

STATEMENT OF SCHOLARHIP

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RESEARCH

My research interests focus on the communicative process between various individuals during an illness event. I am particularly interested in issues related to the intercultural contexts of health care and illness, which have long histories of social inequality experienced by minority patients and offer ample opportunities to both advance theory and affect social change. I have been involved in research on bilingual health communication in the past 10 years. The three aspects that I have investigated are (a) the discrepancies between the beliefs and the practice of medical interpreters, (b) interpreters' influences on the quality of health care services, and (c) interpreters' mediation of conversational partners' identities and communicative goals. In the past few years, I also have extended my theoretical interests to examine coping as a coordinated behavior between various parties. I am particularly interested in how social support and health literacy is coordinated and negotiated between the patient and his/her supportive others. I currently pursue two lines of research dealing with health communication for non-English speaking and/or minority patients. The issues are (a) developing a model of bilingual health communication to explain the effectiveness and appropriateness of interpreters' communicative strategies and (b) investigating how patients' (cultural-specific) social support and health literacy influences their coping strategies and health behaviors. My objective with these two lines of research is to develop theoretical frameworks that not only explain the phenomenon of interest but also guide best practices in health care settings.

In the last few years, I have collaborated with health care providers and faculty members in the University of Oklahoma-Health Sciences Center, the OU Medical Center, and the local American Indian Tribal Clinics. I have invited several faculty members and/or providers to serve as co-investigators in my NIH grant applications. In addition, I viewed our collaboration as a

long-term relationship and worked to develop the infrastructures of those departments/clinics for continuous research collaboration.

Research Line 1: Model of Bilingual Health Communication

This is a line of research that first motivated me to become a health communication scholar when I was working as a medical interpreter at the UCSF Stanford Health Care (now known as Stanford Hospitals & Clinics) while working on my MA degree in translation and interpretation studies at the Monterey Institute of International Studies, one of the top graduate schools for professional, high-level interpreters (e.g., conference interpreters). I also worked as a telephone interpreter for AT&T Language Line during that time. My rigorous training in professional interpreting, clinical experience as a medical interpreter in both on-site and telephonic settings, and extensive education in both qualitative and quantitative methods provided me unique insights and expertise in developing my theoretical model.

Within this line of research I have evolved significantly in my theoretical focus and provided important contributions to the field of bilingual health care that have advanced both its theoretical scopes and clinical practices. I have published extensively and have received an NIH R03 grant in this area. I also have submitted a NIH Challenge grant aiming to continue and expand this line of research. Three stages best describe my line of work in this area up to this point. These stages should not be understood as strict, distinctive, temporal phases; rather, they simply reflect how my work has evolved over the years.

Stage 1: Interpreting as a Communicative Activity

This stage of research forms the basis of my dissertation as I examine the literature from various disciplines and delineate my model of bilingual health communication. I published several articles to highlight the discrepancies in the practice and ideology of interpreting, identify

problems in the conceptualization and design of research in medical interpreting, and explore directions of research that are important in advancing the field of bilingual health communication.

My discussion on the unique characteristics of different types of medical interpreters (Hsieh, 2006) is adopted by American Medical Association's (2007) *Office guide to communicating with limited English proficient patients*.

My list of publications in this stage includes:

Hsieh, E. (2001). Training in different models of medical interpretation. Proceedings of the Fifth Symposium on the Teaching of Translation and Interpretation: The trends and outlook of the teaching of translation and interpretation in the 21st Century (Vol. 2, Sec. 3, pp.1-15). Taipei, Taiwan: Graduate Institute of Translation and Interpretation, National Taiwan Normal University.

This paper provides a detailed review of the different types of medical interpreters who currently are utilized in medical settings, and offers training recommendations for different models of medical interpretation. Currently, there are mainly five types of medical interpreters: chance interpreters (e.g., family members), untrained interpreters (e.g., bilingual support staff), bilingual healthcare providers, telephone interpreters, and on-site medical interpreters. Based on published literature and personal observations, I first discuss the strength and weakness of these five types of medical interpreters in terms of availability, professionalism, comfort to patients, interpreting quality, and their role as interpreters. Next, in view of these strength and weakness, I further explore the different guidelines that should be followed by each type of medical interpreters. Finally, I provide specific recommendations for the training and education for different types of medical interpreters.

Hsieh, E. (2002). Necessary changes in translation ideology. 翻譯學研究集刊 Fan I Hsueh Yen Chiu Chi K'an [Studies of Translation and Interpretation], 7, 399-435.

An earlier version of this article published as:

Hsieh, E. (2002). The necessary changes in the modern translation ideology. Proceedings of the Sixth Symposium on the Teaching of Translation and Interpretation; Twenty-first century innovation in technology: Teaching translation and interpretation (pp. 142-165). Tainan, Taiwan: Department of Applied Languages for Interpretation & Translation, Chang Jung Christian University.

Three major problems in modern translation ideology were identified and the researcher proposed changes necessary for advancements in the development of translation theories and translation technology. Traditionally, the development in translation theory has created a translation ideology that has focused on the faithfulness and the accuracy of target texts in

representing the source texts, encouraging translators and interpreters to become neutral conduits in the language-transferring process. Based on related literature, Bakhtin's Dialogic Model, and Speech Act Theory, I identified three problems in the current translation ideology: (a) an overemphasis on Conduit Model; (b) simplification on the roles of translators; and (c) Quixotism in finding the "best" translation. I suggested that the development of translation theories and ideologies should move toward the Dialogic Model suggested by Bakhtin, which emphasizes the co-construction of contexts and meanings of all participants involved in the communicative process. I proposed a normative approach, which focuses on the practice of translation and interpretation, in developing translation theories, and discussed its implications for translation technology. By understanding the active roles translators and interpreters can play and *do* play and by recognizing the importance and the benefits of such phenomena, it is evident that the emphasis of translation technology should not be eliminating the presence of translators and interpreters or be creating the "best" target text. Rather, a good translation program should involve translators and interpreters in the decision-making process of translation and interpretation, providing necessary information and contexts for translators and interpreters.

Hsieh, E. (2003). The communicative perspective of medical interpreting. *Studies in English Language and Literature*, 11, 11-24.

This paper used medical interpreting as an example to examine the recent attention to the communicative nature of translation and interpretation. In presenting the historical development of community interpreting, I examined the reasons why the communicative aspect of translation and interpretation has been ignored in the traditional translation studies. The recent research on community interpreting highlighted the fact that the neutrality envisioned in traditional ideology (i.e., translators as conduits) is not practiced even among professionals. I provided a brief overview of efforts from various disciplines (i.e., anthropology, sociology, applied linguistics, psychology, and communication) to resolve such discrepancies, which led to the recent attention to the communicative perspective of translation and interpretation. I argued that interpreters' choice of interpreting strategies is not solely dependent on their linguistic ability or interpreting competence. Various factors (e.g., communicative goals, social identities, institutional contexts, contextual factors) may influence interpreters' performances. Communication as a discipline provides well-grounded theories on how these factors may influence interpersonal interactions. Using the constructs and concepts developed in communication research, I presented a theory of medical interpreting that incorporates an interdisciplinary understanding of the communicative perspective of interpreting.

Hsieh, E. (2003). The importance of liaison interpreting in the theoretical development of translation studies. 翻譯學研究集刊 *Fan I Hsueh Yen Chiu Chi K'an [Studies of Translation and Interpretation]*, 8, 283-322.

An earlier version of this article is published as:

Hsieh, E. (2003). The importance of liaison interpreting in the theoretical development of translation studies. *Proceedings of the Seventh Conference on the Teaching of Translation and Interpretation* (pp. 165-199). Taipei, Taiwan: Graduate Institute of Translation and Interpretation Studies, Fu Jen Catholic University.

This paper examined the distinct characteristics of liaison interpreting and explored the contribution of liaison interpreting to the theoretical development of translation studies. The historical development and theoretical themes of translation studies suggested that the ideology and codes of conduct of consecutive interpreting are heavily influenced by theories of translation and simultaneous interpreting. An overview of the theoretical development of interpretation across various disciplines (e.g., anthropology, sociology, applied linguistics, discourse analysis, psychology, and communication) suggests that the latest development of examining interpreter-mediated conversations as a communicative activity will allow researchers to explore the dynamic and interactive aspects of interpretation. I proposed a new field of investigation, liaison interpreting, in lights of its potential contributions to various disciplines. The distinct characteristics of liaison interpreting (i.e., the dynamics of interpreting activity, the mediation of roles and identities, and the contextual influences of interpreting) provide researchers rich resources to explore the complexity of interpreting as a communicative activity coordinated between multiple parties and to develop effective models to facilitate interpreter-mediated interactions.

Hsieh, E. (2006). Understanding medical interpreters: Reconceptualizing bilingual health communication. *Health Communication*, 20, 177-186.

This article provides a new approach in conceptualizing bilingual health communication, emphasizing the differences between types of medical interpreters as well as the interrelationships among all participants in bilingual health communication. Confronted by the conflicting results of interpreting services in medical settings, the author used past research to explain why medical interpreters should be categorized into different categories (i.e., chance interpreters, untrained interpreters, bilingual health care providers, on-site interpreters, and telephone interpreters) so that their characteristics and interpreting styles can be better observed and understood. In addition, by recognizing that interpreter-mediated communications in health settings are dynamic situations and that all participants can influence the outcomes of the communication, researchers can start to investigate the interrelationships among all the participants and, thus, develop different strategies that will improve the quality of bilingual health communication.

Stage 2: Interpreters' Role Performances

The second stage of this line of research focuses on interpreters' management of their roles and its corresponding consequences on the interactional dynamics, communicative process, discursive content, and clinical consequences. This stage of research builds from my dissertation work, which focuses on interpreters' understanding and enactment of specific roles. This line of research follows the recent trends of researchers (Kaufert & Koolage, 1984; Roy, 2000; Wadensjö, 1998) in interpretation studies in examining interpreting as a speech activity that is communicative, interactional, and emergent. This line of research is heavily influenced by theorists like Goffman (1961, 1974, 1979, 1983), Gumperz (1982, 1992), Bakhtin (1986), and Goodwin (1981).

In the last few years, I have provided systematic examinations of specific roles and role performances. Building upon the discussion on interpreters' visibility and active management of the interpreter-mediated interactions (e.g., Angelelli, 2002, 2004), I examined the contextual features that may motivate interpreters to deviate from a neutral and passive role, the potential theoretical and clinical implications for interpreters' choice of communicative strategies, and the interpersonal, institutional, and other contextual challenges to interpreters' management of provider-patient interactions.

The data for these studies are collected for my dissertation work, which include a one-year ethnographic study of two Mandarin Chinese interpreters (which also include 12 interpreter-mediated medical encounters, each lasts 1-1.5 hours) and in-depth interviews with 26 interpreters from 17 languages/cultures. The amount and quality of the data is rare in research in bilingual health care.

My list of publications in this stage includes:

Hsieh, E. (2006). Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science & Medicine*, 62, 721-730.

Interpreters face challenges because of the various role expectations that others have placed on them and then adopt specific strategies to manage these conflicts. This study examines the conflicts in medical interpreters' role performances, the sources of these conflicts, and interpreters' strategies for resolving conflicts. It is based on in-depth interviews with 26 medical interpreters from 17 languages in the Midwestern area of the USA. The results showed that interpreters experienced four sources of conflicts in their role performances: (a) others' communicative practices, (b) changes in participant dynamics, (c) institutional constraints, and (d) unrealistic role expectations. To resolve conflicts, interpreters justified their roles by identifying the source and location of an assignment, (re)defining the relationships and identities of the provider and the patient, and adopting specific communicative strategies. This study highlights the importance of speaker and contextual factors on interpreters' communicative strategies and management of role conflicts.

Hsieh, E. (2007). Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters. *Social Science & Medicine*, 64, 924-937.

This study examined medical interpreters' practice of the co-diagnostician role and further explored its practical, institutional, and ethical implications. Twenty-six professional interpreters (of 17 languages), 4 patients, and 12 health-care providers were recruited for this study, which involves participant observation and interviews undertaken in the Midwestern US. Constant comparative analysis was used to develop themes of interpreters' communicative practices. Interpreters justified their role performances by claiming the identity of a member of the health care team and their work as part of the team effort. Their communicative strategies as a co-diagnostician reflect their preconception of the social hierarchy of health-care settings and the emphasis on diagnostic efficacy. I have identified five strategies for the co-diagnostician role. These were assuming the provider's communicative goals; editorializing information for medical emphasis; initiating information-seeking behaviors; participating in diagnostic tasks; and volunteering medical information to the patients. Although many strategies can be attributed to interpreters' effort to conserve providers' time and to bridge the cultural differences, they also pose risks to patients' privacy, clinical consequences, and provider-patient relationships.

Hsieh, E. (2007). 角色呈現之管理：醫療口譯員於雙語醫病互動中扮演之場域管控。 [Managing role performances: Interpreters as stage managers in bilingual provider-patient interactions]. 翻譯與跨文化交流：轉向與拓展—首屆海峽兩岸翻譯與跨文化交流研討會論文集 *Proceedings of the First Cross-straits Symposium on Translation and Intercultural Communication* (pp. 356-364). Shanghai, China: Shanghai Foreign Language Education Press.

This study examines interpreters' strategies to mediate and negotiate the various roles and role expectations from the participants of interpreter-mediated interactions. In total, 12 medical encounters (each lasted 1-1.5 hours) were observed and 26 professional medical interpreters

from 17 languages participated in-depth interviews. This study suggests that interpreters are sophisticated stage managers in provider-patient interactions, defining the stages for other participants, providing necessary props for the participants to put on a good performance, and controlling the stages so that unwelcome guests are excluded. The study also highlights the interdependence of the speakers' communicative behaviors and interpreters' mediation strategies. Finally, this study explores stage management as a strategy for mediation and its corresponding consequences and theoretical implications.

Hsieh, E. (2008). "I am not a robot!" Interpreters' views of their roles in health care settings. *Qualitative Health Research*, 18, 1367-1383.

In this study, I examined interpreters' self-perceived roles and their corresponding communicative goals and strategies. Twenty-six professional interpreters (of 17 languages), 4 patients, and 12 health care providers were recruited for this study, which involved participant observation of medical encounters and in-depth interviews. Constant comparative analysis was used to generate a typology of interpreters' self-perceived roles, which are different from the roles they learned in their training. Different roles reflect differences in interpreters' concern for other participants' goals, institutional goals, and their own communicative goals. Interpreters' desire to maintain neutrality during the medical encounters influences the communicative strategies they adopt when assuming other roles. I conclude the article with the theoretical and practical implications of interpreters' self-perceived roles.

Hsieh, E. (2009). Bilingual health communication: Medical interpreters' construction of a mediator role. In D. Brashers & D. Goldsmith (Eds.), *Communicating to manage health and illness* (pp. 135-160). New York: Routledge.

This study examines medical interpreters' understanding of their roles as a neutral participant in the provider-patient communication. This study includes participant observation of 12 interpreter-mediated medical encounters and 20 interviews with 26 interpreters (from 17 languages). The results suggest that interpreters explicitly identified themselves with a conduit role, claiming a passive presence during the communicative process. The interpreters aimed to accomplish two communicative goals in this role: transferring complete information and reinforcing provider-patient relationship. The study suggests that the neutral role enacted by interpreters actually requires calculated and purposeful strategies to manipulate the communicative contexts and the conduit model does not explain the complexity of interpreters' practices. In fact, interpreters' understanding of their role is similar to the role of a mediator, which interpreters' primary concern is to intervene in the communicative process in a way that ensures the patients' and providers' equal access to and control over information

Stage 3: Interpreter-Provider Collaboration

The most recent stage of research is supported by my NIH R03 grant, titled *Providers' Views of the Roles of Medical Interpreters*. Extending beyond examining interpreters'

understanding of their practices and roles, I explore providers' attitudes and expectations of interpreters' practices. In addition to the data I collected for my dissertation work, I also have in-depth interviews/focus groups with 39 providers from five specialty areas, including mental health, emergency medicine, OB/GYN, oncology, and nursing. I am currently conducting a large scale survey based on the finding from this line of research. I will begin data analysis of the survey in late 2009.

In several articles, I juxtaposed interpreters' and providers' point of views to explore the differences and conflicts in their perspectives. With this stage of research, I advanced the field of research on bilingual health care by examining the challenges of interpreter-provider collaboration and highlighting interpreters' agency in the communicative process. By recognizing medical interpreting as a goal-oriented activity (e.g., ensuring quality of care and achieving optimal outcomes), I view interpreter-mediated medical encounter as a collaborative activity that requires coordination between all participants in the emergent communicative process.

This stage of research centers on how interpreters' agency (i.e., interpreter as an active participant) influences the dynamics of provider-patient interaction. I identified features that are critical to the success of health communication in general (e.g., trust, emotional support, authority, and power) and explore how these features are performed, interpreted, and negotiated in interpreter-mediated interactions. I also explore how these findings provide insights into the theoretical development of interpreting studies and the best practices of bilingual health care.

My list of publications in this stage includes:

Hsieh, E., Kong, H., Kramer, E. M. (in press). 醫療口譯員與醫護人員如何建構、協調彼此的溝通語意及專業權威. [Constructing meanings and authority in bilingual health care]. *翻譯學研究集刊/Fan I Hsueh Yen Chiu Chi K'an* [Studies of Translation and Interpretation].

An earlier version of this article is published as:

Hsieh, E., Kong, H., Kramer, E. M. (2009). 醫療口譯員與醫護人員如何建構、協調彼此的溝通語意及專業權威. [Constructing meanings and authority in bilingual health care]. *Pre-Conference Proceedings of the Thirteenth Conference on the Teaching of Translation and Interpretation* (pp.33-48). Taipei, Taiwan: Graduate Institute of Translation and Interpretation Studies, Fu Jen Catholic University.

A reprint of this article is also requested for:

Hsieh, E., Kong, H., Kramer, E. M. (in press). 醫療口譯員與醫護人員如何建構、協調彼此的溝通語意及專業權威. [Constructing meanings and authority in bilingual health care]. *Post-Conference Proceedings of the Thirteenth Conference on the Teaching of Translation and Interpretation*. Taipei, Taiwan: Bookman.

This study examines interpreters' and health care providers' understanding and negotiation of authority and trust in bilingual health care. Twenty-six professional interpreters (of 17 languages) were recruited for in-depth interviews. In addition, 32 health care providers from 4 specialties (i.e., mental health, nursing, oncology, and OB/GYN) were recruited to participate in in-depth interviews and focus groups. By recognizing interpreter-mediated medical encounters as a complex phenomenon, we investigate (a) providers' and interpreters' understanding and negotiation of their authority in constructing meanings, and (b) providers' and interpreters' competition and collaboration in constructing meanings in medical encounters.

The findings highlight several issues that are critical to the construction of authority in bilingual medical encounters. First, interpreters utilize a specialized speech genre and various semiotic resources (e.g., linguistic, spatial, nonverbal resources) to construct meanings during bilingual medical encounters. Interpreters actively influence the process and content of the medical discourse. In addition, providers may change their communicative behaviors in response to the interpreters' management of communicative contexts. Second, the frames of references (i.e., frames that are used to derive meanings and construct authority) for individuals involved in a bilingual medical encounter may not be consistent or compatible with each other. Interpreters utilize the genre of interpreter-mediated talk to derive meanings, whereas other participants often are not familiar with such a frame and use their own cultural norms and monolingual talk to derive meanings. In addition, health care providers may filter a patient's talk through their expertise-specific frame, whereas interpreters manage the medical discourse as a holistic event. Third, the construction of meanings and authority in bilingual medical encounter is an interactive

process, requiring individuals to negotiate the appropriate and effective use of semiotic resources and frames of references. Although health care providers have the institutional status and medical expertise to assert legitimate power in the medical encounter, interpreters are the ones who decide how providers' voices are told or heard. By means of their communicative strategies, interpreters construct meanings through the identity of others. Their construction also involves relational and informational management, a power that is de facto to the very process of mediation. Mediation is a form of power. In addition, interpreters may assert their expertise in cultural and linguistic issues, and thus, claim legitimate power in asserting control over the information exchanged in the medical discourse.

Hsieh, E. (in press). Provider-interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions. *Patient Education and Counseling*.

An earlier version of this article received *Top Young Scholar Paper Award at the 2008 Kentucky Conference on Health Communication, Lexington, KY.*

Objective: This study examines (a) providers' and interpreters' perception of their competition in controlling the content and process of provider-patient interactions, and (b) the challenges to providers' and interpreters' collaboration in bilingual health care.

Methods: I recruited 26 professional medical interpreters from 17 languages and 39 providers from 5 specialties to participate in in-depth interviews and focus groups. Grounded theory was used for data analysis to develop themes in areas where providers and interpreters compete and assert their expertise.

Results: Providers and interpreters experience conflicts over their expertise and authority due to their practice in (a) adopting different speech conventions, (b) controlling the other's narratives, and (c) overstepping expertise and role boundaries.

Conclusion: A successful bilingual medical encounter is dependent on the interpreters' and providers' ability (a) to understand, communicate, and negotiate their and others' communicative strategies/goals and (b) be adaptive of and responsive to others' management of the communicative process.

Practice Implication: Authority in bilingual health care should not be established through pre-existing categories or expertise but negotiated and coordinated during the interactive process, which would allow individuals to be adaptive to the issues emerged in the communicative process.

Hsieh, E., Ju, H., & Kong, H. (in press). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research*.

This study problematizes provider-interpreter trust, examining the challenges to providers' and interpreters' collaboration in bilingual health care. We conducted in-depth interviews and focus groups with 26 medical interpreters (from 17 languages) and 32 providers (from 4 specialties) in the United States to provide an empirically-based framework of provider-

interpreter trust. Constant comparative analysis was used for data analysis. We identified four dimensions of trust: (a) interpreter's competence, (b) shared goals, (c) professional boundaries, and (d) established patterns of collaboration. These dimensions are pathways to enhance or compromise provider-interpreter trust. Although they are distinctive categories, they are interrelated and interdependent in constructing provider-interpreter trust. We further explore how these dimensions highlight tensions and challenges that are unique in provider-interpreter relationship. We concluded with practical guidelines that can enhance provider-interpreter trust and propose future research directions in bilingual health care.

Hsieh, E., & Kramer, E. M. (in press). The clashes of expert and layman talk: Constructing meanings of interpreter-mediated medical encounters. In C. Callahan (Ed.), *Communication, comparative cultures and civilizations* (Vol. 2). Cresskill, NJ: Hampton.

An earlier version of this article received *Top Paper Award* (Language and Social Interaction Division) at annual meeting of the International Communication.

This study examines examine interpreters' and health care providers' perception and management of communicative contexts and strategies in interpreter-mediated medical encounters. We recruited 26 professional medical interpreters from 17 languages and 32 health care providers from 4 specialties to participate in in-depth interviews and focus groups. Our findings suggest that no one has the sole authorship to his or her own voice in interpreter-mediated encounter. The provider's (and the patient's) voice is mediated through the interpreter's performance (or voice). The interpreter's voice remains hidden while being constantly monitored, supervised, and rectified by the provider. In addition, the once integrated voice diverged into multiple voices. Individuals *differentiate* their understanding of and response to (a) meanings across various semiotic resources, and (b) functions of the provider-patient conversations. As a result, the integrated, singular voice is perceived and treated with multiple authors and purposes, each with its corresponding expertise and authorities in legitimizing the voice(s).

Grant Activities

Dissertation Grant: Grant application (#1 R03 HS013877-01) for Agency for Healthcare Research and Quality. Priority Score: 288 (initial review) Grants were provided to projects with priority score under 250. Because this grant is for dissertation work, I did not resubmit the application due to graduation.

The specific aim of this study is to examine the communication strategies and beliefs (e.g., interpreting selectively, adding complementary information, omitting details, using common words instead of jargon, making the speakers' utterances more assertive or polite, or using gaze to coordinate the flow of conversation) of both professional and nonprofessional interpreters in health care settings. If interpreters are actively involved in the process through specific communicative strategies, it is important for researchers to ask why and how interpreters

choose one specific strategy over another. The specific research questions are: First, what are relevant categories of (a) types of interpreters, (b) types of communicative goals and goal conflicts, (c) role expectations for interpreters, and (d) types of contextual factors that affect interpreters' communicative performances? Second, what are the relationships between (a), (b), (c), and (d)?

Awarded: *Providers' Views of the Roles of Medical Interpreters.* Grant (#1R03MH76205-01-A1) funded by National Institute of Mental Health of the National Institutes of Health. Role: Principal Investigator. Period: 09/01/2006-08/31/2009. \$146,417

The importance of medical interpreters to improve the health literacy of patients with limited English proficiency (LEP; e.g., through effective communication with health care providers) has been widely recognized; however their roles and functions are less understood and more widely debated. Although there are a few studies that have examined how interpreters understand their roles in health care settings, no studies have examined health care providers' expectations for the roles of interpreters and the quality of bilingual health communication. The objective of the study is to generate a new communication theory that highlights providers' communicative goals during a medical encounter and educates interpreters to respond to the providers' needs more effectively. The specific aims of this study are (a) to assess providers' experiences with, perceptions of, attitudes about, expectations for medical interpreters and (b) to explore differences in these dimensions across different medical specialties. The proposed study is a two-year project, involving both qualitative and quantitative methods. In year one, focus groups will be conducted with health care providers who have worked with medical interpreters to explore their views of interpreter-mediated interactions. In year two, based on the themes and categories developed from the focus group interviews, the PI will develop a questionnaire to survey health care providers about their attitudes about medical interpreters. The use of focus groups in year one to develop and test questionnaires in year two will increase the reliability and validity of the instrument. The specific research questions are: (a) What are providers' experiences with and attitudes about the communicative strategies used by interpreters?; (b) What are the criteria used by providers to evaluate the success of bilingual health communication?; (c) What are providers' expectations for interpreters' roles and performances?; and (d) Do providers in different specialties vary in their perceptions, attitudes, and expectations? Answering these questions will allow the PI to develop a program of research that includes further developing bilingual health communication theory and designing training programs to increase health literacy of patients with LEP.

In Preparation: *Interpreters' Impact on LEP Parents' Communicative Competence in Pediatric Oncology.* New submission anticipated in October, 2009 for PA-07-392: Reducing Health Disparities Among Minority and Underserved Children (R01).

- Initial submission (#1 RC1 HD063635-01) was for NIH Challenge Grants in Health and Science Research (RFA-OD-09-003) in April, 2009. Role: Principal Investigator. NIH Summary Report (07/28/2009):

<i>Criteria</i>	<i>Reviewer 1</i>	<i>Reviewer 2</i>
Significance	outstanding	excellent
Investigators(s)	outstanding	very good
Innovation	exceptional	very good
Approach	excellent	very good
Environment	outstanding	outstanding

This project is also supported by internal funding:

Awarded: Junior Faculty Summer Fellowship (2009), College of Arts and Sciences, University of Oklahoma. Research Project: *Improving the Quality of Care for Child Patients of Parents with Limited-English-Proficiency*, \$6,000.

Interpreters often are considered an essential resource in improving the health disparities experienced by children of Limited-English-Proficiency (LEP) parents and LEP population in general. As researchers have begun to recognize the complexity of bilingual health care, this longitudinal study will explore how different types of medical interpreters influence provider-patient communication and quality of care over the course of an illness event in pediatric oncology. The specific aims of this study are (a) to identify changes in the communicative competence of a LEP parent across the course of an illness event, (b) to explore the influence of interpreters on LEP parental and provider communicative competence, (c) to determine how the coordination among participants in a medical encounter influences the quality of bilingual health care, and (d) to identify specialty-specific needs and perspectives of bilingual health care. The study will include both qualitative and quantitative research designs and a variety of types of data. First, we will track 36 child patients over a 18-month period, collecting 5 video-recorded interpreter-mediated medical encounters from each patient. Second, we will conduct interviews/focus groups with providers, interpreters, and LEP parents (and the child patients) to explore effective and ineffective strategies in coordinating with each other to achieve successful care. The data will be analyzed through qualitative formative research (i.e., constant comparative analysis) and quantitative analyses (i.e., content analysis and statistical analysis). The study represents pioneering work in juxtaposing the actual practice (i.e., 180 video-recorded medical encounters) with the participants' perceptions and evaluation (e.g., interviews). The longitudinal design also provides insights into how providers, patients, and interpreters can develop effective strategies to coordinate with each other over time. The quantity and quality of the data is unprecedented in research on bilingual health care. This study is *significant* because (a) it is the first longitudinal study to examine how on-going relationships can influence the effectiveness and appropriateness of bilingual health care and (b) it recognizes that successful interpreter-

mediated encounters must be facilitated among all individuals involved (and thus, all participants can be a point of intervention to improve the quality of bilingual health communication). This study is *exceptionally innovative* because (a) it is the first empirical investigation that examines bilingual health communication by focusing on the changes and collaborations between participants to achieve communicative competence, (b) it recognizes the importance of ongoing interpersonal relationships and nonverbal behaviors in bilingual health care, and (c) it allows researchers to explore and triangulate research findings through various perspectives (e.g., observed interactions vs. participant reports; evaluations from providers, LEP parents, and interpreters). The long-term goals of the project are to develop communication models for bilingual health care in pediatric oncology, provide effective guidelines for the working with different types of interpreters, and provide training programs for patients, providers, and interpreters to enhance their communicative competence in bilingual health care.

Research Line 2: Social Support and Health Literacy

My second line of research is influenced by Brashers' and Goldsmith's work on uncertainty management and social support (Brashers, 2001; Brashers, et al., 1999; Brashers, Neidig, & Goldsmith, 2004; Goldsmith, 2000, 2004). Research Line 2 also is influenced by the theoretical traditions of Language and Social Interaction, viewing illness management as a socially constructed activity that requires effective and appropriate coordination between various individuals through communicative activities. In addition, I am interested in how culture influences individuals' understanding, interpretation, performance, and negotiation of supportive behaviors.

By recognizing illness management as a coordinated activity between the patient and his/her supportive others, I am interested in how social support can be coordinated in such a way that promotes individuals' health literacy (i.e., the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions). Although health literacy traditionally has been viewed as a fixed, internalized, individual skill, my understanding of health literacy, however, is an interactive,

coordinated accomplishment of all parties involved in the illness event. This is because in my research of bilingual health care, I realized the interpreters' and family members' coordination with the patient in the management of an illness event (e.g., participation in provider-patient interactions) may enhance or compromise a patients' health literacy.

Although Research Lines 1 and 2 may first appear to separate research lines, they both share my view of examining communication as a coordinated activity between all individuals involved. In addition, my research in bilingual health care allow me to explore how culture may influence individuals' coordination of social support and health literacy in an illness event.

Although my publications in Research Line 2 are significantly fewer than that of Research Line 1, I am excited about its theoretical potentials and have been working on a theoretical model of coping that centers on individuals' coordination of social support and health literacy in an illness event. I also am working on a junior investigator grant that allows me to further examine my model in the population of American Indians.

My list of publications in this line of research includes:

Brashers, D. E., Goldsmith, D. J., & Hsieh, E. (2002). Information seeking and avoiding in health contexts. *Human Communication Research*, 28, 258-271.

Information management is an important component of coping with illness and illness-related uncertainty. Normative theory and research on information seeking and avoiding in health contexts can help explain why some information management activities are more adaptive than others. Challenges and dilemmas of information management include relational demands (e.g., the need to coordinate the behaviors and goals of the participants) and contextual features (e.g., cross-cultural considerations or channels available for information seeking and providing). Issues that need to be addressed in a normative approach include (a) how Information management goals can be accomplished while still accounting for other goals (e.g., identity management or relational maintenance), (b) what roles interpreters can play to facilitate effective cross-cultural information exchange (e.g., as cultural informants), and (c) how information seekers can best manage conflicting or overwhelming information when confronted with messages from multiple channels.

Hsieh, E. (2004). Stories in action and the dialogic management of identities: Storytelling in transplant support group meetings. *Research on Language and Social Interaction*, 37, 39-70.

In this article, I examine the practice of storytelling in a transplant support group, investigating how individuals' participation in storytelling activities allowed them to coconstruct collective and individual identities. The sequential ordering and contexts of the storytelling activities in the support group meetings suggest that both the speakers and audience strategically negotiated the meanings of stories as well as identities that emerged. Both the storytellers and the audience incorporated storytelling activities into the management of multiple goals (e.g., identity management, uncertainty management, and communicative efficacy). I conclude with a conceptual framework that outlines the practice of dialogic management of identities through storytelling activities by individuals with chronic illness.

Brashers, D. E., Hsieh, E., Neidig, J. L., & Reynolds, N. R. (2006). Managing uncertainty about illness: Health care providers as credible authorities. In R. M. Dailey & B. A. Le Poire (Eds.), *Applied interpersonal communication matters: Family, health, and community relations* (pp. 219-240). New York: Peter Lang.

This chapter examines how the credible authority of providers influences patients' uncertainty management and their interaction with providers. Patients with HIV participated in focus group interviews to discuss their uncertainty in illness events. Their narratives suggest that providers are considered credible authorities of medical knowledge but not of the patients' subjective illness experiences. Providers were able to reduce a patient's uncertainty by providing medical-related information, providing access to secondary resources, and validating patients' illness experiences. Both providers and patients are motivated to maintain the credible authority of providers and to manage the uncertainty in the illness events through modified provider-patient relationships and coordinated management of uncertainty.

Brashers, D. E., Rintamaki, L. S., Hsieh, E., & Peterson, J. L. (2006). Pragma-dialectics and self-advocacy in physician-patient interactions. In P. Houtlosser & A. van Rees (Eds.), *Considering pragma-dialectics* (pp. 23-34). Mahwah, NJ: Erlbaum.

This chapter first presents pragma-dialectics and the ideal model of critical discussion. One case in which deliberative interactions might vary from the ideals of critical discussion is self-advocacy. Healthcare interactions are a particularly interesting context in which individuals might need to advocate for themselves. It is important to understand more fully how and why patients promote their own interests, and what outcomes are associated with self-advocacy. The next section describes patient self-advocacy and outlines some challenges. The remainder of the chapter considers data from two samples of people living with HIV or AIDS: A set of focus group interviews with 32 participants and a set of one-on-one interviews with 72 participants. Transcripts were reviewed for comments associated with self-advocacy. Two related themes are examined here: (a) the subjectivity of the illness experience leads to a need for self-advocacy and

(b) negotiation and critical discussion occur together in self-advocacy situations. Selected examples are presented in the following sections to elaborate these themes.

Hamm, R. M., Bard, D. E., Hsieh, E., & Stein, H. F. (2007). Contingent or universal approaches to patient deficiencies in health numeracy. *Medical Decision Making*, 27, 635-637.

Medical decision-related numeracy includes aptitude with numbers, fractions, and ratios. It is an aptitude assumed necessary for complete understanding of the risks of health behaviors and medical treatments, for communicating one's utilities when the patient's individual preferences can swing the decision, and for considering costs and cost-effectiveness of alternative treatments. Articles in this issue of *Medical Decision Making* provide support for each of these competing approaches. One of the article reports on the development of a subjective measure of numeracy intended to facilitate its measurement for research. Another article describes a communication tool, a "Drug Facts Box," that tabulates the efficacy and side effect rates of a treatment. Research and theory may be needed to identify the key concepts for each disease's decisions as well as effective ways to present quantitative concepts accessibly.

Grant Activities

Awarded: *Illness as a Coordinated Family Activity: Use of Traditional Chinese Medicine by Elderly Chinese in the United States*, Oklahoma Clinical and Translational Sciences Institute (OCTSI) Scholar Program funded by the Clinical and Translational Science Award Planning Grant (NIH-NCCR-1 P20 RR023477-01P) and the College of Medicine at the University of Oklahoma-Health Sciences Center. Role: Faculty mentor to OCTIS scholar: Haiying Kong. Period: 06/01/2009-07/31/2009. Scholar stipend: \$4000; Mentor's expense: \$500.

I serve as Haiying Kong's mentor in this grant. This is a research topic that she has worked with me over the years and planned to use this project as the basis of her dissertation work. The specific aims are (a) to understand what TCM practice means to the elderly Chinese in their management of health and illness, (b) to examine the roles and influences of elderly Chinese in the overall family health care practice. We collected data through in-depth individual interviews with elderly Chinese in the US and used grounded theory, a qualitative analytical method, for data analysis. The research questions are: (a) How should health literacy as a theoretical concept be applied to the elderly Chinese in the contexts of TCM? (b) What does it mean to them by using Traditional Chinese Medicine?

Under Review: *Situating Health Literacy and Social Support in the Management of Diabetes.* Grant application (#1 P20 RR024487-01) for National Institutes of Health (Title: Centers of Biomedical Research Excellence [CoBRE]; RFA-RR-06-002). Role: Principal Junior Investigator. 2nd resubmission in April, 2009. [1st revision: Priority score: 192; Scientific Evaluation rating: Excellent], \$1,229,446

This grant was initially submitted as a R01 application in 2006 but later withdrawn due to the invitation of the University of Oklahoma to submit this under the CoBRE mechanism as a principal junior investigator. [In total, the CoBRE grant is budgeted at approximately 10 million dollars; my project is budgeted at approximately 1.2 million dollars.]

This project is also supported by internal funding:

Awarded: Junior Faculty Summer Fellowship (2005), College of Arts and Sciences, University of Oklahoma. Research Project: *Health Literacy and Communication about Risk*, \$6,000.

Awarded: Junior Faculty Research Program (2006), Vice President of Research, University of Oklahoma. Research Project: *Communicative Patterns in Support Group Meetings*, \$6,000.

This proposal is the first longitudinal study to situate a patient's changes in and management of health literacy and social support during the progression of diabetes. The specific aims of this study are: (a) to identify the changes in a patient's health literacy and social support across the course of an illness event (i.e., diabetes), (b) to determine how social support influences a patient's health literacy, (c) to explore variations in the effectiveness of health literacy and social support for the management of a chronic illness, and (d) to identify the cultural-specific needs and perspectives of social support and health literacy of American Indians. (The specific research questions are presented in the Research Design and Methods section). These aims will be addressed through qualitative formative research and quantitative surveys. The long-term goal of the project will be to develop intervention tools that increase health literacy by incorporating a patient's social support network into their illness experience and improving the quality of care for patients with diabetes. The proposed study is a five-year project, involving both qualitative and quantitative methods. The qualitative study will include (a) 6 quarterly interviews and surveys with 80 patients who are recently diagnosed with diabetes and 2 interviews and surveys with 160 members of their support network over an 18-month period, and (b) follow up focus groups will be conducted each year after the initial 18-month period. The data will be examined using qualitative and quantitative analysis to extract important themes and relationships between different variables. Compared to past research on health literacy and social support, this study is innovative because it is (a) the first empirical investigation to situate a patient's (changes in) health literacy and communication patterns in the progression of an illness event and (b) the first longitudinal study that examines the moderating effects of social support on patients' health literacy and coping. This study is significant because it (a) focuses on an illness that disproportionately affects American Indians, (b) investigates the role of a patient's

social support network in influencing health outcomes, (c) examines the changes in a patient's health literacy and communicative behaviors throughout the course of an illness event, and (d) will serve as a foundation for future interventions to improve health literacy and outcomes for people living with diabetes.

Future Research Directions

My two research lines complement each other as I examine individuals' coordination in an illness event to achieve optimal outcomes. The grants I have applied reflect my theoretical interests and future research directions. More specifically, for research line 1, I aim to incorporate patients' perspectives into my model of bilingual health communication, explore interpreters' role in patients' management of an illness event, and develop a comprehensive model of communication for all parties involved bilingual health care. My goal is to publish a book on my model of bilingual health communication in the next five years. The book will incorporate perspectives from providers, patients, and interpreters, identify specific contextual features that may present challenges to interpreter-mediated interactions, and provide solutions and guidelines for best practices of bilingual health care.

For research line 2, I plan to conduct a longitudinal study of how individuals coordinate with their supportive others to manage their diabetes. The data will be essential to my theoretical model of coping, which I have been working closely with Dr. Dale Brashers. The model of coping situates a patient's changes in and management of health literacy and social support during the progression of an illness event. By examining the variables that influence individuals' health literacy, their interrelationships, and causal pathways, we aim to identify intervention points to improve the patients' coping and health literacy in illness events.

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