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Chase Wesley Raymond

Department of Sociology, University of California, Los Angeles

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Epistemic Brokering in the Interpreter-Mediated Medical Visit: Negotiating “Patient’s Side” and “Doctor’s Side” Knowledge

Chase Wesley Raymond

Department of Sociology
University of California, Los Angeles

A significant dilemma involved in communication in medical care is the interactional negotiation of “doctor’s side” versus “patient’s side” knowledge—two divergent, yet indispensible, understandings of sickness. The present study examines the ways in which language interpreters, as active coparticipants in the clinical encounter, can engage with these emergent territories of knowledge by reformulating how information is presented in the ongoing talk. Although related to the strategies used in language and culture brokering, the practices described here for epistemic brokering are distinct in that they redesign action types and stances, as well as initiate sequences, in the service of aligning with and satisfying the social, communicative, and medical objectives that exist on each side of the mediated interaction. It is argued that epistemic brokering practices are one means through which interpreters can accomplish—on a turn-by-turn basis—their various roles of codiagnostician, gatekeeper, patient advocate, etc., which previous research has identified. Data are in American English and in Central American dialects of Spanish with English translation.

Much of the complexity involved in clinical interaction derives from the negotiation of knowledge between medical personnel and those who seek their care. Doctors, through their scientific training and understanding of how diseases operate, are certified to diagnose and treat sickness, and they possess the cultural authority that this certification has earned them (Starr, 1982). Patients, on the other hand, while typically lacking in scientific knowledge of disease, have primary access to their own personal, biographical experience of living with the illness (or, in the case of parents in pediatric visits, having a child who is living with the illness)—that is, the symptoms they are/have been experiencing, the illness’s progression over time, their failed attempts get well, and so on (Kleinman, 1980, 1988; Mishler, 1984).

Thus there are two distinct yet indispensible “territories of knowledge” (Heritage, 2011b, 2012a, 2012b) that come into contact inside the walls of a medical examination room, and doctors and patients can be seen to orient to this epistemic divergence as they engage in talk.

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Correspondence should be sent to Chase Wesley Raymond, Department of Sociology, University of California, Los Angeles, 264 Haines Hall, 375 Portola Plaza, Los Angeles, CA 90095-1551. E-mail: craymond@ucla.edu
with one another (Halkowski, 2006; Heath, 1989; Heritage & Robinson, 2006; Stivers, 2002; Weidner, 2012). The dilemma for these interactants becomes: How is knowledge from either side of the interactional divide best designed for the interlocutor at any given moment in the medical visit? What are the potential communicative and interpersonal—not to mention medical—risks of “undersupposing and overtelling” versus “oversupposing and undertelling” with regard to each piece of information introduced into the interaction (Heritage, 2013a; see also Sacks & Schegloff, 1979; Terasaki, 1976/2004)? While on the one hand undertelling can fail to provide sufficient information needed to achieve understanding, on the other hand overtelling risks coming across as patronizing to recipients, and thus speakers work to design the presentation of knowledge from their domain in a format that is appropriate for particular hearers, at particular moments.

The prototypical interaction between physician and patient presupposes the existence of a common communicative medium—i.e., language—between the two interactants, through which this “epistemic landscape” (Heritage & Raymond, 2012) can be effectively navigated. However, such a reality is not always guaranteed. In the case of the United States, for example, the 2011 American Community Survey reported that 13.6 million individuals spoke English either “not well” or “not at all” (Ryan, 2013, p. 3). While certainly not an option in all clinical settings, a substantial number of larger hospitals across the globe employ on-staff interpreters (often in several languages, based upon the demographic makeup of the area) who are brought into the examination/emergency room to mediate visits in which patients and medical personnel are linguistically divergent from one another (cf. Raymond, 2014).

Drawing on U.S. pediatric genetics consultations with Spanish-speaking parents, the present study investigates how the individuals brought in to bridge the linguistic gap between the two interactants—the interpreters themselves—simultaneously engage in practices that serve to negotiate the territories of knowledge being co-constructed in and through the interaction. While previous research has described interpreters as “brokers” in the linguistic and cultural sense when specific terms, concepts, or belief systems are not shared between clinicians and patients (see, e.g., Baraldi & Gavioli, 2007; Fadiman, 1997; Haffner, 1992; Kaufert & Koolage, 1984; Tse, 1995), here we focus on a distinct set of interpreter-authored interactional practices that we term epistemic brokering. Epistemic brokering refers to the interactional steps taken by interpreters to ensure that linguistically discordant doctors and patients/parents are socially aligned at each step in the ongoing interaction by facilitating the establishment of common ground (Clark, 1996). That is, interpreters are seen to be taking into account not solely the basic transfer of informational content between the interactants but also the specific discursive formats mobilized to do so, thereby finessing the inherent asymmetries of knowledge in patient–provider encounters, along with interactional contingencies that can arise during the ongoing medical encounter.

By reformulating the action type (e.g., from a directive to a request for information or to an informing) and stance embodied in participants’ contributions to the talk, as well as launching their own sequences, interpreters-as-epistemic-brokers take steps to resolve the “undersuppose and overtell” versus “oversuppose and undertell” dilemma that might otherwise negatively affect the communicative and medical goals of both doctor and patient. The structure of the present analysis aims to underscore the bidirectional affordances of this form of brokering by illustrating first how “doctor’s side” knowledge can be brokered for patients, and then how “patient’s side” knowledge can be brokered for medical personnel. It is ultimately argued that epistemic brokering is one method through which interpreters—on a moment-by-moment basis in the interaction—accomplish the variety of roles that previous researchers have found them to perform, including
As a set of interactional practices, epistemic brokering may thus serve to promote patient participation in the visit and facilitate positive provider–patient relationships.

INTERPRETING AS SOCIAL INTERACTION

Investigation of live interpreting—particularly in the context of medicine—has received much academic attention in recent decades. Early models of interpreting that posited a simple transfer/conduit of information from one language to another (e.g., Reddy, 1979) have proven inadequate to account for the microlevel of detail involved in interpreter-mediated interaction in which interpreters’ practices can profoundly impact the ongoing talk (see, among many others, Angelelli, 2004a, 2004b; Baraldi & Gavioli, 2007, 2012; Bolden, 2000; Davidson, 2002; Eksner & Orellana, 2012; Elderkin-Thomson, Cohen Silver, & Waitzkin, 2001; Haffner, 1992; Hsieh, 2006, 2007, 2009; Hsieh & Hong, 2010; Hsieh & Kramer, 2012; Kaufert & Koolage, 1984; Mason, 2001; Metzger, 1999; Orellana, Dorner, & Pulido, 2003; Pasquandrea, 2011; Roy, 2000; Tse, 1995; Wadensjö, 1995, 1998; Weisskirch & Alatorre Alva, 2002). While these investigations range in methodology from discourse-/conversation-analytic, to ethnographic, to survey- and interview-based (many combining multiple methods), as a whole, research in this field has worked to recast interpreters as active coparticipants in interaction who not only translate language but simultaneously mediate the divergent social and cultural ideas, norms, and expectations of the other parties in the interaction.

Exemplifying a conversation-analytic approach is Bolden’s (2000) analysis of interpreters’ participation in the history-taking phase of the medical visit. Bolden illustrates how experienced medical interpreters go beyond turn-for-turn translation, instead orienting to the medical end goal of the interaction by actively taking steps to get there as quickly and efficiently as possible. Consider how such an orientation is demonstrated by the interpreter in Excerpt 1, taken from the present corpus:

(1) Cyclinex¹

11 INT: What’s the formula called er?
12 DOC: It’s a- just uhm Cyclinex one is fer (.)
13 infants and toddlers,
14 And then Cyclinex two is for children.
15 So it’s like a- ah: for older.
16 (.) When you get older.

((INT verifies which one MOM is giving the child now.))

23 INT: E: con la número dos puede:: e-w-
24 um with the number two she ca::n e-w-

¹Names and other identifying information have been anonymized from the transcripts included here.
In this example, the doctor explains the difference between two formulas: Cyclinex One and Cyclinex Two. The interpreter takes this explanation as foreshadowing a change in prescription from the former to the latter, and she begins to verify that assumption explicitly in line 24. Although in this particular instance the doctor was ultimately not headed in such a direction at this time, it was the understanding of the interpreter—as a coparticipant in the interaction—that prompted the inquiry at this specific point in the ongoing talk. Nonetheless, as Bolden (2000, p. 388) notes, most studies of translation in medical visits focus on more macrolevel phenomena and thus do not take a systematic approach to what is happening interactionally on a turn-by-turn basis within interpreter-mediated discourse.

Two primary, often-intersecting forms of brokering have been identified in the literature: Brokering of language and brokering of culture. Language brokering occurs when interpreters need to relay some term or piece of information from the source language into a language that lacks the necessary linguistic counterpart(s)—for example, “having” to find an equivalent concept in Cree or Saulteau for an anatomical term such as the appendix” (Kaufert & Koolage, 1984, p. 284). Because a given culture’s belief system affects what lexical resources are available in the language of its speakers, practices for engaging in language brokering are inextricably linked to those for culture brokering. Mediation of the beliefs and desires of patients vis-à-vis those of their doctors by way of culture brokering—for example, “arbitrat[ing] between the physician-directed regimen in the intensive care unit and the family’s insistence on holding a
4-day healing ceremony” (Kaufert & Koolage, 1984, p. 285)—goes beyond in-depth knowledge of the languages themselves, into the culturally based worldviews inhabited by the speakers of those languages (see Fadiman, 1997).

Just as language and culture brokering are not mutually exclusive sets of practices, in what follows we posit the existence of an additional set of interactional strategies that we term *epistemic* brokering. Distinct from the previously identified linguistic and cultural dimensions of interpreter-mediated interaction, the epistemic gradient (Heritage, 2010) invoked by a turn’s design is itself brokerable by reshaping the stance or action it is being mobilized to accomplish. There are no linguistic or cultural divergences between, for example, an English-speaking American doctor and Spanish-speaking Mexican patient that would prevent the doctor’s directive “Weigh it out” from being translated as such into Spanish. Nonetheless, as we will see, interpreters can instead reformulate such an action as a request for information, for instance, thereby deferring epistemic authority over past instances of food weighing to the patient, while at the same time sequentially legitimizing the patient’s participation in the visit. By reframing the presentation and receipt of knowledge for both doctors and patients, interpreters-as-epistemic-brokers take into account not only *that* some content is transferred from one interactant to another but also the sequentially conditioned discursive means through which that transfer is achieved. These adjustments to the emergent epistemic landscape serve to temper the social-interactional assumptions and expectations embodied in turns-at-talk, working to facilitate the establishment common ground (Clark, 1996) by negotiating the “undersuppose and overtell” versus “oversuppose and undertell” dilemma.

**ETHNOGRAPHIC BACKGROUND TO THE DATA**

The present investigation draws upon a corpus of recordings from interpreter-mediated pediatric genetics consultations, a subset of data from a larger, three-year ethnographic study that recorded a total of 193 clinical visits involving 75 families and four geneticists (Timmermans & Buchbinder, 2013). The infants and toddlers who are the subjects of the consultations have either been definitively diagnosed with, or are otherwise at a significant risk of developing, one or more genetic disorders that affect their ability to metabolize various amino acids. For these children, ingesting too much protein (e.g., from meats and dairy) can cause serious brain developmental problems, including mental retardation, microcephaly, irregular motor function, seizures, attention deficit disorders, and also death. Nonetheless, as children, they require a certain amount of protein so that they may grow healthily. A careful balance must therefore be struck between giving them enough protein for bodily growth and maturation but not so much that their cognitive development suffers.

The supreme importance of diet for these children is highlighted in the medical visits analyzed here, which involve both a doctor and a dietician in addition to the mother and child. Occasionally other family members or hospital personnel are present as well, at times totaling up to nine people in the examination room, though not all of these individuals participate equally in the consultation. The data analyzed here are taken primarily from the elaborate sit-down consultations between dieticians and parents in which the child’s eating habits are documented. In most cases, parents have been asked to keep a detailed food log to track everything given to the child. During these discussions, accuracy and precision are paramount: As will be illustrated, “fruit”
or “formula” are insufficient descriptions of the child’s food intake. Such reports are routinely pursued by medical personnel: “What type of fruit?,” “How many pieces?,” “How many scoops of powder with how many ounces of water to mix the formula?,” etc., so that precise nutritional facts can be calculated and compared with test results. One visit in the corpus even includes an elaborate, 3-minute deliberation (a portion of which is analyzed in the next section) concerning how many individual pieces of popcorn equate to one gram of protein.

The visits in question occur approximately once every three months and include not only the discussions of diet, but also a physical examination of the child and blood and urine tests in the hospital laboratory to longitudinally monitor the child’s levels of various acids. Multiple visits are recorded for each family.

In the subset of encounters analyzed here, a professionally trained, on-staff, bilingual Spanish-English interpreter is also present, as these parents are monolingual Spanish speakers communicating with monolingual English-speaking health-care providers. The medical center at which these consultations were recorded employs several interpreters, and thus a variety of individuals are represented in the data.

2While we use the term “monolingual” here to describe these parents, many do have at least some passive competence in English in that they are able to understand some of what doctors say without translation (lines 10–11). Similarly, simple words like sí/no (“yes”/”no”) are also often directly understood by the hospital personnel without translation (lines 20–22). The interpreter is nonetheless present in case of a misunderstanding (lines 12–20). Note that, with the exception of a few simple words, patients typically provide their responses in Spanish, which are then translated by the co-resent interpreter.

(A) Oral medicine vs. injection

10 DOC: So you give it to her everyday,

11 MOM: =Sí.

   yes

   Yes.

12 DOC: =So that’s easier than () the injection;

13 MOM: No.

14 INT: [Dice que es más fácil que la inyección.

he-says that is more easy than the injection

He says it’s easier than the injection.

15 DOC: >No no< I know.

16 MOM: [Mouth.

17 DOC: =It’s easier than the injection.

18 INT: [Más fácil=

   more easy

   Easier=

   que la inyección ( ).

   than the injection

   than the injection ( ).

19 MOM: Sí.

   yes

   Yes.

20 DIET: Yeah.

21 DOC: =Yes.
To illustrate precisely how knowledge can be negotiated through epistemic brokering, we will focus our attention on the two dyadic interactions (interpreter–parent and interpreter–clinician) that constitute the overall triadic (parent–interpreter–clinician) interaction in these pediatric visits. We begin by examining the ways in which interpreters discursively (re-)shape—for parents—knowledge expressed by medical personnel. Then we analyze how interpreters do the same in the other direction, navigating for doctors, dieticians, and nurses the knowledge evoked in and through the talk of parents. Despite this organizational distinction, it must be underscored that these two categories naturally—and productively—overlap with one another in this setting of triadic talk, a point to which we will return later in our discussion.

Brokering for the Patient/Parent

Epistemically brokering interaction for parents/patients involves reformulating the knowledge expressed and implicated in doctors’ turns-at-talk. Interpreter transformation of doctors’ action types and stances can work to level out the potentially steep epistemic gradient (Heritage, 2010) between the interactants, or it may function to give one or another participant primary authority over a given piece of knowledge. In each case, these brokering strategies effectively recalibrate the moment-by-moment social relationship among doctor, parent/patient, and interpreter by redesigning how “doctor’s side” knowledge is “talked into being” (Heritage, 1984b) during the visit.

Take the following Excerpt 2, which occurs at the beginning of a discussion of a patient’s blood test results. The doctor launches this new topic by describing the child’s “levels of methylmalonic acid” in line 1, a clear mobilization of the physician’s medical expertise through the use of a “specialist term” (Kitzinger & Mandelbaum, 2013).

(2) Methylmalonic acid

1) DOC:  -->  Her levels of methylmalonic acid have gone from
2) ()
3) Eighteen: (0.2) hundred.
4) .hhhhhh down to (_) two hundred.
5) An- Two hun’red an thirty six.
6) INT:  -->  ‘Tonces los niveles de: mtethylmalónico le llamα?    
then the levels of methylmalonic to-it he-calls
So the levels of methylmalonic he calls it?
7) .hhh Los ha bajado de dieci-
them she-has decreased of ei-
 .hhh They’ve gone down from ei-
8) de mil ochocientos, <a:: doscientos >>treinta<<.
from one-thousand eight-hundred to two-hundred thirty
 from one thousand eight hundred, <to: two hundred >>thirty<<.
9) (1.0) ((DOC scoots chair))
Although the knowledge being evoked here is clearly medical in nature, the unmitigated and through-produced design of the doctor’s extended turn as he looks at the patient’s chart (lines 1–5) inherently projects the interlocutor(s) as having at least some level of access to “methylmalonic acid,” which will, in turn, allow her/them to make sense of the reported information (i.e., to know whether this decrease in acid levels is a positive or negative test result). While the doctor may have reason to believe that these parents already know what methylmalonic acid is (e.g., from previous visits), in the event that they do not, such a turn-at-talk would, at this moment in the ongoing interaction, “oversuppose and undertell” knowledge from his domain.

The interpreter, through his translation, interactionally reshape the presentation of this knowledge to a less-presupposing format that no longer holds Mom accountable for recognizing the referent in question. He accomplishes this in line 6 by extracting the potentially problematic noun phrase from the rest of the doctor’s turn and framing it with the turn-final le llama? (“he calls it?”), in its own try-marked intonational phrase. This reframing not only makes a distinction between the knowledge bases themselves of doctor versus parent but also serves to modify the social and interactional expectations that accompany those divergent epistemic domains. That is, the interpreter discursively conveys to Mom that because knowledge of this term lies within the medical realm, she is not being held responsible for extracting meaning from it. By extension, she is also no longer being expected, at this moment, to demonstrate an active understanding of the medical significance of the test results that that specialist term was used to report. Of course, if Mom does have access to the referent in question, she would still able to display her understanding; however, the interpreter’s reframing of the doctor’s presentation of knowledge has made it so that no such uptake by Mom is interactionally due (i.e., noticeably absent if not produced).

While epistemic brokering of this sort can indeed further underscore doctors’ and parents’ divergent territories of knowledge, it simultaneously performs crucial interpersonal work between the interpreter and the parent. The le llama/“he calls it” formulation used here contrasts with other designs (e.g., se (le) llama/“it’s called”) that would have portrayed the interpreter as possessing his own independent access to this medical terminology. That is to say that Mom is not alone in her potential lack of access to this piece of medical knowledge; rather, the interpreter has presented himself as co-implicated in being one step removed from the “doctor’s side” domain. This serves to socially and interactionally legitimate such a relatively unknowing status as understandable and acceptable, thereby reducing the face costs (Brown & Levinson, 1987) for Mom should she wish to request further explanation of the try-marked noun phrase. Furthermore, in the event that Mom is already aware of the significance of this term, she and the interpreter can nonetheless find common ground in that their individual levels of understanding of what exactly “methylmalonic acid” is and how it functions are undoubtedly still distinct from the understanding of the doctor.

In sum, by way of this brief epistemic brokering event, the interpreter has neither undertold nor overtold, neither undersupposed nor oversupposed, Mom’s level of knowledge with regard to this specific piece of information. Knowledge expressed from the “doctor’s side” is thereby successfully conveyed to the parent in an interactionally appropriate manner, and thus the situated interaction can progress onward with this grounding in intersubjectivity.

Epistemic brokering does not require interpreters to consistently place themselves on level (i.e., co-knowledgeable or co-unknowledgeable) footing with patients/parents. On the contrary, based on the sequential progression of the interaction, interpreters are fully capable of taking the epistemic high ground—meaning they can discursively place patients/parents in a relatively
unknowledgeable position vis-à-vis their own/the doctor’s knowledgeable one. While such a steepening of the epistemic gradient (“undersupposing and overtelling”) might potentially be understood as patronizing in monolingual interactions, reformulating medical personnel’s utterances as explicit informings can serve not only to acknowledge but simultaneously to legitimize, as we saw earlier, parents’ lack of knowledge regarding a given topic.

The sequence in Excerpt 3 is initially launched by Mom asking a question about the protein content of store-bought macaroni and cheese that can be prepared at home. After verifying that macaroni and cheese does indeed have a significant amount of protein, Mom confesses that it is one of her daughter’s favorite foods. She then inquires as to what other options exist so that she might still allow her to eat it, proposing to leave out some of the cheese. Observe how the dietician’s directive response regarding alternatives in lines 14–21 is subsequently reformulated into an informing by the interpreter in lines 22–24/26.

### (3) Macaroni and cheese alternatives

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>MOM:</strong> Y:: entonce- (.) para darle yo los macarrones así, and so for to-give-her I the macaroni like-that <strong>A:::nd so- (.) for me to give him macaroni like that,</strong></td>
</tr>
<tr>
<td>2</td>
<td>Con menos pro- (.) Qué es lo que no le tengo que poner.= with less pro- what is it that no to-her I-have that to-put With less pro- (.) What is it that I shouldn’t put in.=</td>
</tr>
<tr>
<td>3</td>
<td>=El ques=:o? (0.3) o::: “qué.”= the cheese or what =The cheese? (.3) or::: what=</td>
</tr>
<tr>
<td>4</td>
<td><strong>INT:</strong> =U::h If she wants to giveuh her macaroni an cheese,=</td>
</tr>
<tr>
<td>5</td>
<td>=and doesn’t want (.) as much protein,</td>
</tr>
<tr>
<td>6</td>
<td>What does she- m:like leave out. The cheese: e?</td>
</tr>
<tr>
<td>7</td>
<td>(0.7)</td>
</tr>
<tr>
<td>8</td>
<td><strong>DIET:</strong> tch If you wanna give er macaroni an cheese?</td>
</tr>
<tr>
<td>9</td>
<td>()</td>
</tr>
<tr>
<td>10</td>
<td><strong>INT:</strong> [(Yes)</td>
</tr>
<tr>
<td>11</td>
<td><strong>MOM:</strong> [Yeah</td>
</tr>
<tr>
<td>12</td>
<td><strong>DIET:</strong> [Is’at what you mean?=</td>
</tr>
<tr>
<td>13</td>
<td><strong>MOM:</strong> =Yes &quot;yeh.=&quot;</td>
</tr>
<tr>
<td>14</td>
<td><strong>DIET:</strong> .h Then you’d have to u:::s: (=)</td>
</tr>
<tr>
<td>15</td>
<td>Either jus give a very small amount or: u- u:m:</td>
</tr>
<tr>
<td>16</td>
<td>−−&gt; Use the low protein (.)</td>
</tr>
<tr>
<td>17</td>
<td>−−&gt; macaroni er “the low” protein cheese,</td>
</tr>
<tr>
<td>18</td>
<td>()</td>
</tr>
<tr>
<td>19</td>
<td>And so it doesn’t have that much.</td>
</tr>
<tr>
<td>20</td>
<td>(0.2)</td>
</tr>
<tr>
<td>21</td>
<td>In it.</td>
</tr>
<tr>
<td>22</td>
<td><strong>INT:</strong> −−&gt; <strong>Hacen: macarone: especial</strong> con menos queso, &lt;o con queso they-make macaroni special with less cheese or with cheese</td>
</tr>
<tr>
<td>23</td>
<td><strong>They ma:ke special macaroni:</strong> with less cheese, &lt;or with cheese</td>
</tr>
</tbody>
</table>
In this excerpt, the dietician answers Mom’s question by referring to “the low-protein macaroni” and “the low-protein cheese” (lines 16–17). Her use of the definite article “the” in both cases presupposes that the knowledge of these items is shared with Mom (“you’d have to use,” line 14). However, the design of Mom’s original question presented Mom as not having any access to knowledge of such a product: Indeed, lines 2–3 and the interpreter’s translation thereof reveal Mom’s assumption that leaving something out of the normal recipe would be the most viable option to allow her child to continue to eat macaroni and cheese. The dietician’s response is therefore inappropriately designed for this recipient, at this moment, with regard to the epistemic gradient it embodies.

In addition to oversupposing and undertelling this bit of “doctor’s side” knowledge, the dietician’s formulation also constitutes a potential threat to Mom’s face by delegitimizing the asking of Mom’s question in the first place: If Mom already knew that such distinct, low-protein macaroni and cheese options were available, then indeed she should not have proposed omitting ingredients from the original recipe.

The interpreter orients to these interactional contingencies by transforming the presentation of this information in a way that acknowledges Mom’s very likely unknowing position with regard to the availability of these macaroni and cheese alternatives. This is accomplished through the turn-initial framing hacen . . . /“they make . . .,” which sets up this turn in its entirety as an informing for Mom—not as a oversupposing directive for her to mobilize knowledge to which she already has (or should have) access. Furthermore, because Mom’s initial question was an explicit request for information, the action of informing in the response is an overall better sequential fit. The interpreter additionally presents this option not as regular macaroni, but rather as macarone: especial/“special macaroni:” (line 22) that naturally and understandably exists outside of the epistemic domain of everyday, average macaroni consumers. Similar to the le llama/“he calls it” framing we saw used in Excerpt 2, here the design of the interpreter’s turns works to no longer hold Mom accountable for possessing knowledge that she may not have had prior access to. Note Mom’s immediate change-of-state token (Heritage, 1984a) in line 25, acknowledging receipt of this information as indeed new knowledge.
By changing the action-type from a directive to an informing, as well as the inherent “oversupposing and undertelling” stance embodied in the dietician’s turns-at-talk, the interpreter creates an epistemic brokering event that qualifies Mom’s question as an appropriate one at the same time as it provides the medically relevant answer she was seeking.

In addition to taking a knowledgeable stance vis-à-vis patients/parents, interpreters may also recalibrate doctors’ presumed access to “patient’s side” knowledge by adopting an epistemically *downgraded* position. This effectively allows interpreters to defer knowledgeable authority to patients when it comes to matters that lie in the patient’s domain.

Prior to the following Excerpt 4, the participants have been discussing the protein content of popcorn. The child enjoys popcorn, but Mom is nervous that it contains too much protein based on the contents listed on the box. There has been confusion as to how many grams of popcorn correspond to how many grams of protein, as these are two gram-based measurements that refer to different things. Toward the end of this discussion, the interpreter’s reformulation of the dietician’s bald imperatives (lines 1 and 3) launches a new sequence that serves to demonstrate respect for Mom’s epistemic primacy (lines 4 and 6) as to her own past experiences in weighing the popcorn.

(4) Popcorn

1  DIET:  
   -   
   \[\text{Weigh it out. You have a scale.}\]

2  INT:  
   [\text{una-}  
    \text{a scale}  
    \text{a scale}  
   ]

3  DIET:  
   -   
   \[\text{Just weigh out (. ) one (y’know (. ) twenty eight ounces.}\]

4  INT:  
   -   
   \[\text{Tiene una pesa?}  
    \text{you-have a scale} \]
   \[\text{Do you have a scale?}\]

5  MOM:  
   \[\text{Sí,}  
    \text{yes}  
    \text{Yes,}\]

6  INT:  
   -   
   \[\text{Ha pesado::: las palomitas?}  
    \text{you-have weighed the popcorn}  
    \text{Have you weighed the popcorn?}\]

7  MOM:  
   \[\text{£} \text{$\uparrow \text{hay}$ L(h)as he pes(h)ado(h).hah hah}  
    \text{yes them I-have weighed}  
    \text{£} \text{$\uparrow \text{YES}$ I’ve we(h)ighed th(h)em.hah hah}

8  INT:  
   \[\text{She’s weighed it.}\]

9  DIET:  
   \[\text{OH you weighed it.}\]

Nearly an hour into the visit at the time of this exchange, weighing food with a scale has already been topicalized, as Mom detailed out her child’s daily food intake since their last visit. Despite this interactional history, the interpreter does not adopt the presupposition intrinsically conveyed in the dietician’s utterance and legitimately assumable from the interactants’
preceding talk. Instead, in line 4, she epistemically downgrades the dietician’s directive to a question format that projects the interpreter (and potentially the dietician as well) as unknowing with regard to Mom’s experience with a scale. By deferring the epistemic high ground to Mom with regard to this inherently “patient’s side” knowledge, the interpreter is able to “test the waters” and avoid making a recommendation that is potentially redundant and therefore face-threatening—particularly for parents (Heritage & Sefi, 1992).

Following Mom’s confirmation that she does have a scale, the interpreter formulates another question as to whether or not she has already done what the dietician is directing her to do. This is, again, a productive strategy because, in deferring knowledgeable authority to Mom, the interpreter lays the groundwork for an affiliative exchange no matter what the response. If Mom says that she has not yet attempted to weigh out the popcorn, the interpreter can retroactively convert that question into a pre-request or pre-announcement (Terasaki, 1976/2004), following the turn by suggesting that she do so (Heritage & Sefi, 1992). Or, in the event that Mom responds that she has weighed out the popcorn, as occurs here in line 7, the interpreter can report back to the dietician that the initial directive is inapposite, as the activity has already been performed. Either way that the sequence plays out, the interpreter has carried out face-affirming work for both the dietician (who is no longer presented as oversupposing and presuming access to Mom’s past actions) and the parent (whose original question from 2 minutes prior has now been rendered a legitimate one).

In this particular case, the dietician displays surprise upon being informed of this fact: “↑OH you weighed i:t.” (line 9). Subsequent to this exchange, the interactants discover that Mom did not fully comprehend how to correctly weigh food using the scale and then compare/calculate protein quantities using food boxes’ nutritional facts (cf. Williams, Baker, Parker, & Nurss, 1998). However, given the substantial amount of research that has demonstrated the overall diminished levels of vocal participation (problem presenting, question asking, etc.) among disadvantaged social groups (e.g., ethnic minorities, individuals with low levels of literacy/education, members of the working class, and so on) (Epstein, Taylor, & Seage, 1985; Korsch, Gozzi, & Francis, 1968; Mangione-Smith, Elliott, Stivers, McDonald, & Heritage, 2006; Pendleton & Bochner, 1980; Roter & Hall, 2006; Stivers & Majid, 2007; Van Ryn, 2002; Waitzkin, 1985), it is quite possible that this essential information would never have been brought to light had the interpreter not created the interactional space for Mom to offer up knowledge from her own domain. Furthermore, if this experiential information had been mobilized in response to a directive, as originally produced by the dietician, Mom would have run the risk of contaminating the in-progress activity (Whalen, Zimmerman, & Whalen, 1988) by launching what might have been understood by the other interactants as an argument (see also Heritage, 2011a). Epistemic brokering can therefore constitute a means through which additional, medically relevant information can be safely communicated by parents/patients and discussed with clinicians during the visit in a face-affirming way.

The exchanges considered in our analysis thus far have underscored not only that there are territories of knowledge at work in the interpreter-mediated medical visit but also that these territories of knowledge have pragmatic and social implications that must be taken into consideration. As interpreters epistemically broker interaction for patients—reshaping the knowledge-based landscape of which they are a part—they undertake crucial interpersonal work that socially realigns the participants in the interaction and serves to legitimize and thereby encourage parents’/patients’ active, ongoing participation in the medical encounter.
Brokering for Medical Personnel

Brokering strategies can be mistakenly conceptualized as performed uniquely “for the patient”—that is, to facilitate patients’ understanding of medical knowledge (test results, diagnoses, treatment recommendations, and so on). However, medical territories of knowledge are not the only domains that can potentially create confusion and threaten the success of the communication between doctor and patient, and thus patients are not the only interactants who stand to benefit from epistemic brokering practices. Discursive negotiations of the epistemic landscape can work to grant medical personnel better access to patients’ firsthand knowledge of their experience with the illness, which is necessary for appropriate and effective treatment recommendations to be offered. Indeed, what Bolden (2000, p. 392) has previously described as an “orientation to obtaining from the patient and conveying to the doctor medically-relevant information about the [patient] . . . and doing so as efficiently as possible” is, in fact, one strategy through which interpreters can accomplish epistemic brokering (see Excerpt 1 [Cyclinex]).

In Excerpt 5, the dietician is reading off of a sheet of paper that Mom has provided that lists what the child has been eating on a daily basis. Recall that this information needs to be quite detailed—more so than this particular parent has noted in her log—and thus the dietician and nurse are modifying its contents, item by item, by talking with Mom. Of particular interest here is the interpreter’s self-authored turn in line 8 that mobilizes her own knowledge in an effort to secure the clinicians’ understanding of the fruta/“fruit” in question.

(5) Dole cup

1    DIET:     Fruta:::. ((Reading; English phonology))
         fruit
         Fru:::it.

2    MOM:     Yeah.=

3    DIET:     =What kinda [fruta: heh heh heh ]

4    MOM:     [A::h heh heh [heh Es] mi::xed.<the fruta.
         it is mixed the fruit
         A::h heh heh heh It's mi::xed.<the fruit.

5    INT:     [heh heh]

6    INT:     [It’s a fruit] mix.

7    MOM:     [Los de fruit]
         those of fruit
         The fruit ones

8    INT:     --> Como las: [(). copitas de Do::le?]
         like the cups.DIM of Dole
         Like the: (.) little Do::le cups?

9    MOM:     [A- hhh.

10   MOM:    --> Uh huh.

11   INT:    --> Like a Dole cup.

12   (.)
\[
\text{After a moment of shared laughter, Mom’s response in line 4 gives an answer to the dietician’s question: The fruit in question is “mixed.” This answer, however, is oriented to as an “under-telling” one through the dietician’s lack of uptake (lines 6–7) as it does not provide the medically relevant information that the original question was in search of. In response to this interactional hitch, the interpreter introduces a comparative referent—not previously stated by any of the other participants—into the interaction to aid in the transfer of knowledge from Mom to the dietician:}
\]
Como las (.) copitas de Dole? /“Like the (.) little Dole cups?” (line 8). While the interpreter is indeed mobilizing her own knowledge and understanding in this turn, the question’s design defers final authority on the matter to Mom. This short, dyadic sequence between Mom and the interpreter ends when Mom confirms that the Dole cup is an appropriate comparison in line 10, and this is reported to the dietician by the interpreter in line 11. The dietician’s enthusiastic change-of-state and acknowledgement tokens display her newfound level of understanding, even being followed by repetition of the specific referent that registers the content of that understanding (Goldberg, 1975; Heritage, 2013b; Heritage & Sefi, 1992): “↑OH Okay. Dole cup.” (line 13). By actively orienting to the dietician’s need for a more-informative response to her question and self-authoring a turn in line 8 to seek out the necessary information, the interpreter-as-epistemic-broker was thus able to lay the groundwork for shared understanding between the coparticipants.

What is particularly salient in this exchange is the genuine medical relevance of this seemingly mundane “patient side” information. The knowledge invoked and negotiated during this epistemic brokering event has a direct effect on the patient’s medical record: Description of what exactly a Dole cup is becomes the objective of subsequent talk (lines 13–14, 27–32, and beyond the talk shown here). That is, through the interpreter’s brokering of two distinct domains of knowledge, a “unit of measurement” that is both interactionally and medically appropriate is invoked by the interpreter, confirmed by Mom, endorsed by the medical staff, and ultimately entered into the patient’s official nutrition documentation.

Despite its obvious value, epistemic brokering is not entirely without its risks. Just as is the case for participants in monolingual patient–provider exchanges, it is possible for interpreters to misjudge the epistemic status of those for whom they are interpreting and consequently “oversuppose and undertell” or “undersuppose and overtell” some element of information. This, in turn, opens the door for resistance from one or more of the interactants. Take Excerpt 6, for example, in which the interactants are discussing the details of a specific brand of premade baby food, called “Gerber Graduates,” which is sold in jars.

(6) TV dinners

1 INT: That’s the Gerber Graduates.=
2 DIET: =U:mm: What-Does she remember what-
3 [What?
4 INT: [Se acuerda qué tipo de:
self you-remember what type of
Do you remember what type of
((28 lines omitted describing what the meal
includes: potatoes, vegetables, etc.))
32 DIET: The whole jar?
33 INT: Se come [todo el] bote:?
self she-eats all the jar
Does she eat the whole jar?
34 DIET: [Half a jar?]
EPISTEMIC BROKERING

35 MOM: No:. La mitad.
no the half
No. Half.

36 INT: No: Half.


38 .hhh A:nd

39 INT: --> Esos son los que vienen como (chamitas) verdad?
those are the that come like premade truth
Those are the ones that come (premade) right?

40 MOM: --> Sí.
yes
Yes.

41 INT: --> Yeah those are like little TV dinners[:

42 DIET: --> [Right.

43 DIET: --> Ri-I-I know what [they are. Yeah.

44 INT: --> [Yeah.

45 INT: --> Okay.

46 FAM: --> hah [hah

47 MOM: --> [Ella me los enseñó(h)hah [hah
she to-me them showed
She showed them to m(h)ehah hah

48 INT: --> [Oh. Y:ou showed (.)

49 INT: --> them (.) to her.

50 MOM: --> ((coughs))

51 DIET: --> That’s ri[ght. I did.

52 MOM: --> [hah [hah hah hah hah

53 FAM: --> [e: hah hah hah

Here, just as in the previous Excerpt 5, the interpreter brings in outside information in the form of a question to Mom in line 39. After Mom confirms this hypothesis in line 40, the interpreter presents it to the dietician. In this case, however, the dietician refuses to be placed in the reciprocal, unknowing position, and she pushes back on the informing action’s inherent presupposition that she would need to be informed about the specifics of this food item (lines 42–43). Mom, in line 47, then further corroborates the dietician’s claim to primary access to the knowledge in question by remarking that it was the dietician who showed them to Mom in the first place.

The crucial difference between this exchange and the “Dole cup” interaction seen in the previous example occurs in lines 37–38 of this most-recent case. After topicalizing the food item and specifying how much of it the child has been consuming (lines 4–36), this dietician accepts this information and moves to progress the activity forward: “Half jar. Okay. .hhh A:nd” (lines 37–38) (Beach, 1993; Heritage & Sorjonen, 1994). That is, she does not offer any indication that the TV dinner referent being discussed is in any way problematic for her. It is in this sequential environment that the interpreter launches an epistemic brokering sequence (lines 39–41) that is
ultimately deemed inapposite. This contrasts with the previous “Dole cup” example in which the interpreter’s engagement in epistemic brokering was directly responsive to a lack of uptake by the dietician in response to the dietician’s own request for information.

Comparison of these two exchanges underscores that “doctor’s side” and “patient’s side” knowledge do not exist a priori in the minds of doctors and patients respectively. Rather, these territories of knowledge are co-constructed features of the ongoing interaction, and interpreters can be seen to be actively participating in the negotiation of this emergent epistemic landscape on turn-by-turn basis in talk.

DISCUSSION

The present analysis has demonstrated ways in which negotiations of knowledge in interpreter-mediated interactions transcend simple “translation” and move into the realm of epistemic brokering—a set of practices that were argued to be related to, but distinct from, those for language and culture brokering. Regardless of the existence or lack of linguistic/cultural equivalents for a given turn-at-talk, interpreters-as-epistemic-brokers take sequential context into account as they work to facilitate the development of common ground between patients and clinicians. As we have demonstrated, this entails not only the transfer of knowledge itself from one interactant to another but also the discursive designs through which such intersubjective understanding is sequentially achieved in talk.

We began by examining how interpreters can discursively reshape “doctor’s side” knowledge for the benefit of patients’ understanding and continued participation in the medical visit. We then illustrated how interpreters similarly work to negotiate intersubjectivity with medical personnel with respect to medically indispensible, “patient’s side” experiential knowledge. But the line between epistemically brokering interaction for the patient versus for the doctor is fundamentally and necessarily an obscure one, given that these practices serve to establish affiliative and face-affirming common ground among all of the interactants.

By tempering the actions and stances invoked in a physician’s oversupposing turn-at-talk, for example, the interpreter not only transfers the medically relevant information itself, but does so in a way that actively legitimizes the patient’s participation in the medical exchange, thereby rendering medical personnel—and the institution of medicine that they embody more generally—as more socially and interactionally accessible. This is particularly relevant given the wide range of studies that have demonstrated the negative impact that language discordance between doctor and patient can have on patient participation in medical visits (including avoidance of seeking medical attention altogether) (see, e.g., David & Rhee, 1998; Derose & Baker, 2000; Rivadeneyra et al., 2000; Roter & Hall, 2006; Stein & Fox, 1990). Similarly, in epistemically brokering the knowledge produced in patients’/parents’ turns-at-talk, interpreters not only aid medical personnel in achieving their medical objectives (Bolden, 2000; Hsieh, 2007; Watermeyer & Penn, 2009) by facilitating the understanding of medically relevant information, but they also present themselves and patients/parents as willing co-collaborators in the successful completion of medical tasks.

This discussion underscores the fact that interpreters’ navigation of the emergent epistemic landscape is as socially and interpersonally consequential as it is medically significant. Epistemic brokering is therefore argued to be one method through which interpreters enact their variable role as what Hsieh and Kramer (2012) call “smart technology.” Epistemically brokering interaction
allows interpreters to accomplish—at the ground level of the ongoing, turn-by-turn talk—the various social identities of co-diagnostician, gatekeeper, patient advocate, and so on, which have been reported in the literature (Bolden, 2000; Davidson, 2000; Hsieh, 2006, 2007, 2009; Hsieh & Hong, 2010). By coparticipating in and actively engaging with the territories of knowledge present in the medical encounter, interpreters-as-epistemic-brokers work to align with and satisfy the social, communicative, and medical objectives that exist on each side of the mediated interaction.

CONCLUSIONS AND AVENUES FOR FUTURE RESEARCH

The present analysis has proposed the concept of epistemic brokering as a method of explicating the ways in which interpreters can navigate and negotiate the distinct, emergent territories of knowledge present in the interactions they mediate. Such findings inspire future inquiry into both the range of specific practices used for this sort of brokering, as well as the social and interactional limits involved in their deployment. What are the various discursive formats through which epistemic brokering can be accomplished? Where exactly is the line, for example, between the proactive, productive use of these formats to facilitate understanding, and “taking them too far,” as we saw in Excerpt 6? More generally, what might the implications be for relieving medical personnel of engaging in this sort of epistemic navigational work for themselves?

Additionally, investigation of the epistemic landscape in interpreter-mediated medical visits raises questions about other co-constructed “territories” in interaction. For instance, what role do deontic rights and responsibilities (Stevanovic & Peräkylä, 2012)—e.g., “↑ Weigh it out. You have a scale. Just weight out (. ) one y’know (. ) twenty eight ounces.” (lines 1/3 of Excerpt 4)—play as interpreters broker the unfolding talk in which they are active coparticipants? And how might such additional brokering practices work in tandem with each other and with the knowledge-based strategies described here?

At the same time as they mediate the surface-level issue of the language barrier, interpreters are, quite literally, mediating the social and interpersonal relationship that is being developed between the interactants through the moment-by-moment use of language. As a set of interactional practices for ensuring common ground, epistemic brokering is one way that interpreters can engage as coparticipants in clinical visits and thereby potentially affect the outcomes thereof—both socially as well as medically.

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