looks very good</i>
23	okay ... entonces (0.5) esta comezón ...	<i>okay ... so (0.5) this itch...</i>
24	le duele el pecho?	<i>does your chest hurt?</i>

R= Rosana; C= Carrie

Excerpt 2

Think Aloud

1 →	DT: oh that's February okay where's ..where	
2 →	is it? wait a minute (2.3) I can do this (2.5)	
3 →	okay <L2> este es hoy (3.0) ah: no en	<i>this is today (3.0) ah: no</i>
4	realidad...en dos semanas estoy aquí	<i>actually...in two weeks I'm here</i>
5	A: ((whispers)) sí	<i>Yes</i>
6	DT: la trece <L1> or <L2> la trece por la: ah	<i>the thirteenth or the thirteenth in the:</i>
7	A: mañana	<i>Morning</i>

A = Arturo; DT = Dr. Thomas

Excerpt 3

Evaluation

1	PC: =siento como..como me duele como el=	<i>I feel like..like it hurts me like the=</i>
2	C: =estirando?= →	<i>=stretching?= →</i>
3	PC: =uhuh [estirando]	<i>=uhuh [stretching]</i>
4	C: [estirando] okay y (.5) suéltelo	<i>[stretching] okay and (0.5) let it go</i>
5	(.5) <L1> ((quiet)) mkay that's good (.5)	
6	<L2> esta le duele?= →	<i>does this hurt?= →</i>

PC = Cynthia; C = Carrie

Excerpt 4

Evaluation

1	L: okay...(CLICK)...y en el pasado te dolía	<i>and in the past did it hurt</i>
2	la espalda como ahora o no?	<i>your back like now or no?</i>
3	M: m: no	
4	L: no?	
5	M: [no]	
6	L: [nun]ca esa es la primera vez...de las	<i>[ne]ver this is the first time...of the</i>
7	cirugías...tuviste <L2> tubal ligation <L1>	<i>surgeries...you had <L2> tubal ligation</i>
8	en el dos mil seis?	<i><L1> en two thousand six?</i>
9	M: sí	<i>Yes</i>
10→	L: okay...excelente...y: la familia tiene	<i>okay...excellent...and the family has</i>
11	diabetes?	<i>diabetes?</i>

M = Maria; L = Laura