Published in final edited form as:

J Pragmat. 2015 July ; 84: 154–171. doi:10.1016/j.pragma.2015.05.009.

Third Party Interaction in the Medical Context: Code-switching and Control

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Abstract

The purpose of this paper is to examine the micro-interactional co-construction of power within Spanish language concordant medical consultations in California involving a third party family member. Findings indicate the third party instigates code-switching to English on the part of medical providers, a language that the patient does not understand, rendering the patient a non-participant in the medical consultation. In these consultations involving a third party family member, monolingual Spanish-speaking patients are stripped of control in ways that are similar to other powerless groups in medical consultations. Implications include the need to further examine how micro-level interactions reproduce societal ideologies and shape policy on the ground.

Introduction

In the medical context, unequal power relations are micro-interactionally constructed as medical providers tend to take control over the content of the consultation (Mishler 1984, Heath, 1992, Heritage, 2005; Maynard, 1991; Stivers and Heritage 2001; ten Have, 1991). In part, medical provider control becomes possible because of the interview nature of the medical consultation. Like interviews more generally, the interviewer is typically in a position of power over the interviewee (Hutchby, 1996). As Eggly (2002) notes, the medical provider's questions and interpretations tend to become ratified as the provider and patient interact, shaping the constructed reality of the patient's ailment.

In this paper, we will examine the micro-interactional co-construction of power within Spanish language concordant medical consultations in a low cost community clinic in Southern California involving a third party family member; in addition, we will demonstrate

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that the presence of the third party instigates code-switching to English, a language that the patient does not understand. We will begin the paper by reviewing scholarship on triadic interaction, including the growing literature on triadic interaction in medical consultations. We will then demonstrate through conversation analysis (Schegloff, 2007; Sidnell & Stivers, 2013) how triadic interaction in bilingual medical consultations can result in the patient's non-participation (Hutchby and O'Reilly, 2010) as the third party and provider take control over the constructed reality of the patient's ailment in a language the patient cannot understand.

The consultations that we examine involve a provider and patient who are language concordant in Spanish. It is the introduction of a third party family member that instigates the code-switching to English within the consultation. Therefore, we are interested in instances in which provider-companion interaction occurs in a language the patient does not use and how such instances affect the micro-interactional co-construction of the patient's medical issue.

Data

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, 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 as part of the clinic mission is to provide language concordant care. For instance, the clinic provides all signs and brochures in Spanish and English and employs all bilingual staff.

Data Collection

Data was collected in the consultations of two nurse practitioners (Carrie and Laura). All names are pseudonyms. Carrie was a native English user and second language user of Spanish, while Laura was a native Spanish user and a second language user of English. The data for this particular paper is drawn from a corpus of 50 audio-recorded and transcribed medical consultations. 47 of these consultations were conducted in Spanish. The providers in our study routinely used Spanish more than English in their professional practice. We also collected field notes to gain a sense of the spatial arrangement and non-verbal expression of the participants, and we collected audio-recorded post-consultation interviews with patients and providers to gain self-report about the consultation. Finally, we conducted ethnographic work to gain an understanding of macro-level clinic policies. We collected the corpus over a period of nine months from October 2009 to July 2010. The corpus includes +/- 250,000 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.

Nine of the 50 medical consultations collected represented consultations in which there was a companion (triadic interaction). Of the nine consultations in which there was a companion, two contained the participation framework of interest to us in this particular paper. In these two cases, the companion and provider were both self-identified bilinguals in English and Spanish, and they used both English and Spanish in the consultation. These companions were native users of Spanish and highly proficient second language users of English. The patients in these two consultations, however, were self-identified monolingual Spanish speakers and used only Spanish during the consultation. These two consultations included the triad of Rosario (monolingual Spanish), her daughter (bilingual Spanish English), and Laura (bilingual Spanish English); and the triad of Luisa (monolingual Spanish), her daughter (bilingual Spanish English), and Carrie (bilingual Spanish English). Although two consultations represent a small percentage of our data set, the participation framework we examine is one that appears in clinical settings, such as the well-documented issue of family members acting as ad hoc interpreters in the medical context (see Leanza et al., 2010). In our data, triadic interaction was not common, and triadic interaction of the type studied here (monolingual patient and bilingual medical provider and third party) was even less common because the medical consultations we examined were designed to be language concordant in Spanish. However, in light of Leanza, we assert that the triadic interactions that we focus on have important implications for language minority people.

Third Party Interaction in the Medical Setting

In the medical setting, typical clinic visits are *dyadic* interactions. However, fine-grained studies of social interaction within the medical consultation have shown that the balance of power within the consultation takes on another layer of complexity when a third party family member, or companion, is present in the consultation (Adelman et al. 1987, 1991; Aronsson and Rundström, 1989; Beisecker 1989; Cahill and Papageorgiou, 2007; Coe and Prendergast 1985; Sakai and Carpenter, 2011; Stivers 2001; Bates and Meeuwesen, 2001; Tsai, 2005, 2007a, 2007b). In third party interactions in the medical contexts, like other kinds of triadic interaction (e.g., Barton and Tomasello, 1994), the presence of a third party family member seems to take floor time away from the patient, as companions address doctors rather than doctors addressing patients (Beisecker, 1989). According to Beisecker, companions tend to play the role of “watchdog,” “significant other,” and “surrogate patient.” Beisecker described the watchdog as a companion who “provided information for the doctor and elaborated on information provided by the patient, clarified or obtained information from the doctor for the patient (frequently questioning the doctor in the process), and challenged the truth of the information provided by the patient to the doctor” (p. 61). The significant other also directed attention away from the patient by causing the doctor to address the companion rather than the patient, “culminating in the patient’s being discussed by the doctor and the companion in the third-person form” (p. 63). When the companion acted as the surrogate patient, “they took over the patient’s role, interrupted the patient, answered questions for the

patient and provided unrequested information regarding the health problem, patient behavior, or patient feelings” (p. 65). Therefore, though companions seem to interact in ways that are supportive of the patient, their very presence is actually detrimental to the patient’s ability to co-construct reality with the doctor.

To illustrate, in a comprehensive review of the literature on triadic interaction in pediatric medical consultations, Cahill and Papageorgiou (2007) show that children do not have much floor time and that when parents interrupt doctor-child conversations, the doctor tends to orient toward the parent, initiating a doctor-parent dyad that excludes the child. As Cahill and Papageorgiou assert, “the adults dominate and control these consultations” (p. 910). It seems then that companions may take on quite powerful roles in medical consultations, whether “watchdog” or parent. However, Stivers (2001) demonstrates that although doctors most frequently select children as “problem presenters,” the parents most often end up presenting the problem. Parents do not simply grab control away from children. Rather, they do not present problems unless children have demonstrated difficulty in doing so themselves, and some parents give children more time to formulate their problem than others do (Stivers, 2001).

The role of the companion may also be contingent on the provider style, on the segment of the consultation, and possibly on the medical condition of the patient. In a study of triadic medical consultations in Taiwan, Tsai (2007) found that patients actually contribute more than companions in the “information-providing cycles.” Conversely, companions seem to contribute slightly more than patients in the “non-information-providing cycles.” As Tsai asserts, “The patients mainly participate in activities of providing information to the doctors and the companions in gathering or responding to information regarding the diagnosis and management plan” (p. 43). Moreover, in the case of Sakai and Carpenter’s (2011) study of triadic interactions in consultations involving dementia patients and their companions, neither the patient nor the companion was afforded much floor time. Rather, the doctor dominated the conversation and used power laden linguistic features.

Additionally, the complexity of third party interaction in the medical consultation can involve a similar kind of playing with the participation framework as Mateosian (2005) identified when lawyers construct witnesses as animating the message of a third party author.

Multilingual Triadic Interaction in the Medical Consultation

Research on triadic interaction in the multilingual medical consultation involves studies on the presence of an interpreter in consultations in which the provider and patient lack language concordance necessitating an interpreter to mediate communication between the two (Cambridge, 1999; Davidson, 2000, 2001; Hsieh, 2007; Pasquandrea, 2011; Valero Garcés, 2005). Some types of interpreters seem to lead to better patient care outcomes than others. Valero Garcés (2005) demonstrates differences between triadic interactions involving interpreters of two types. The first type involves the husband of the patient who acts as an ad hoc interpreter and the second type involves a trained interpreter. Her comparative study indicates that less information loss occurs with the trained interpreter than with the ad hoc interpreter.

However, trained interpreters are afforded control over the flow of information in the consultation that can be detrimental to patient care outcomes. Davidson (2000, 2001) asserts that interpreters tend to play a powerful gatekeeping role, deciding which information to convey to both the provider and the patient. Furthermore, Hsieh (2007) argues that interpreters tend to play the role of co-diagnostician, which may negatively affect the formation of relationships between providers and patients, and Cambridge (1999) demonstrates the loss of information that occurs when providers, interpreters, and patients engage in “language switching.” In these cases, the interpreter has control over which information to include in the process of interpretation. Therefore, neither the patient nor the provider has access to the full range of information conveyed. Interpretation is of course a kind of code-switching that takes place in the medical consultation, and as studies of interpretation demonstrate, it is the person who has access to both languages in use in the medical consultation who carries the interactional power.

Data Analysis

Code-switching has of course been extensively studied as an important conversational phenomenon among bilinguals (Auer, 1984, 1998; Blom & Gumperz, 1972; Bullock & Toribio, 2012; Gardner-Chloros, 2009; Gumperz, 1964, 1982; Heller, 1988, 1992; Myers-Scotton, 1993, 2006; Wei, 2000, 2005; Zhang, 2005). In this paper, we employ a conversation analytic approach to code-switching in our analysis of data (e.g., Auer, 1984, 1998; Cashman, 2005; Gafaranga, 2001, 2005; Milroy & Muysken, 1995; Wei, 2000, 2005). However, similar to Zhang (2005), we also examine “the relationship between macro level social structures and microlevel conversational structures” (p. 276) in an effort to understand how Spanish-English code-switching works in the construction of power and control in the medical consultations under examination here.

Micro-Analytic Approach to Code-Switching

In our analysis of data, we analyzed transcripts of medical consultations, concentrating on how participants make meaning in the medical consultation interactions as they go along (Garfinkel, 1967; Goodwin & Heritage, 1990). As such, in line with conversation analysis (Schegloff, 2007; Sidnell & Stivers, 2013), we engaged in a sequential analysis of the conversational events within the medical consultation.

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...code-switching is essentially a conversational activity; it takes place within specific conversational contexts; it is structured in accordance with the general conversational organisation. The starting point of any meaningful analysis of bilingual code-switching must therefore be its location in the conversational context in which it actually occurs.

Code switching is to be expected in a study of bilingual people, and as Auer (1998) asserts, interactionally relevant instances of code switching carry situated meanings. It is therefore

important to understand how particular instances of code-switching are interactionally relevant. A Conversation Analytic (CA) framework allows for a turn-by-turn analysis of how meaning unfolds in the process of conversational interaction as the conversational participants themselves orient toward particular meanings. We took this sequential approach to conversation in this paper.

We were particularly concerned with processes of co-construction that occurred in our data. Co-construction is defined as “the joint creation of a form, interpretation, stance, action, activity, identity, institution, skill, ideology, emotion, or other culturally meaningful reality” (Jacoby and Ochs, 1995 p. 171). As people interact, participants co-construct the participation framework and in turn whose contributions carry more weight. Hutchby and O’Reilly (2010) show how participants in family therapy session, particularly children, are relegated to “half-member” status as other participants, particularly parents, fail to ratify them and author their contributions during conversational interaction in the therapy session.

Footing

When Goffman first introduced the notion of footing (Goffman, 1981), he used a bilingual conversation to vividly illustrate how a switch in language accompanies a switch in social role and alignment. We were concerned with footing, particularly the shifting participation framework and production format (Goffman, 1981) that occurred during third party interaction. Understanding who was a ratified participant and who was authoring patient accounts was important to our analysis of interactional control. Goffman (1981) defined footing as follows: “the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance. A change in our footing is another way of talking about a change in our frame for events ... participants over the course of their speaking constantly change their footing, these changes being a persistent feature of natural talk” (p. 128). Goffman’s footing then allows for the analysis the laminated structure of roles involved in the production of an utterance. One person may be the principal, meaning the person whose views are being expressed in an utterance. Another person may be the author, the one who authored the content of a message, and yet another person may be the animator, the one who delivers the utterance. One person may of course play all three roles, or the roles may be divided among various individuals. Footing also allows for a complex examination of participation in which hearers take on different roles, including status as ratified, addressed, or unratified, not addressed, participant.

CA studies have taken up Goffman’s notion of footing to understand how institutional roles are interactionally achieved (Greatbatch, 1988; Hutchby, 1996). Through the sequential analysis of conversational interaction, we identified changes in footing that occurred in our data as the three participants expressed their alignments within the three party bilingual medical consultation.

Macro-Analytic Approaches to Code-Switching

We also found that it was important to analyze how code-switching related to the macro-level social structure within which the medical consultations were embedded especially because by code-switching, the participants were making relevant their identities as

members of particular macro-level groups within the context of Southern California. Although attention to macro-level social structure seems to be in opposition to CA's goals of identifying how the conversational participants build context by orienting toward particular kinds of meanings within the conversation itself, an increasing number of scholars have argued that it is possible to examine data from an integrated approach in which analysis of both the micro-interactional level and the macro-level social structure work together to explain interactional phenomena (Auer, 2005; Cashman, 2005; Gafaranga, 2005; Zhang, 2005).

One important concern that requires examination of the micro and the macro is how participants index membership categories in the process of conversational interaction. Auer (2005) poses important questions with concern to how studies of code-switching in particular might consider the relationship between the micro and the macro. He asks "first, what kind of identity predicates (membership categories) can the alternating use of two languages be an index of in conversation? And second, how, exactly, can such an index be shown to be interpretively relevant?" (p. 404). Participants produce macro-societal social structure as they interact with each other. In a CA study of Putonghua and Cantonese code-switching on a talk radio show in Hong Kong, Zhang (2005) demonstrates that "the host seems to try to strike a balance between the program's base language and the caller's choice at a conversational level, and between the regional and the standard dialects at the societal level" (p. 371). Zhang further makes the argument that the use of particular languages on the talk radio show indexes the ideologically hierarchical relationship between the languages at the societal level. As Zhang concludes,

"...through sequential analysis of naturally occurring data of talk-interaction, we are able to discover members' procedures for doing code-choice and codeswitching. We hope to have shown here that individual acts of speech and interaction at the microlevel allow participants to 'play out' the social structures relevant to the macrosociolinguistic setting in which particular speech events are situated" (p. 372).

Similar to Zhang, we also took the step in our analysis to focus on how what occurs in the micro-interactions within the consultations involves a playing out of macro-societal structure as made relevant by the participants in their choice of language.

Findings

In the excerpts that follow, we demonstrate ways that the third party companion takes "the role of the other" (Schiffrin, 1994, p. 131) and the consequent disempowerment of the patients as they become half-members (Hutchby and O'Reilly, 2010). We further demonstrate the process of patient disempowerment that occurs because of the loss of information for the patient when the provider and third party communicate in a language the patient cannot understand.

Speaking for Another: Third Party Constructs the Patient's Stance

In excerpt 1, the provider, Laura (L), consults with a patient, Rosario, whose main concern is treating diabetes. Laura gives the patient a treatment plan for the patient's diabetes in lines

1–8 based on the patient history that she had received earlier in the consultation. Then in line 9, Laura changes the topic to the patient's skin tag, which the patient's husband had brought up earlier in the consultation as a concern. He indicated that the skin tag scraped her when she walked making walking difficult for her.

Excerpt 1

Nurse Practitioner: Laura (L), Patient: Rosario (R), and Companion: Husband (H)

-
1.	L:	=dos cientos cincuenta miligramos (.) tres veces al día (.) okay? después de	
2.		Trazodone ya te dije vamos a tratar de bajar [un]	
		<i>=two hundred fifty milligrams (.) three time a day (.) okay? after the Trazodone I already told you that we're going to try to lower [a]</i>	
3.	R:		[sf]
[yes]
4.	L:	poco (.) y eso del skin tag me puedes enseñar?
<i>little (.) and this about the skin tag can you show me?</i>	
5.	R:	(1.0) okay	
6.	L:	(.5) heh heh heh okay	
7.		(3.0) ((Laura examines the skin tag))	
8.	H:	you're gonna cut off her (.) skin tag?	
9.	L:	well I wanna take a look at it (LOUD BANG) let's see what we can do	
10.		(5.3) ((Laura examines the skin tag))	
11.	R:	traigo un curita porque no me:=
<i>I wear a bandaid because I don't=</i>	
12.	L:	=hm=	
13.	H:	=she she wanted me to cut it off but I wouldn't dare	
14.	L:	mhm oh that's just nothing	
-

Laura examines the skin tag in line 7, and the husband asks in English in line 8 if Laura intends to cut off the skin tag, speaking for the patient. By asking about the provider's intention with regard to the skin tag, the husband seems to be playing the role of “watchdog” (Beisecker, 1989) by clarifying what the provider's intention is. The code-switch to English serves as a contextualization cue (Auer, 1984, 1998; Wei, 2005) signaling a change in the participation framework from triadic to dyadic with Laura and the husband acting as the ratified participants. The husband and Laura's switch to English constitutes what Auer (1984) terms a language negotiation sequence. After the husband's switch to English in conjunction with his use of the technical term “skin tag,” Laura orients toward the dyadic participation framework he initiated by responding in English. We can also argue that her switch to English serves to align with the husband's watchdog role. Because the interaction between the husband and provider in lines 8–9 is in English, the patient becomes a non-participant (Hutchby and O'Reilly, 2010).

In line 11, after Laura had been examining the skin tag for 5.3 seconds, Rosario indicates that she wears a bandaid presumably to cover the skin tag, but her reason for wearing the bandaid is interrupted by her husband as he takes the floor and constructs Rosario's position toward the skin tag in English in line 13. He constructs a stance in which Rosario is

somewhat desperate to remove the skin tag. He even constructs her as taking dangerous measures to rid herself of the skin tag (“I wouldn’t dare”). The husband’s contribution in line 13 constitutes a change in footing (Goffman, 1981) in which Rosario is constructed as the principal of the message, while the husband animates Rosario’s position. Then in line 14, Laura downplays the seriousness of the skin tag, stating in English that it’s “nothing.” However, Rosario is not an addressed recipient. Indeed she could not even be an overhearer or an eavesdropper because she does not use English. Therefore, Rosario becomes an invisible participant as her husband speaks for her and positions her. Laura does not actually have access to Rosario’s position toward the skin tag but only to the husband’s construction of Rosario’s position as well as visual access to the skin tag. However, Rosario is powerless to contribute her position toward the skin tag because of the use of English. This is important because the skin tag is not a serious condition but its removal would be contingent on whether or not it causes the patient discomfort. The information loss for both Rosario and the provider is quite striking here. It is more striking because Laura and Rosario both use Spanish, so that there was no need to use English in this consultation.

Nevertheless, the provider proceeds as though Rosario wants the skin tag to be removed. As the excerpt continues, Laura examines the skin tag in lines 15–16 and seems to determine in Spanish in line 17 that the skin tag does not need to be removed. Laura’s switch to Spanish in lines 15 and 17 serves to ratify Rosario as a participant. In line 18, the husband switches to English and then in line 19 Laura indicates in English that she will remove the skin tag. It is interesting that the husband seems to translate for Rosario as the excerpt continues.

Excerpt 1, continued

Nurse Practitioner: Laura (L), Patient: Rosario (R), and Companion: Husband (H)

-
15. L: esta?=
 this?=
16. R: =hhh ow=
17. L: =() (.9) no lo tiene que sacar todo si ()
 =*(.) (.9) you don't have to remove all ()*
18. H: (.8) she was putting it on uh (.8) uh uh ()
19. L: (1.2) hm:: (1.5) okay
20. R: okay?
21. L: we can cut it off (.) entonces lo que voy a ah puede [hacer una]
 so what I am going to ah you can [make a]
22. H: [lo va a cortar]=
 [she's going to cut it off]
23. L: =una-haz una cita otro día porque estoy tan atrás de mi [schedule]
 =*a-make an appointment another day because I am so behind in my [schedule]*
24. H: [mhm]=
25. L: =hoy=
 =*today*=
26. R: =uhuh=

27. L: =otra cita solamente para [te corten eso]
 =another appointment only [to cut this off you]
28. R: [me estaba] poniendo esto pero=
 [I was] putting this on but=
29. L: =sí
 =yes
30. H: [she was] putting that on
31. L: [vamos a cortar]
 [we're going to cut]
32. H: va a cortarlo Rosario
 she's going to cut it off Rosario

In line 22, the husband translates what Laura had said in line 21 into Spanish. Laura then directs the patient in Spanish in lines 23–27 to make an appointment to have the skin tag removed. In line 28, Rosario indicates that she was putting on the bandaid, which Laura uptakes in line 29. It is interesting that the husband then translates what Rosario said in line 30 into English despite the fact that Laura uptook Rosario's turn and is a Spanish user. Laura then repeats the intention to cut off the skin tag in Spanish in line 31, and in line 32, the husband repeats Laura's contribution in Spanish even though Rosario could presumably understand what Laura had said since it was in Spanish. Rosario's husband, then, not only acts as “watchdog” but also as an ad hoc interpreter. However, his interpretation seems superfluous since Laura and Rosario both use Spanish.

Speaking for Another: Third Party Constructs the Patient's Question

As in the consultation in excerpt 1, the consultation in excerpt 2 also involves patient disempowerment and information loss as the third party bilingual daughter takes control over questioning the provider, Carrie. Throughout the consultation, the conversation moves between English interactions involving the daughter and Carrie, and Spanish interactions involving Luisa and Carrie. It is important to note here that in our estimation, based on conversations we had with the daughter in Spanish, that she was highly proficient in Spanish.

Luisa's primary concern was maintaining control over her blood sugar levels. She had been diagnosed with diabetes a few months previously. Her diagnosis was particularly traumatic because it occurred when she was admitted to the emergency room at a local hospital for a severely infected foot. Medical personnel informed her that her blood sugar was dangerously high and that the infected foot was likely related to the fact that she was living with diabetes. She was admitted to the hospital where her toe was amputated. Luisa's self-report during the consultation and the post-consultation interview revealed that she understood the medical personnel who treated her in the hospital as telling her that she could not eat any carbohydrates, sugary or fatty food. She reported that they indicated that not changing her diet could result in more amputations, coma, and death. At the time of the consultation with Carrie that we analyze here, Luisa was quite thin and reported depression and anxiety.

Excerpt 2

Nurse Practitioner: Carrie (C), Patient: Luisa (L), and Companion: Daughter (D)

-
1. C: podríamos hacer unas estudias de sangre..que puede decirnos como está su
 2. control: por los tres meses anteriormente [entonces]
we could do some blood work..that can tell us how your control is for the previous three months [then]
3. D: [oh okay]
4. C: =podríamos
 =we could
5. D: yeah but I mean su medicamento=
yeah but I mean her medication=
6. C: =yeah=
7. D: =is it is it really hi:gh or is it-
8. C: oh is it a lot of medicine? [no]
9. D: [yeah] no?
10. C: it's it's a really small dose
11. D: oh okay=
12. C: =((quietly)) it's a really small dose okay?
13. D: so no es mucho (.) hhh
so no it's not a lot (.) hhh
14. L: no es mucho a la azúcar (.) está normal?=
the sugar isn't a lot (.) it's normal?
15. C: =no no=
16. L: =y:[es:]
17. C: [it's not high]
18. L: cuántos pastillas-how many pills-
19. D: what kind of um: (.) qué tipo de diabetes tiene ella? one to two: [or]
what kind of un: (.) what type of diabetes does she have? one to two: [or]
20. C: [dos]
 [two]
21. D: dos
 two
22. C: [okay?]
-

In lines 1–2, Carrie proposes in Spanish to Luisa that they run blood sugar tests in response to Luisa's concern with her blood sugar control in the previous discourse. However, the daughter changes the topic in line 5 beginning the utterance in English and ending with the Spanish phrase “su medicamento.” Carrie then provides the backchannel cue, “yeah” in line 6, and the daughter continues in line 7 in English, asking if Luisa's medication is “really high.” Carrie rephrases the daughter's question in line 8 and responds that it is not a lot of medicine. The daughter is acting as “watchdog” (Beisecker, 1989) here. Similar to what occurred in Rosario's consultation, Luisa becomes a non-participant because the provider and daughter begin at line 5 to interact in English, a language Luisa does not use.

Carrie and the daughter continue to clarify that Luisa's medication is a small dose in lines 9–12. Then in line 13, the daughter translates the exchange for Luisa, but the translation results in information loss as the daughter ellides what precisely is not high. Luisa specifically asks the provider if her blood sugar level is not high, if it is normal, in line 14. Carrie confirms that the blood sugar is not high in lines 15 and 17. Luisa, however, seems to attempt to change the topic starting at line 16 and into line 18 to the medication. However, her daughter asks a question in English in line 19 that usurps the floor from the mother, and it is the daughter's topic that the provider uptakes. What is important to notice here is that Luisa does not receive the information about her medication, and the topic of the dose does not come up again as the consultation continues. The daughter grabs control from her mother in the consultation by asking questions in English, a language her mother does not use. Indeed this grabbing of control is even more disempowering for Luisa because the use of English renders Luisa a non-participant, a half-member. Additionally, it causes considerable interference in the provider's ability to communicate clearly with Luisa.

Speaking for Another: Constructing the Patient's Account

Later in the consultation in Excerpt 3, Carrie educates Luisa about diet in Spanish, and Luisa explains her current diet. However, the daughter takes the floor and uses specific kinds of linguistic strategies to gain control over the positioning of her mother.

Excerpt 3

Nurse Practitioner: Carrie (C), Patient: Luisa (L), and Companion: Daughter (D)

-
1.	C;	=pero las cosas que puede comer cuando le gusta (.) es com-cosas (.) que:	
2.		so:n hecha que se hecha co:n productos de animal (.) por	
3.		ejemplo (.) l-leche (.) queso (.) estas cosas (.) okay yo sé que tiene queso	
4.		tiene en bastante grasa (.) pero es buena-buena cosa por su diabetes	
5.		porque queda en la panza y no sube el azúcar (.) [okay?]	
		<i>but these thing tht you can eat when you like (.) it's li-things (.) tha:t a:re made that are made with animal products (.) for example (.) m-milk (.) cheese (.) these things (.) okay I know that it has cheese has a lot of fat (.) but it's good-good thing for your diabetes because it stays in the belly and it doesn't raise the sugar.[okay?]</i>	
6.	Luisa;		[yo no] como comidas
7.		grasosas ni [nada]	
			<i>[I don't] eat like fatty food or [anything]</i>
8.	C;	[good]=	
9.	Luisa;	=como pescado	
		<i>=like fish</i>	
10.	C;	good	
11.	Luisa;	pescado lo que como y nopales y la lechuga=	
		<i>fish that like and cactus and lettuce=</i>	
12.	D;	=that's all she eats a::ll day=	
13.	C;	=oh my gosh (.) she must be <u>starving</u>	
14.	D;	y:es...and then she gets mad and then she cries porque dice (.) I'm still	

15. hungry [well]
16. C; [yeah:]=
17. D; =because you don't eat-
18. C; because you're eating nothing=
19. D; =y:eah:=
20. C; =okay porque no hay mucha nutrición en los nopales no hay mucha en la
21. la lechuga=
=okay because there's not a lot of nutrition in cactus and there's not a lot in lettuce
22. Luisa; =es por el azúcar me evita en todo el harina..puedo comer las nopales..sin
23. comida solo agua en la noche?
=it's because of the sugar I completely avoid wheat I can eat cactus without food only water at night
24. C; sí: sí porque tiene hambre tiene que comer comida comida [por]
ye:s yes because you're hungry you have to eat food food [for]
25. D; [heh heh]=
26. C; =ejemplo productos de animal como: um (.) tsk pollo co:[mo:]
=example animal products li:ke um (.) tsk chicken l:i[ke]
27. Luisa; [pollo] también
28. poco carne también=
[chicken] also a little meat also
29. C; =uhuh pero tiene que comer poco de esto diario (.) okay? le gusta: what
30. else can you eat? pescado es bueno (.) puede comer (.) um: (.) res (.) a
31. veces (.) okay? no no no: diario diario pero dos veces por semana puede
32. comer (.) um: carne de res...puede comer cualquier cosa..pero estas cosas
33. con mucha grasa (.) entonces tiene que comer menos...pobrecita no está
34. comiendo nada por eso está perdiendo peso porque está tan [controlada]
=uhuh but you have to eat a little of this daily..okay? you li:ke what else can you eat? fish is good..you can eat..um: res..soemtimes..okay? not not not daily daily but two times a week you can eat..um: meat de res..you can't eat whatever thing..but these things with a lot of fat..so you have to eat less..poor little thing is not eating anything because of this you are losing weight because you are so [controlled]

In lines 1–5, Carrie is in the process of giving Luisa educational information. However, Luisa's response in line 6 somewhat contradicts Carrie's recommendation. Even so, Carrie positively evaluates Luisa's contribution in English, "good." Luisa continues to describe her diet in lines 9 and 11, which Carrie positively evaluates in English in line 10, constructing Luisa as competent in managing her diet.

However, the daughter resists the construction of Luisa as competent as she adds "that's all she eats a::ll day" in line 12. Notice that "a::ll" in "all day" contains a lengthened vowel, which serves to emphasize the extended time period and give a somewhat urgent tone to Luisa's seemingly unvarying diet. It is also an extreme case formulation (Pomerantz, 1986), constructing Luisa's dietary habits as particularly extreme. Carrie aligns with the daughter's account in line 13 by stating that Luisa "must be starving" with prosodic emphasis on "starving." Carrie's use of the modal "must" also constructs certainty of Luisa's starving status. Thus, Carrie and the daughter co-construct Luisa as urgently malnourished in a language Luisa does not use.

As the daughter continues in line 14, she ascribes an emotional state onto Luisa (“she gets mad”), and then uses constructed dialogue (Tannen, 2007) to re-contextualize and construct the mother as angry because she is hungry. The use of habitual present tense constructs Luisa’s behavior as a pattern so that the daughter’s construction of her mother is a consistently angry, hungry person. Moreover, as Bauman and Briggs (1990) argue, “to decontextualize and recontextualize a text is...an act of control, and in regard to the differential exercise of such control the issue of social power arises” (p. 76). The daughter takes control over the construction of her mother’s social identity, and the provider legitimizes the daughter’s account. In line 17, the daughter says, “because you don’t eat.” Carrie’s repetition of the daughter’s contribution in line 18 (“because you’re eating nothing”) shows her involvement and agreement with the daughter’s construction of Luisa’s reality (Tannen, 2007). It is important to notice here that Carrie and the daughter deny Luisa access to this emergent English construction since Luisa does not use English. Therefore, Luisa is completely stripped of agency in positioning herself and resisting the way that her daughter and Carrie position her, rendering her a non-participant in her own identity construction.

Carrie switches to Spanish in line 20–21 to educate Luisa about the lack of nutrition in cactus and lettuce. Luisa then conveys her own stance in lines 22–23. Carrie expresses disagreement with Luisa’s stance in line 24 stating that she needs to eat “comida comida” (food food), which she defines in negotiation with Luisa through line 34. As excerpt 3 continues below, Luisa demonstrates resistance to Carrie’s advice, but in the end, Carrie and the daughter delegitimize the basis of her resistance.

Excerpt 3, continued

Nurse Practitioner: Carrie (C), Patient: Luisa (L), and Companion: Daughter (D)

-
35. Luisa; [porque] no_n_n_porque no
 36. quiero que me suba la azúcar porque me [dicen]
[because] no_n_n_because don't want to raise the sugar because they [tell me]
 37. C; [sí]=
[yes]=
 38. Luisa; =que si te sube la azúcar (.) te puedes (.) te puede k—puedes caer en coma
 39. si te sube mucho
=that if you raise the sugar (.) you can (.) you can k-you can fall into a coma if you raise much
 40. C; well es la verdad pero estamos dos cientos..no tiene coma hasta seis
 41. cientos..entonces te[nemos bastante verdad heh heh heh ? (.) lo siento que
 42. esta persona]
well it's true but we are two hundred..you don't have coma until six hundred..so w/e enough right heh heh heh? (.) I'm sorry this person]
 43. Luisa; [hasta que: ha_ha hasta que: no sé no]=
[until un_un until I don't know no]
 44. C; =le asustó tanto=
=scared you so much=
 45. Luisa; =hasta que numeraciones (.) puede afectar tanto uh paq—pudes caer

46. en coma?=
=*until numbering (.) it can have a big affect uh paq-you can fall into a coma?*
47. C; =aw ((sympathetic))
48. D; heh[heh heh]
49. Luisa; [a a qué] numero [puede:]
[*a a what*] number [*ca:n*]
50. C; [we:ll]=
51. Luisa; =llegar?=
=*it come?*=
52. C; =estamos muy lejos de coma (.) heh heh=
=*we are very far from a coma (.) heh heh*=
53. D; =((xxx)) like=
54. C; =mm:=-
55. D; =yo tengo tengo fa-amigos=
=*I have have fa-friends*=
56. C; =yeah
57. D; que ya de they go—they do um what's it called? when they go to sacar la
58. sangre y te lavaban? dialysis?=
=*that already de they go-they do um what's it called? when they to take the blood and you wash?*
dialysis?=
59. C; =oh yeah=
60. D; =and they eat (.) everything=
61. C; =yeah=
62. D; =and I [tell her]
63. C; [((xxx))]=
64. D; =you need to start eating you know=
65. C; =she needs to eat...we'll give her some information about [that]
66. D; [yeah]=

In line 35, Luisa resists Carrie's dietary advice. She frames her resistance as following the advice of the hospital providers who treated her. She uses indirect reported speech to recontextualize their recommendations. Luisa decontextualizes the advice of the medical personnel in the hospital to frame her resistance as legitimate. As Bauman and Briggs (1990) assert, "institutional structures and mechanisms confer legitimate authority to control texts" (p. 77), and legitimacy is based in assumptions about competence, "the knowledge and ability to carry out the decontextualization and recontextualization of performed discourse successfully and appropriately" (Bauman and Briggs, 1990, p. 76). In lines 40–42, Carrie puts into question Luisa's competence as she informs her that her blood sugar level is not close to what would invoke a coma. Carrie's contributions construct Luisa as lacking legitimate authority to recontextualize the texts produced by the medical personnel at the hospital. Carrie nails down this construction of illegitimacy in line 44 when she indicates that she is sorry that the hospital medical personnel scared Luisa so much. Then in lines 45–51, Luisa asks what blood sugar level would put her in danger of a coma. What is important to notice here is Carrie's response in line 47 (aw) and the daughter's laughter in line 48. Luisa's concern is that of the lovable incompetent (Goffman, 1981) who is not capable of

agency. In line 52, Carrie does not answer Luisa's question about the specific blood sugar level but simply informs her that she is very far from a coma. Carrie's contributions could be seen as reassuring moves and as Carrie putting forward a professional persona that gives her the authority to categorize Luisa's concern as non-urgent, a normal part of medical practice. Following Heritage (2009), Stivers (2005), and Stivers (2006), Carrie is working within her role as a medical provider to assert her competence in assessing symptoms. It is not uncommon for medical providers and patients to have moments of conflict regarding differing interpretations of symptoms based in the patient's experience and the provider's professional expertise. However, it is important to note that Luisa was orienting toward the critically ill person she had recently been, one whose toes had to be amputated because of uncontrolled diabetes rather than the healthier person she was in the current consultation. Luisa's trepidation related to diet is rendered invisible in terms of the treatment Luisa will receive. For instance, she is not referred to ongoing education classes or other means of empowerment. She is simply told that she is very far from coma.

In line 55, the daughter then switches between Spanish and English to provide accounts about friends who are living with diabetes and eat a wider variety of foods. The switch to English accompanies an attempt to come up with the word dialysis in Spanish. She circumlocutes in Spanish to describe the process of dialysis, and then comes up with the word dialysis, articulated with English phonology, which could indicate that the daughter did not know the word for dialysis in Spanish. Carrie responds in English in line 56 negotiating English as the new language of interaction.

The daughter then switches to English emphasizing "everything" in line 60. The daughter constructs herself as "the voice of reason," asserting a habitual action, "I tell her" in line 62, "you need to start eating you know" in line 64. Carrie aligns with the daughter in line 65 and legitimizes the daughter's concern by translating that concern into professional terms (Sarangi, 2001), stating that she will give Luisa information on diet. Luisa is of course a non-participant in this English conversation.

Clinic Policy and Bilingual Third Party Interactions

Through these excerpts, we have demonstrated that in the medical consultations involving a bilingual provider, a bilingual third party, and a monolingual patient, the bilingual family member and provider can code-switch to a language the patient does not use. We have argued such code-switching can result in a taking of control over the consultation as the third party and provider interact in a language the patient cannot understand. The three excerpts presented in this paper indicate that a need for control seems to motivate the switches to English that occur. In the case of Rosario's husband in excerpt 1, he takes control over the construction of Rosario's stance toward her own body. Luisa's daughter takes control over the questions directed to the provider in excerpt 2 and in excerpt 3, the daughter takes control over the account of Luisa's dietary habits.

In excerpts 1, 2, and 3, the third party's grabbing of control is co-constructed by the providers as they make the switch to English and ratify the third party contributions. This taking of control is similar to Cahill and Papageoriou (2007) as they demonstrate that parents tend to take control over their children's medical consultations. The powerful moves

enacted by the bilingual third parties in excerpts 1, 2, and 3 place the monolingual Spanish-speaking patients in the position of lovable incompetent (Goffman, 1981). This occurs as the third parties speak for their loved ones in English in collusion with the providers, who align with the third parties by switching to English. The patients become half members, non-participants (Hutchby and O'Reilly, 2010) in their own consultations.

At this point in our discussion, we will turn to the implications of the code-switching that occurs in these bilingual provider-bilingual third party-monolingual patient consultations in terms of how these micro-interactional practices translate into macro level realities. To consider such implications, we will contextualize the micro-interactions that we have examined above in terms of stated clinic mission and policy as well as the local neighborhood where the clinic is located. Ethnographic field notes and interviews have provided important data that allow us to make sense of aspects of social context that the participants make relevant in the medical consultations that we analyzed in this paper.

The clinic is located in an urban, low-income, largely Spanish-speaking neighborhood in Southern 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, all signs and brochures in the clinic are in Spanish and English. As stated in the clinic mission statement and service materials in clinic brochures, this clinic aims to provide culturally sensitive and 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.

The clinic then outwardly promotes language concordance between the provider and patient, and in dyadic interaction, language concordance is largely achieved. Despite the clinic's mission to provide language concordant care, this ideal is not reached in the third party interactions we discussed here. Considering Auer's (2005) question regarding how code-switching indexes membership categories in conversation, we assert that in our data, similar to Zhang's (2005) findings, code-switching indexes the ideologically hierarchical relationship between the two languages at the societal level. Use of English then indexes membership in the ideologically dominant group of English speakers in Southern California, while use of Spanish indexes membership in the ideologically subordinate group of Spanish speakers in Southern California. These identities became relevant in our data as third party family members and medical providers switched to English in the consultations. Their orientation toward powerful identities such as watchdog and medical expert respectively as they used English constituted multiple layers of power and multiple ways of subordinating the patient.

It seems that policy regarding such interactions is enacted and constituted on the ground through the micro-interactional processes that occur within the consultation. These micro-interactions seem to be affected by the ideologically hierarchical relationship between English and Spanish in Southern California. Not only is English dominant and preferred in the local context outside of the clinic walls, but in the two consultations that we examined in

this paper, this English dominance, even English preference, is reproduced in a context that is supposed to be language neutral. The monolingual Spanish-speaking patient in turn becomes a disempowered in her own “language concordant” medical consultation.

Moreover, in our interview with Carrie, she makes explicit her orientation toward Luisa as incompetent (Excerpt 4). Carrie explicitly mentions Luisa’s competence in her justification for directing her “stuff” toward the daughter.

Excerpt 4

Researcher (R) and Carrie (C): Nurse Practitioner

-
1.	C:	~Lu:isa Luisa was a very interesting patient and she was my first (1.5) uh it
2.		was the first time that I was seeing her
3.	R:	mhm
4.	C:	um::... tsk an:: ((asks herself)) how did the communication go?...um:: (3.0)
5.		well it’s always different when you have (.) rea:lly three o-two patients
6.		participating in the egz—in the [((xxx))]
7.	R:	[right] yeah
8.	C:	mm um:...so:...that was a little funny and I didn’t always knew which way
9.		to...direct my comments or: whatever I was saying (1.5) um: ...and she-she’s
10.		a...uhm: very anxious lady and so (.) I kind of directed a lot of my stuff
11.		towards...the daughter because I thought she would remember what I said and the other
12.		woman you know with her anxiety so high...I was afraid that=
13.	R:	=mhm=
14.	C:	=she’d leave an’ say ‘huh?’ ‘what’d she say?’
-

Although Carrie does not discuss her switch to English, she makes clear that she considered Luisa to be less competent than the daughter. Carrie then was quite intentionally orienting toward the daughter as the more competent participant as she interacted with her in English. This example demonstrates the multiple levels of subordination that occurred: the patient was constructed as incompetent and as a non-participant as the daughter and medical provider interacted in English.

A dialectic between the microsociological and the macrosociological occurs as the microsociological processes at work in the consultation both affect and are affected by macrosociological processes. As Philips (1983) argues. “there is a real sense in which *only micro phenomena exist or happen, and macroanalyses are simply ways of conceptualizing relations among microphenomena.*” (p. xiii, italics in original). As such, providers constitute policy on the ground as they interact with patients. Lipsky (2010, p. 3) asserts that “when taken together the individual decisions of these workers become, or add up to, agency policy.” In this sense, the language choices that bilingual third parties and providers make act to constitute unwritten policies.

Conclusions

In our data, then, the pattern seems to be one in which monolingual Spanish-speaking patients are stripped of control. It raises the possibility of a cultural ideology at work within these consultations in which non-English-speaking people in an English dominant context are considered to be less capable. Obviously, this is a dark possibility that should receive sustained, critical research attention in all aspects of the literature on medical consultations with limited English proficient people in English dominant contexts. It speaks to the way micro-interactions within the clinical context reproduce ideologies about the relative value of language (Hill, 1998) as well as the people who use or do not use particular languages.

Finally, our study demonstrates the importance of understanding a distinction between stated and unstated policy in line with Lipsky (2010) and the importance of examining the constitution of unstated policy as it is enacted in micro-interactional moments in line with Philips (1983). The medical literature has identified what they term Limited English Proficiency (LEP) as a health disparity and often calls for *cultural competence* in medical settings that serve language minority patients to alleviate this health disparity (Carmona, 2007; Diamond et al., 2010; Dysart-Gale, 2007; Gregg & Saha, 2007; McElmurry et al., 2009; Ngo-Metzger et al., 2007; Payne, 2012). But like any ideology, cultural competence is not simply an abstract concept. Rather it is based in practice. As Philips (2000) argues, language is a window into ideology. The data in this paper has demonstrated that written, explicit, stated policy does not necessarily translate to the micro-interactional life of the medical consultation. Stated policies that resist the intrusion of cultural ideologies, such as the case with the clinic in our data, may become hidden as human beings work to enact the actual practice of patient care on the ground.

Acknowledgments

Funding

This research was supported by a grant from the National Institute of Nursing Research (1R15NR010630-01A1).

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- Code-switching occurs in triadic multilingual medical consultations.
- Code-switching causes patient non-participation in medical consultations.
- Code-switching in triadic medical consultations contradicts stated clinic policy.
- Code-switching in triadic medical consultations may index language hierarchy.