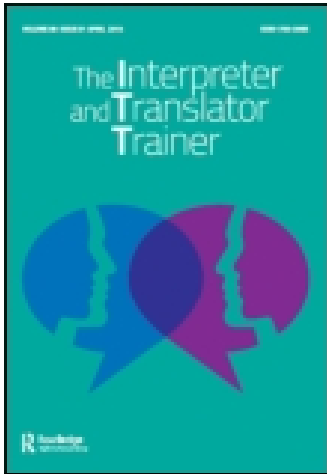


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### Gaze and body orientation as an apparatus for patient inclusion into/exclusion from a patient-centred framework of communication

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## **Gaze and body orientation as an apparatus for patient inclusion into/exclusion from a patient-centred framework of communication**

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Dialogue interpreter training has traditionally focused on the way in which the interpreter manages, and maintains, verbal interaction between the primary participants while it seems to overlook the importance of specific non-verbal aspects that are inherent in mediated interaction. This article presents an alternative method for the training of medical interpreters by drawing on research on non-verbal communication in interpreter-mediated consultations with a view to drawing attention to the interpreter's impact on the patient's inclusion in a patient-centred framework during mediated consultations. More specifically, it provides evidence of non-verbal interaction that might open up new trajectories in the interpreters' training by foregrounding the impact of the interpreter's and others' direction of gaze and body orientation on the accomplishment and maintenance – or lack thereof – of a patient-centred framework of communication. The present article reports on findings that emerged from the analysis of selected excerpts of authentic interpreter-mediated consultations within the framework of a training experiment. Coded instances of interaction are analysed by relying on Goffman's 'ratification process', Goodwin's 'participation and engagement frameworks' and Norris' 'modal density foreground–background continuum'. Hospital ethical approval and participants' written informed consent were obtained prior to the collection of data.

**Keywords:** gaze; body orientation; posture; patient-centredness; interpreter training; role

### **1. Introduction**

A review of the literature on interpreter training reveals that the vast majority of the models of interpreter training focus mostly – if not solely – on the trainee interpreters' development and acquisition of skills that are inherent in their verbal interaction with the primary participants. Consequently, little attention has been paid to aspects of non-verbal communication that participants employ in interaction with each other. While the importance of the interpreter's interaction with the primary participants by means of non-verbal communication is less apparent in settings such as conference interpreting, it has a much stronger bearing on the interaction among participants in face-to-face triadic exchanges which are still perhaps the most common way of interacting in community settings (e.g. immigration offices), despite the increasing use of remote interpreting (Braun 2006; Ko 2006; Braun and Taylor 2011).

What is more, interpreter training has traditionally relied on a deontological ethical framework, in which interpreters learn what they 'shall ... will ... [or] never do' (Dean

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and Pollard 2011, 157). In other words, drawing on the relevant literature and on my own experience as an interpreter and interpreter trainer, I believe that interpreter training seems to be rather interpreter-centred, to the detriment of the goals the primary participants strive for during interaction. For instance, in healthcare settings, the accomplishment of the doctor's goals in interaction with his or her patient, within the framework of patient-centred communication (PCC), might have a significant impact on the outcome of the consultation (Mead and Bower 2000; Rivadeneyra et al. 2000; Epstein et al. 2005; Hudon et al. 2011). If we acknowledge that the interpreter's function in healthcare settings is to enable and/or facilitate communication between patients and healthcare providers, then I argue that the training of medical interpreters should take into account the doctor's interactional goals in a patient-centred framework of communication.

Another shortcoming that is to be found in the training of community interpreters is the frequent use of mostly simulated role plays, which constitute a common part of the training of community interpreters (Corsellis 2005). However, although the practice of role plays as a pedagogical tool for the training of interpreters relies on the assumption that role playing 'sufficiently mimics an actual interactional event to be useful for rehearsing the same conversational moves that would comprise it', the issue of authenticity has not received much attention in the relevant literature (Stokoe 2011). Role plays are usually scripted by interpreter trainers who, despite their familiarity with the topic, are usually unable to predict how a participant's utterance might be formulated and situated in a real situational context (Stokoe 2011). At the other end of the continuum, the stakes of the participants in a role play differ from the stakes of participants in authentic interactions. This means, for instance, that for trainee interpreters who participate in a role play on healthcare settings, what is at stake is their performance and the evaluation they will receive from their tutor. This is in stark contrast to real-life interactions, where it is the patient's own health and the provision of healthcare by the doctor that are at stake.

## 2. What this article deals with

As argued above, the one-sided focus of interpreter training on the acquisition of verbal skills and simulated role plays on the one hand, and the lack of attention to the primary participants' interactional goals as inherent in authentic interpreter-mediated interactions on the other, reveal a gap in the current form of community interpreter training. This article aims to address aspects of this gap and to pave the way for new trajectories in the training of (medical) interpreters. More specifically, this article

- (1) focuses on the study of participants' gaze and body orientation in interpreter-mediated consultations,
- (2) moves away from the traditionally interpreter-centred training methods, and studies gaze and body orientation in interaction in relation to the doctor's and patient's interactional goals, and
- (3) suggests an alternative training method by drawing on, and providing, insights into a training experiment, for which authentic videotaped interpreter-mediated interactions were used.

This data-driven article adopts an interactionist approach, meaning that all participants' behaviour, both verbal and non-verbal, is taken into account. More specifically, I investigate participants' shifts in gaze and body orientation by taking into account the doctor's interactional goals within a patient-centred framework of communication.

The object of the study is threefold: (i) to grant insights into a part of interpreter-mediated interaction that has not received much scholarly interest in interpreter training, namely that of participants' gaze and body orientation; (ii) to foreground a number of implications in the study of gaze and body orientation for the training of medical interpreters; and (iii) to propose an enhanced model of training for interpreters in healthcare settings.

The findings that will be presented in this article are innovative in that they demonstrate that the interpreter's presence might trigger participants' behaviour, in terms of shifts in the direction of their gaze and body orientation, which might affect the doctor's interactional goals in a patient-centred framework of communication.

In what follows, I will first of all consider some important aspects of the study on gaze and body-orientation and patient-centred communication, before presenting the methodology adopted in the training experiment and my suggestion for a new approach to the training of medical interpreters.

### **3. Gaze and body orientation in (mediated) medical encounters**

A review of the literature reveals that in research on doctor–patient interaction, the study of verbal communication has attracted far more attention than the study of non-verbal communication. Yet the study of participants' gaze and body orientation has received significant interest in the study of unmediated doctor–patient interaction (Heath 1984, 1986; Psathas 1990; Frankel 1993; Robinson 1998), compared to interpreter-mediated interaction. Studies that include aspects of multimodal analysis in interpreter-mediated interaction in healthcare settings include, for example, Wadensjö (2001) on interpreters' proxemics in psychotherapeutic encounters, Bot (2005) on gaze patterns in mental healthcare and Pasquandrea (2011) on doctors' involvement in interaction by relying on multimodality. In all of these studies, there seems to be an underlying consensus that participants express engagement in others' utterances and availability for participation in the interaction by shifting their gaze and the orientation of their body towards other participants. By contrast, 'aversion of gaze means lack of interest or disapproval' (Argyle and Cook 1976, 121).

The above widely acknowledged principles pertaining to participants' engagement in, and availability for, interaction are to be found in the seminal work by Goodwin (1981) and later on in the work by Kendon (1990) and others. Yet, despite the invaluable insights into multimodal interaction that earlier research had offered, the participants' attention to actions they engage in, or are aware of, has not received enough attention in the literature.

In her attempt to capture a greater number of subtleties in multiparty interaction and shed light on under-investigated zones of it, Norris (2006) applies her 'modal density foreground–background continuum' to her multimodal research. With her model she manages to address participants' levels of attention/awareness, offering in my view a very relevant tool for the study of PCC, since attention (and, more specifically, attentive listening, as usually found in the clinical literature) is considered as an important competency for doctors engaging in this type of communication (Robertson 2005; Silverman, Kurtz, and Draper 2005; Wouda et al. 2011). More specifically, literature from the field of clinical communication suggests that attentive listening involves placing the individual's attention at the other participants' disposal (Robertson 2005).

### 3.1. Norris' analytical framework

Norris (2004, 2006) makes a distinction in interaction between 'higher-level actions' (HLAs), such as meetings, and 'lower-level actions' (LLAs), such as utterances and gestures. HLAs are marked by social openings and closings and consist of multiple LLAs. The interaction within HLAs is broken down into interdependent 'modes', namely heuristic units (such as spoken language, gesture and gaze) whose definition varies according to the analyst's focus. Modes in a specific HLA might be interrelated and vary in intensity ('modal density', Norris 2004, 2006). Interestingly, Norris (2004, 2006) manages to illustrate the way in which ongoing interactions are linked to participants' 'phenomenal mind of consciousness', as described by Chalmers (1996, 11), by equating the latter with the notion of the 'foreground-background continuum'. Within this framework Norris perceives participants as social actors who perform, or are engaged in, multiple and parallel HLAs, which, depending on their modal density, are placed on the continuum of the social actor's attention/awareness. The higher the modal density, the more in the foreground HLAs are placed.

If we acknowledge that all interactions are co-constructed, then an HLA might be linked to more than one participant, and this at different levels of the individual's attention. In order to investigate co-constructed interactions in a more comprehensive way, Norris (2006) maintains that a two-level analysis of interaction is required. First, the analyst should identify and analyse participant-linked actions; that is, who does what with whom. Here the analyst defines the modal density that the individual who performs the HLA employs in order to construct the action in question. At a second level, the analyst should unlink the actions from the participant and study only what the participant does (Norris 2006, 419) without presupposing other participants' involvement. The second level of analysis allows the analyst to identify whether and how a certain HLA might be linked to other participants as well.

Norris' (2004, 2006) modal density foreground-background continuum provides the tools for the analysis of participants' simultaneous engagement in parallel interactions and an explicit link between them and participants' level of attention to these interactions. The study of participants' levels of attention/awareness can play a crucial role in the study of interaction within the framework of PCC, as will be shown below. However, it should be clarified that despite the more comprehensive analysis of interaction within the framework of PCC, in this article I will not be able to make a valid claim about participants' thoughts, feelings or experiences. Instead, I will provide partial insights into them as verbalised and perceived by participants on the basis of their expressions.

### 3.2. Ratification process in interpreter-mediated interactions

Useful for the observation of participants' attention/awareness levels is the study of participation and engagement frameworks (PEFs; Goffman 1981; Goodwin 1981), as it allows for the identification of participants' relationships in interaction and paves the way for the analysis of attention/awareness levels. Goodwin's (1981) 'participation and engagement frameworks' are in keeping with Goffman's (1981) 'ratification process', namely participants' positioning in terms of spatial orientation, eye contact and proxemics with each other. In monolingual interaction, participants ratify each other (Goffman 2005), by signalling to one another when one's turn is finished and when another participant may take the floor. Yet, in interpreter-mediated interaction, the speaker might ratify two different participants at the same time: one verbally (verbal ratification) and one through

gaze (visual ratification) (Krystallidou 2013). In interpreter-mediated interaction a participant might be both verbally and visually addressed (full ratification) or only verbally or only visually addressed (split ratification; Krystallidou 2013). While PEFs might be initiated by both speakers and listeners, ratification process – in Goffman's terms – is initiated by speakers only. For this reason, in this article I treat PEFs and ratification process as complementary analytical tools in a bid to capture more aspects of interpreter-mediated interaction.

### 3.3. *Interactional goals in patient-centred frameworks of communication*

Doctor–patient communication has been increasingly oriented toward patient-centred models of communication in western medicine, which have been strongly advocated (e.g. Roter 1989; Smith et al. 1995; Little et al. 2001; Hudon et al. 2011). In these models the doctor's interactional goal is the creation of a relationship of trust between him or her and the patient (Meeuwesen, Schaap, and van der Staak 1991; Mead and Bower 2000; Little et al. 2001; Stewart 2001). The patient's inclusion in a patient-centred framework of communication is typically associated in the literature on PCC with increased patient's disclosures, which enable the doctor to provide care which is customised to the needs and expectations of the patient (Mead and Bower 2000; Epstein et al. 2005).

In order for the above relationship of trust to develop, a set of core requirements must be fulfilled: the patient must be included in the patient-centred framework of communication, while both the doctor and the patient must, among other things, be willing to interact with each other (by projecting their availability for participation in each other's communicative framework) and engage in conversation. The doctor–patient relationship is built on the interdependency of the following aspects: (i) the doctor's patient-centred invitations to the patient for participation in interaction, (ii) the patient's responses (disclosures) to the doctors' patient-centred invitations, and (iii) the doctor's responses to the patient's 'offers' (Brown et al. 1986). In the words of Balint et al. (1993), in patient-centred models, 'the doctor and patient are influencing each other all the time and cannot be considered separately' (1993, 13).

## 4. The training experiment

As stated above, the present study reports on an alternative training method, an 'experiment', that I incorporated in my interpreting classes (master's level) at University College Ghent in 2012 and 2013. At the time of the experiment, the students had received training on a number of community settings. The experiment formed part of a two-day training course (eight hours) on interpreting in healthcare settings. The objectives of the experiment in question were primarily to immerse trainee interpreters into real-life interpreter-mediated consultations and, more specifically (i) to confront them with authentic language, and (ii) to raise awareness of the impact of the participants' direction of gaze and body orientation on the doctors' ultimate interactional goal, that of the patient's inclusion in a patient-centred framework of communication. In this article I will expand only on the second objective of the experiment.

The data that were used for the experiment were taken from a larger corpus of authentic consultations which were video recorded in an urban hospital in Flanders, Belgium. The consultations were held between Dutch-speaking doctors, Russian-speaking and Turkish-speaking patients and trained and certified professional interpreters. Hospital ethical approval, as well as all participants' written informed consent, was obtained prior

to the collection of the data. All video-recorded consultations were transcribed and translated into Dutch and English. For the purpose of the experiment Dutch subtitles were provided for the patients' turns in Turkish and/or Russian, since not all of the students who participated in this experiment had command of these two languages.

#### 4.1. Methodology of the experiment

In order for the experiment to be carried out, the use of a laptop, a projector, a projection screen, a sound system and PowerPoint software was required. Below, I present the five distinct stages I followed during the experiment.

- (1) Students were briefed on the subject matter of the consultation, and relevant information on all of the participants in the exchange was provided. Information that could potentially influence the students' understanding of the exchange (e.g. the patient's failure to understand a medical term), however, was not shared in advance. As such, students were left to 'live through' (Stokoe 2011) the consultation.
- (2) An authentic interpreter-mediated consultation was projected onto a big screen. Students could follow the doctor's and the interpreter's turns spoken in Dutch and could rely on the Dutch subtitles that were provided for the patient and the interpreter's turns in Russian or Turkish.
- (3) The projection of the video was interrupted by me at moments during which the interaction among participants presented a particular interest in terms of the direction of participants' gaze and body orientation. The selected extracts were previously identified by me on the basis of possible implications for the patient's inclusion in a patient-centred framework of communication as a result of shifts in participants' gaze and body orientation.
- (4) Groups of three students (doctor, patient, interpreter) were given the transcript of the selected extracts and were asked to role play it (before seeing on the big screen how the authentic interaction evolved) by paying special attention to shifts in gaze and body orientation and trying to maintain a patient-centred framework of communication. The rest of the class were instructed to monitor the gaze and body orientation of the participants in the role play and to comment on possible implications for the patient's inclusion into a patient-centred framework of participation. It should be added at this point that the student interpreters had received from me the necessary theoretical background on the study of gaze, body orientation and patient-centred communication frameworks, as outlined above.
- (5) The selected extract was projected onto the big screen and students were asked to perform a series of tasks, as given below in chronological order. The students were asked to:
  - (i) rely on Goffman's (1981) and Goodwin's (1981) participation and engagement frameworks and identify how the doctor, patient and interpreter participated in interaction;
  - (ii) observe the real participants' direction of gaze and body orientation, comment upon it and discuss its potential impact on the patient's inclusion into, or exclusion from, a patient-centred framework of communication;
  - (iii) identify any simultaneously constructed actions in interaction and determine participants' levels of attention/awareness of the actions in which they engage;



- (iv) revisit the instances which they had initially marked as '*potentially leading to patient's exclusion*' by relating them to participants' levels of attention/awareness;
- (v) suggest ways to increase the doctor's and the interpreter's levels of attention/awareness in simultaneously constructed actions in which some signs of interaction with the patient were identified in earlier steps of the analysis. In other words, the students were instructed to suggest ways of increasing the modal density in specific HLAs which presented signs of interaction with the patient.

The underlying question that guided us through the discussion was whether the patient becomes excluded in the selected extracts and, if so, why/how? In order to facilitate discussion, video stills, similar to the ones included in the present article, were projected onto a big screen. Gaining access to participants' gaze and body orientation in 'slow motion' enabled both students and me to scrutinise participants' behaviour.

In this article I will focus only on the fifth stage of the experiment. At this point it should be clarified that the patient-centred models of communication consider the doctor's and patient's willingness to participate in interaction with each other and engage in each other's talk as a prerequisite for the doctor–patient relationship. For this reason, and for the purpose of the experiment, I equated the participants' willingness for availability for interaction with the initiation of, and response to, a participation framework (PF) on the one hand, and the participants' engagement in each other's talk with the initiation of, and response to, an engagement framework (EF) on the other.

## 5. Investigating participants' gaze and body orientation in interpreter-mediated interaction

For reasons of space and clarity, I will divide the analysis into two main sections, as I did during the experiment with my students. The first section illustrates the creation of PEFs within participants' full ratification, while the second section includes cases of PEFs in which the participants' ratification is 'split' (Krystallidou 2013).

It will become evident that instances of interaction which at first sight would be labelled as 'patient-exclusive' might present signs of interaction with the patient by means of various communicative modes.

### 5.1. PEFs within participants' full ratification

Excerpt 1 is taken from an interpreter-mediated consultation in the ward of paediatrics. At the beginning of the experiment the following information was shared with the students: (i) the 9-year-old patient is almost unable to interact with the other participants in the room; (ii) the patient's condition is known to all participants, and (iii) the doctor believes that PCC in this ward is subject to the patient's age and physical and mental condition and therefore it might be extended to include the patient's parent(s)/guardian(s).

In the preceding turns (Figure 1), which have been omitted here for reasons of space but were shown to the participants in the experiment, the doctor announces a number of medical tests which the patient needs to undergo, one of which is an electromyogram (EMG) test. The participants in the experiment watched the doctor explain what the acronym of the test in question stands for.

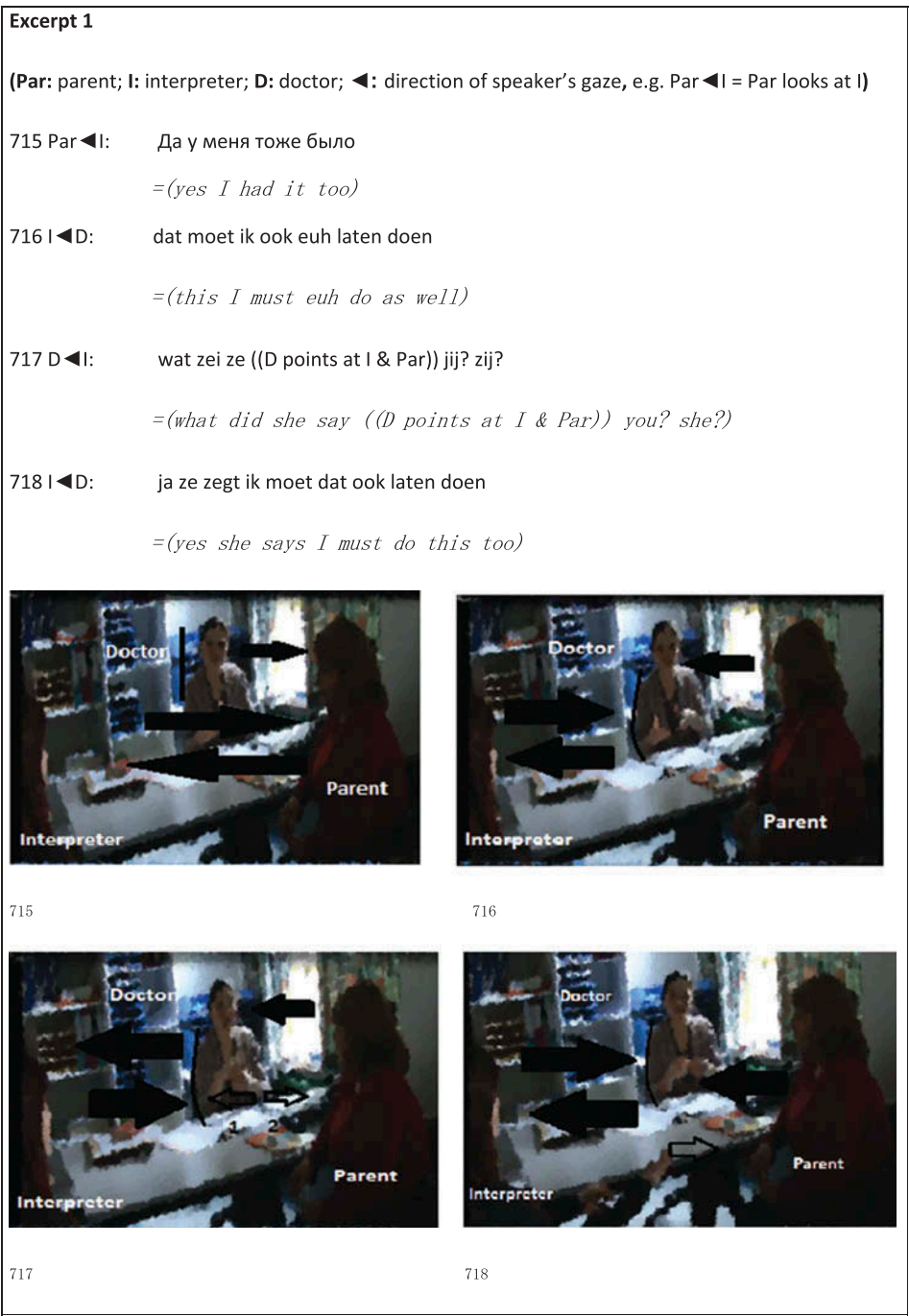


Figure 1. PEFs within participants' full ratification.

#### 5.1.1. Stage 5, step 1: mapping participant interaction by relying on PEFs

In excerpt 1 (Figure 1) the students watched the patient's parent fully ratifying the interpreter (turn 715: both verbally and visually), who in turn 716 fully ratifies the doctor. In turn 717 the students identified the interpreter's full ratification by the doctor and the latter's full identification by the former (turn 718). At the end of the analysis, as prescribed in step 5(i) the students identified two PEFs: one between the parent and the interpreter, and one between the interpreter and the doctor.

#### 5.1.2. Stage 5, step 2: observing participants' direction of gaze and body orientation

*Parent-interpreter PEF.* The students agreed that the parent displays both participation/involvement (body orientation) and engagement (gaze) in the interaction with the interpreter. It was noticed that the parent's body orientation and gaze include the interpreter in and exclude the doctor from the PEF (715). What was also identified was the interpreter's body orientation shifts between the doctor and the parent, while the interpreter establishes mutual gaze (Goodwin 1981) with the parent. The students concluded that by adopting this body posture the interpreter displays availability for participation to both the doctor and the parent, while her gaze in turn 715 projects engagement in the parent's talk.

*Interpreter-doctor PEF.* The students noticed that in turn 716 the interpreter maintains the same body orientation but shifts her gaze to the doctor. This shift was marked by the students as an invitation to the doctor to attend to a PEF with the interpreter, an invitation which is accepted by the doctor who slightly leans forward to the interpreter's side. The students agreed that the newly established interpreter-doctor PEF is '*potentially leading to the parent's exclusion*', whose gaze at the doctor shows her engagement in the doctor's talk. The parent's body orientation shows availability for interaction with the interpreter.

In turn 717 the direction of the doctor's gaze was perceived by the students as showing the doctor's engagement in the interpreter's talk. The students indicated that: (i) the doctor's body is oriented slightly more towards the interpreter, yet some of the doctor's gestures are directed to the parent; (ii) the parent's gaze is directed to the doctor, displaying the parent's engagement in the doctor's talk; (iii) the parent's body orientation towards the interpreter reveals the parent's availability for interaction with the interpreter. A similar pattern was identified in turn 718.

At the end of the analysis, as was conducted in step (ii), the students drew the following conclusion: each time the parent and the doctor shift their gaze to the interpreter, the latter shifts her gaze to them as well. It was argued that this mutual ratification which is established by means of mutual gaze, body orientation and spoken language seems at first sight to exclude one of the participants from the interaction, due to the language barrier.

#### 5.1.4. Stage 5, step 3: identifying simultaneously constructed actions and determining participants' levels of attention/awareness

In this step, the students were asked to identify any simultaneously constructed actions and determine the participants' levels of attention/awareness. The following simultaneously constructed HLAs were identified:

- HLA1: '*the parent addressing the interpreter*' (turn 715)
- HLA2: '*the interpreter rendering the parent's utterance to the doctor*' (turn 716)
- HLA3: '*the doctor interacting with the interpreter*' (turns 717, 718).

It was agreed that HLA1 and HLA2 are marked by high modal density (i.e. spoken language + gaze + posture) toward the interpreter and the doctor respectively. Consequently, it was concluded that the high modal density in both HLAs places them on the foreground of the foreground–background continuum, indicating both the parent's (HLA1) and the interpreter's (HLA2) increased attention to the HLA that is being constructed.

Interestingly, the students drew special attention to HLA3, which presents a slightly different pattern. Although the doctor's body is oriented slightly more toward the interpreter and her gaze remains on the interpreter as well, part of the doctor's gestures points at the parent. The same pattern is to be found in the interpreter's turn (718). The students concluded that what happens here is that both the doctor and the interpreter are engaged in an HLA that comprises high modal density, yet a part of the doctor's and interpreter's postural behaviour (i.e. gestures) is directed toward the parent and so is part of their attention. Consequently, the students noticed that what becomes now a little clearer is that both the interpreter and the doctor dedicate part of their attention to the parent of whose presence they are both aware. It was also pointed out by the students that the doctor's and interpreter's attention to/awareness of the parent is perceived by the latter by means of the latter's gaze on the doctor and the interpreter respectively (visual ratification), as can be seen in turns 717 and 718.

In order to identify how specific HLAs are linked to multiple participants, the students were asked to relabel the HLAs by distancing themselves from predefined connections between HLAs and specific participants. The HLAs were labelled as follows:

- HLA1: '*communicating EMG experience*'
- HLA2: '*interpretation*'
- HLA3: '*clarification*'

By means of the new level of analysis the students realised that the parent is aware of the doctor's gaze on her (715), as well as of the fact that the information she is communicating to the interpreter might be important for the doctor to know. It was argued that although the parent is foregrounding the interaction with the interpreter, she is mid-grounding (Norris 2006) her interaction with the doctor despite the language barrier. (Part of the parent's body is oriented to the doctor as well.) The same pattern was found in HLA2: although the interpreter is foregrounding the interaction with the doctor, at the same time she is mid-grounding the interaction with the parent (716). HLA3 was approached in this way too. While it was argued earlier on that the doctor–interpreter PEF seemed to exclude the patient from interaction, the students noticed that both the doctor and the interpreter are mid-grounding their interaction with the parent showing signs of the parent's inclusion in the interaction.

#### 5.1.5. Stage 5, step 4: revisiting instances marked as '*potentially leading to patient's exclusion*'

At the end of the analysis of excerpt 1, it was argued that the interpreter's presence seems to affect the dynamics of the participants' gaze and body orientation. It was also

concluded by the students that the parent's inclusion into/exclusion from a patient-centred framework of communication can result either from (i) the parent's attempt to enter a PF/EF with the interpreter instead of the doctor (715; in so doing, the patient is moving away from the doctor's objective to build a relationship of trust with the patient); or (ii) from the PF/EF established between the doctor and the interpreter (716–718). However, a more comprehensive analysis, as outlined in step 3, provided evidence of the doctor and parent's *inclusion* in interaction and hence in the patient-centred framework of communication, since the parent is involved in actions that are simultaneously constructed, as shown above.

## 5.2. PEFs within participants' split ratification

In excerpt 2 below (Figure 2), for reasons of space, I will refrain from offering a thorough analysis as I did above for excerpt 1, although the same type of analysis was conducted by my students. Instead, I will refer only to aspects that are of special interest for cases in which a participant (e.g. doctor) shifts his or her gaze to one of the participants (e.g. patient) while the former actually verbally addresses another participant (e.g. interpreter).

Prior to the analysis of the excerpt, the following information was shared with the students: the doctor, who strives to practise PCC, discloses the diagnosis about a disorder in the patient's blood.

### 5.2.1. Interruption of doctor-patient PEF and initiation of doctor-interpreter PEF

As can be seen above, the patient's full ratification by the doctor (49a) is relatively short. This is a case of 'split ratification' (Krystallidou 2013), since the patient is the recipient of the doctor's *visual* ratification, while the interpreter receives the doctor's *verbal* ratification. However, the patient's full ratification is very brief, since the doctor turns her gaze to the interpreter (49b), whom she now ratifies fully, in order to explain to her the patient's condition. Interestingly, the interpreter acknowledges the doctor's ratification by turning her gaze to the doctor (49d).

What was identified by the students was the doctor's attempt to create a patient-centred framework of communication by initiating a PEF with the patient (49a), from which the interpreter seems to be excluded. It was also suggested that the patient's full ratification by the doctor (49a) places the interpreter in a position that brings to mind the metaphor often used in the literature in which the interpreter is perceived as a translation machine (Roy [1993] 2002; Wadensjö 1995; Fatahi et al. 2008), who, against all odds, needs to deliver her renditions. Further to that, some students also argued that the interpreter's positioning as a translation machine by the doctor would set off the patient's inclusion in the patient-centred framework of communication. Yet one can imagine that such a constantly occurring pattern in the participants' interaction, as described above, could also affect the doctor–patient communication in a negative way.

Soon, the interpreter joins the PEF that was previously initiated by the doctor (49d). At this point, a change in the interpreter's body orientation was noticed by the students, as she emphasises her availability for interaction with the doctor by leaning forward and thus joining the doctor-initiated PEF (49d). The same pattern was detected by the students in 49f. In the meantime, the students considered the patient to be excluded from the PEF shown in 49d and 49f, whose gaze and body orientation remain remarkably the same, projecting availability for interaction with the doctor and engagement in her turns, despite the language barrier.

## Excerpt 2

(D: doctor, P: patient, I: interpreter, ◀: direction of speaker's gaze, e.g. Par ◀I = Par looks at I))

49a D ◀P: ja (.) dus (.) e:eh bD ◀I wij weten in de bloedstolling zijn heel veel factoren e:ehm die daarvoor moeten zorgen dat het bloed KAN klonten en daarvan zijn er een aantal bij haar onderzocht om te kijken e:eh wat dat er mis is met de bloedstolling hé? want zo klonten maken op een jonge leeftijd is meestal niet normaal en cD ◀documents daarbij is er e:en eerste test gevonden een afwijking in dD ◀I factor 5 en die hebben allemaal een nummer (.) een afwijking in eD ◀documents factor 5 die daarvoor zorgt dat eigenlijk dat de stolling te lang fD ◀I actief blijft (.) en dat dat dan klonten kan geven

*=(yes (.) so (.) e:eh bD ◀I we know that in the coagulation there are a lot of factors eh: ehm which ENABLE the blood to clot and some of which have been analysed in her blood test in order for us to find out what is wrong with the coagulation hey? because such clots at such an early age are mostly abnormal cD ◀documents and in an initial test a deviation dD ◀I in factor 5 was found and all of them have a number (.) a deviation in eD ◀documents factor 5 which results in the coagulation being active fD ◀I for too long (.) and that this can give clots)*

50 I ◀P/notes: А то есть они сделали а есть разные факторы которые за то что как бы кровь слишком быстро сворачивается если слишком много вот этих тромбоцек появляется (.) А и очень странно что вы в молодом возрасте у вас уже появляются вот такие тромбоцки поэтому они (.) провели некоторые тесты (.) и (.) на различные факторы все факторы имеют свои номера (.) Провели фактор (.) тест на отклонение фактор и - пятом (.) Фактор и 5-ом обозначает что//11

*=(so they have there are different factors which make blood coagulate too fast if there are many of these factors then clots appear (.) it is really strange that at such an early age you already have such clots (.) therefore they have done some tests on different factors (.) each factor has a number (.) factor 5 was checked (.) factor 5 means that//)*

Figure 2. PEFs within participants' split ratification.



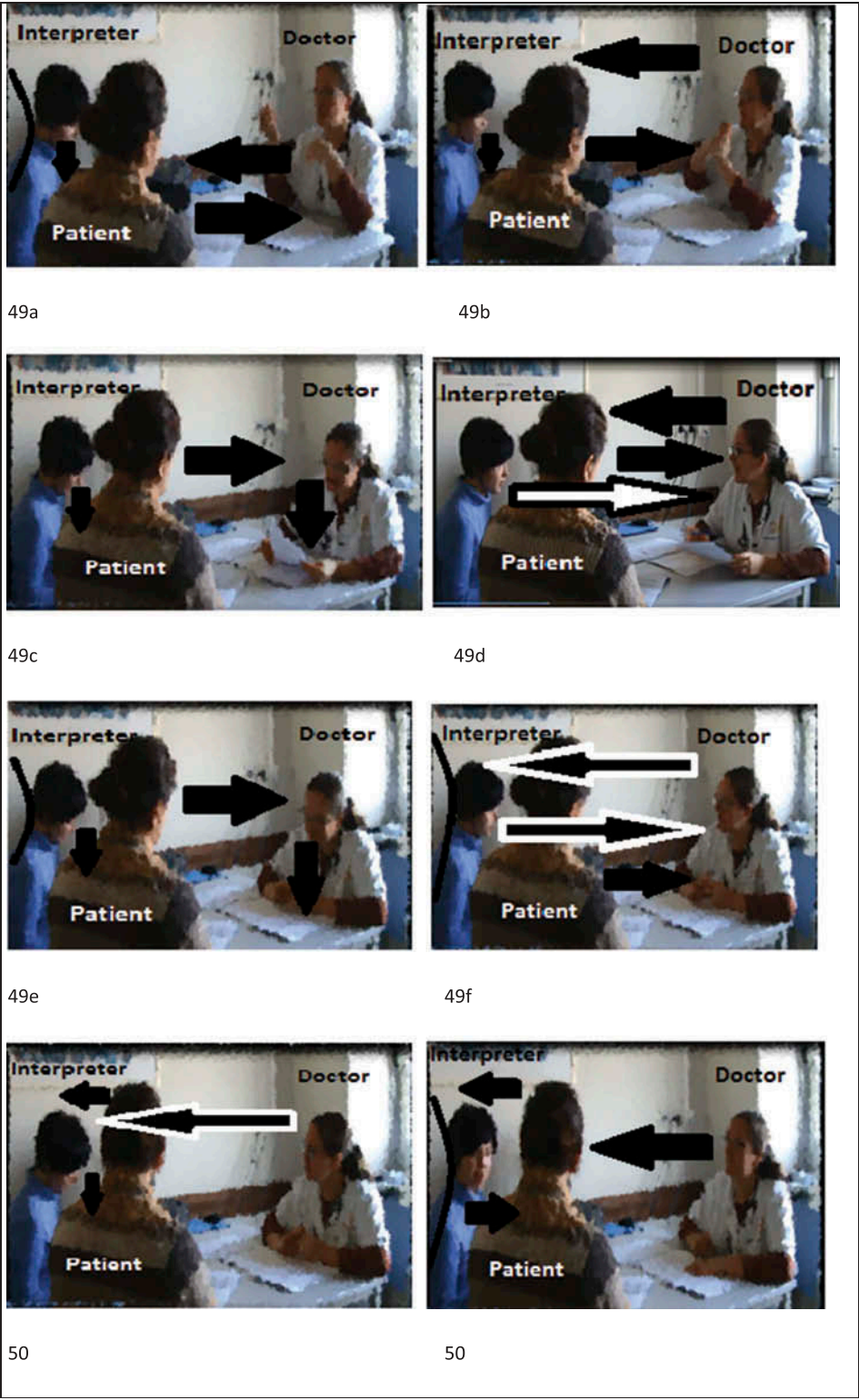


Figure 2. Continued.

The next level of analysis revealed a patient-inclusive PEF (initiated by the doctor), which involves split ratification and which, however, is interrupted by the interpreter's full ratification by the doctor. The newly established doctor-initiated PEF ostensibly seems to include the interpreter and exclude the patient. However, a second-layer analysis revealed a different interactional landscape. More specifically, in turn 49a, the HLA which was previously labelled as '*doctor interacting with patient*' comprises high modal density showing the doctor's increased level of attention to her interaction with the patient, which is placed on the foreground of the foreground-background continuum. A similar pattern, this time between the doctor and the interpreter, was found in 49b as well.

Interestingly, in turn 49a the students also identified simultaneously constructed interaction between the doctor, the patient and the interpreter, as the doctor is aware of the interpreter's presence and is expecting the interpreter to deliver her utterances in Russian to the patient. While the doctor-patient interaction in 49a is marked by gaze and posture, the doctor-interpreter interaction is based on spoken language.

Attention was drawn to turn 49b which illustrates a different pattern: the doctor is demonstrating high levels of attention to the HLA ('*doctor interacting with interpreter*') in which she is engaged, as opposed to the lower modal density in the simultaneously constructed doctor-patient action. The students concluded that what allows for the doctor-patient interaction to emerge is (i) the doctor's awareness of the patient's presence; (ii) the patient's awareness of the interpreter's presence; (iii) the doctor's awareness of the interpreter's presence; (iv) the patient's awareness of the purpose of the doctor's action (the doctor addresses the interpreter whom she expects to deliver to the patient); and (v) the patient's gaze directed to the doctor.

### 5.2.2. *Initiation of interpreter-patient PEF further to the patient's verbal ratification by the interpreter*

While in excerpt 1 (Figure 1) the creation of PEFs did go hand in hand with the participants' full ratification, in Figure 2 (turn 50) the patient, who at the beginning is only verbally ratified by the interpreter, initiates a PEF to which the interpreter responds later on.

Again, in turn 50, the students noticed a harmoniously and simultaneously occurring interaction between the interpreter and the patient on the one hand, and the doctor, the interpreter and the patient on the other. It was argued that in the case of the interpreter-patient interaction, the HLA '*rendition of doctor's turn into Russian*' is marked by high modal density and is placed on the foreground of the interpreter's and, as can be seen from the patient's gaze, patient's attention/awareness. At the same time, it was suggested by the students that the doctor is displaying signs of interaction with the interpreter and the patient by means of gaze and posture despite her inability to follow the interpreter's renditions in Russian. Again, the analysis of this excerpt (Figure 2) provided evidence of the patient's inclusion into patient-centred frameworks of communication.

## 6. Conclusion: what the students learnt from the experiment

After the analysis of instances of interaction, as shown above, the remainder of the session was used to debrief. The students were asked to work in groups and list the top-three findings that, in their view, emerged from the analysis of the selected excerpts and from them being role played by the students. Each group was asked to give an overview of their top-three findings and justify their inclusion in the top-three list. Below, I provide a



selection of the most commonly recurrent findings as presented by the participants in the experiment.

- (1) Interactions are not constructed only through participants' utterances. Instead, they might be realised by means of non-verbal behaviour, such as participants' gaze and posture (body orientation).
- (2) Interaction in authentic interpreter-mediated communication does not seem to follow the pattern of dyadic interaction that is usually portrayed in scripted role plays used for the training of interpreters and to which students are traditionally steered during their interpreter training. This implies that, while student interpreters' attention is usually drawn to the way in which they 'should' manage their verbal interaction with the primary participants (e.g. use of first person singular, accurate rendition of primary participants' utterances, signalling of misunderstandings to primary participants, etc.), non-verbal aspects that clearly have a strong bearing upon interaction, as shown in the above analysis, are systematically neglected. Instead, equal attention should be given to interpreters' (and primary participants') use of non-verbal behaviour and to the way it shapes interaction.
- (3) Although the establishment of PEFs in interpreter-mediated interactions might seem as if they unavoidably lead to the exclusion of one primary participant, due to the language barrier and the natural tendency of the primary participants to often display certain non-verbal behaviour toward the interpreter, aspects which are inherent in this type of interaction, there is evidence of simultaneously ongoing interactions between the seemingly excluded participant and the PEF participants. In other words, the interpreter's presence creates the conditions for all participants' inclusion in interaction by means of (i) the interpreter's renditions (spoken language), gaze and posture; and (ii) the primary participants' awareness of the interpreter's physical presence and professional capacity (i.e. the interpreter is expected to make the one primary participant's utterances accessible to the other).

What is more, during the debriefing session with the students (and more specifically in step 5), as described above in the section on the methodology adopted in the experiment), a number of possible ways of enhancing the patient's inclusion in patient-centred frameworks of communication emerged. For instance, it was suggested that doctors and interpreters should perhaps be instructed to employ, or expand, certain modes of communication (both verbal and non-verbal) such as:

- the doctors' extension of gestures pointing at the patient when he or she fully ratifies the interpreter;
- the doctor's body oriented more toward the patient than the interpreter;
- the doctor's explicit acknowledgment of the interpreter's introduction at the outset of the consultation followed by the doctor's statement that the patient remains at the focus of the doctor's attention (a statement that should definitely reach the patient and set the tone for patient-centred frameworks of communication);
- the patient's visual ratification by the doctor at the outset and at the end of the doctor's turns during which the interpreter is the verbally ratified participant;
- the interpreter's alternating use between the traditionally recommended I-form and the combination of the emphasised agency<sup>1</sup> and the intended recipient of the

doctor's utterance, as in, for example, '*the doctor is asking you whether you could possibly try and recall any past incidents*' instead of '*can you recall any past incidents?*'.

## 7. Implications for the training of medical interpreters

The findings of this alternative training method are innovative, in that they shed light on an area that has largely been ignored in the training of medical interpreters. The findings that emerged from the analysis of authentic videotaped interpreter-mediated consultations demonstrate that participants' gaze and body orientation might have a significant impact on interaction and consequently on the patient's inclusion in the patient-centred framework for which the doctor might strive. The analysis that was conducted with the student interpreters and presented in this article should be food for thought for interpreters and their trainers. If we acknowledge that, nowadays, doctors (especially those with recent medical training) in the Western world aim to provide patient-centred care to their patients, both in unmediated and mediated consultations, by working towards the co-construction of patient-centred frameworks of communication, then I argue that the training of medical interpreters should take the doctors' interactional goals into account. The present article has suggested an alternative training method that could be incorporated in training curricula, as well as ways of boosting the patient's inclusion in patient-centred frameworks of communication. This method is more comprehensive than traditional fictive role plays which, apart from the fact that they lack authenticity, mostly serve as tools for the training of interpreters' oral skills, usually leaving the study of non-verbal interaction unattended.

In sum, I argue that the training of medical interpreters should:

- give due consideration to the impact of the interpreters' and other participants' gaze and body orientation as means of including themselves and others in interaction on the accomplishment of communicative goals within a doctor-initiated patient-centred framework of communication;
- involve professionals from both the field of interpreting and the field of medicine in order to increase the authenticity factor and the training benefits for students in interpreting and medicine (who also receive training in intercultural communication). To paraphrase Turner and Harrington (2000), I argue that, in general, the curricula for the training of medical interpreters should be designed, and implemented *on*, *for* and *with* doctors and the professionally and institutionally stipulated communicative goals they seek to accomplish within the framework of the patient-centred provision of healthcare. In this way, we will be able to train doctor-minded interpreters and interpreter-minded doctors who work together towards attaining the provision of high-quality, patient-centred care for the linguistically disadvantaged patient population, which is in need of interpreter-mediated communication.

This article has suggested an alternative take on the training of medical interpreters. Despite the warm response that the experiment received from the student interpreters and its innovative insights, it is suggested that more data be collected across a wider variety of languages in order to detect any alternate patterns of participants' gaze and body orientation that could confirm, or indeed contradict, the above findings. With a

larger and diverse volume of authentic data, we would be able to draw conclusions and proceed to specific recommendations for the training of medical interpreters.

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### Note

1. It should be conceded here that the suggested switch between the recommended use of the first person singular and the third person singular with an explicit reference to the originator of the utterance triggered some heated discussions among the students on breaching important aspects of the interpreter's code of conduct when acting in this fashion.

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