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# THE CLASHES OF EXPERT AND LAYMAN TALK

## CONSTRUCTING MEANINGS OF INTERPRETER- MEDIATED MEDICAL ENCOUNTERS

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This chapter examines 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 four 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 an 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).

Several literature reviews in the areas of intercultural health care have concluded that professional medical interpreters have a positive impact on the quality of patients' health care and provider-patient communication. Traditionally, interpreters have been envisioned as neutral, invisible linguistic conduits, faithfully transferring information from one language to another.<sup>1</sup> Interpreter-as-conduit<sup>2</sup> is a popular ideology that is held by public and health care providers.<sup>3</sup> Recent studies, however, have found that interpreters often actively and systematically adopt specific strategies to manipulate the content and process of provider-patient interactions,<sup>4</sup> which can influence patients' therapeutic processes and treatment decisions. For example, sometimes an interpreter may provide medically related information, offer emotional support, and intervene in the treatment process by acting as a co-diagnostician.<sup>5</sup> When interpreters' style sought to engender trust and rapport, Latino patients were more likely to agree to amniocentesis.<sup>6</sup> A neutral or slightly cheerful interpreter can serve as a buffer to a patient's mood if the therapist is despondent; alternatively, a despondent interpreter can cause significant negative mood changes in the patient even when the therapist's mood is neutral or cheerful.<sup>7</sup>

Recent studies also have highlighted the health care providers' role in influencing interpreters' communicative practices. Hsieh noted that providers' communicative behaviors (e.g., directing comments to the interpreter rather than the patient) can create dilemmas for interpreters who wish to assume an invisible role.<sup>8</sup> Health care providers may become suspicious of interpreters' performances due to differences in the lengths of original and interpreted messages or can become distrustful of interpreters' efforts with respect to providers' control over the treatment process.<sup>9</sup> They also complained about the time-consuming nature of interpreter-mediated interactions.<sup>10</sup> Interpreters are not unaware of these concerns and often report adopting proactive strategies to address the concerns that providers may have. For example, in Hsieh's study, interpreters reported intentional use of nonverbal behaviors (e.g., avoiding eye contact when interpreting) to encourage other speakers to perceive the provider-patient relationship as the primary relationship.<sup>11</sup> Davidson found interpreters adopting strategies to facilitate providers' agendas in time management.<sup>12</sup> In short, several researchers have argued that the interpreter as an invisible conduit is an ideological myth that does not exist due to the interactive and goal-oriented nature of an interpreter-mediated medical encounter.<sup>13</sup> Although interpreters may utilize various resources to create an image of neutrality, their management of the communicative contexts, identities, and communicative goals suggest deliberate efforts to facilitate provider-patient interactions.<sup>14</sup>

In cross-cultural health care, providers and patients are faced with significant differences in their worldviews, which often lead to disagreements in their understanding of the illness and preferences for treatment.<sup>15</sup>

Interpreters often are perceived as the solution to bridge these differences. The challenge of the interpreter-mediated medical encounter is that participants involved in the provider-patient interactions need to negotiate meanings across various *languages*, *cultures*, and *expertise*, which often entail differences in worldviews and values. Health care providers are the medical experts who are well acquainted with Western biomedical culture and knowledge.<sup>16</sup> However, they are laymen in their understanding of the patients' culture and the complexity of interpreter-mediated interactions.<sup>17</sup> In contrast, medical interpreters are the linguistic and cultural experts who often engage in complex management of interpreter-mediated interactions.<sup>18</sup> Nevertheless, the latter are novices when it comes to medical knowledge and procedures.<sup>19</sup> Although the differences in the providers' and interpreters' expertise may appear to be complementary to each other, we believe that the co-construction of meanings in interpreter-mediated medical encounters is a complicated process that warrants further investigation.

First, bilingual health care presents challenges for the participants to navigate through various cultures, such as medical, ethnic, and socioeconomic cultures, as well as their corresponding worldviews. These cultural differences may not be compatible with each other. For example, researchers found that patients from European and African cultures viewed information receiving as empowerment and believed that obtaining illness-related information has positive consequences (e.g., gaining self-efficacy or developing autonomy). In contrast, patients from Mexican and Korean cultures viewed information receiving as an agent for negative consequences, such as stripping away a patient's hope or hastening the progression of a poor diagnosis (i.e., saying it makes it so).<sup>20</sup> In other words, in health care settings, the differences between patients from these cultures are not only about whether they want to know their poor prognosis but also what *happens* when a poor prognosis is disclosed to them. The differences in individuals' perceptions of the meanings and functions of information become more complicated as the participants in bilingual medical encounters attempt to negotiate within the values and hierarchy of the institutional structure. For instance, when a provider believes that respecting family values is a compromise to a patient's autonomy, and as such can be the equivalent of destroying the provider's "moral compass,"<sup>21</sup> an interpreter then faces the challenge of mediating the seemingly irreconcilable cultural and value differences between the provider and the patient. In addition, interpreters not only need to be attentive to these differences but often are mindful of the institutional hierarchy and social disparity in health care settings.<sup>22</sup>

Second, providers and interpreters may utilize different conventions and social norms in constructing and interpreting meanings in bilingual medical encounters. Angelelli noted that interpreters are "engaged in the

co-construction of meaning with other interlocutors within an institution, which is permeable to cultural norms and societal blueprints."<sup>23</sup> As linguistic experts, interpreters are trained to adopt specific linguistic strategies that may not be familiar to other participants. Interpreters do so to manipulate communicative contexts. Although interpreters may adopt those strategies with a particular objective in mind, it is unclear how those strategies are interpreted or understood by other participants. In addition, interpreters need to navigate and situate their strategies in (at least) two different languages (and their corresponding conventions and social norms). It is possible that their communicative strategies may not be recognizable to other speakers or may be interpreted in ways that deviate from the interpreters' intended meaning. Considering that (a) individuals derive and construct meanings through social conventions and cultural norms,<sup>24</sup> and (b) interpreters and health care providers may utilize different frameworks of conventions and norms, it is important to examine how providers and interpreters understand and negotiate conventions and norms in the co-construction of meanings during provider-patient interactions.

Third, providers and interpreters may compete for authority in interpreting and constructing the meanings of medical interactions. In cross-cultural health care, providers are the medical experts and interpreters are the linguistic and cultural experts. Culture has a pervasive influence on patients' health behaviors<sup>25</sup> as well as their symptoms and experiences of illness.<sup>26</sup> Because illness experiences are socially and culturally constructed, patients and physicians may have serious conflicts if they are not aware of each other's understandings of specific symptoms or illness experiences, which often are situated in individuals' worldviews.<sup>27</sup> For example, whereas American physicians view epilepsy as a life-threatening illness that needs to be eliminated, a Hmong patient may perceive epilepsy as a gift from God that needs to be managed.<sup>28</sup> In these situations, providers and interpreters may face difficulties in defining the boundaries of medicine, religion, culture, and language. The challenges in establishing the boundaries may lead to conflicts and misunderstandings between the participants as providers and interpreters possess different expertise and may wish to exert authority in defining the meanings of the medical dialogue.

Although recent studies have highlighted the active roles that interpreters play in the communicative process,<sup>29</sup> few have examined how interpreters' co-constructing of meanings in the bilingual medical encounter is understood, interpreted, and negotiated by other participants. The objective of this study is to examine interpreters' and health care providers' perception and management of communicative contexts and strategies in interpreter-mediated medical encounters. By recognizing interpreter-mediated medical encounters as a complex phenomenon that requires participants to negotiate meanings across different cultures and worldviews, we

will investigate (a) interpreters' strategies to construct meanings, (b) providers' understanding and negotiation of their control over meanings, and (c) providers' and interpreters' competition and collaboration of constructing meanings in the medical encounters.

## METHOD

This study is part of a larger study that examines the roles of medical interpreters. The data included in this study are in-depth interviews and focus groups with health care providers and interpreters. The interview data with medical interpreters were used in earlier articles to examine interpreters' experiences of role conflicts and communicative behaviors in health care settings.<sup>30</sup> This study further develops analysis of data reported in earlier studies by incorporating health care providers' experience and perceptions of medical interpreters' communicative strategies.

The first author recruited 26 interpreters (from 17 languages) and conducted 14 individual and 6 dyadic interviews (each lasting 1–1.5 hours). She recruited interpreters from two interpreting agencies in the Midwestern United States. Both agencies view medical interpreting as their primary task and have contractual relationships with local hospitals. Interpreters included in this study are all considered professional interpreters (as opposed to informal or untrained interpreters, such as family members and friends).<sup>31</sup> The first author relied on her experience as a medical interpreter and prior data collected during a set of previous participant observations of bilingual medical encounters to navigate through the design, preparation, and interview processes. The research questions focused on exploring interpreters' understanding and practice of their roles.

After the initial analysis of the interpreters' interview data, the first author recruited 32 health care providers from a major health care facility in the Southern United States. The health care providers recruited were from four specialty areas: OB/GYN ( $n = 8$ ), nursing ( $n = 6$ ), mental health ( $n = 7$ ), and oncology ( $n = 11$ ). In total, we conducted eight focus groups and seven individual interviews (each lasting 1–1.5 hours). The research questions were designed to examine providers' perceptions and expectations of interpreters' roles and practices. In addition, whenever applicable, we explored the similarities and differences in the providers' and interpreters' perspectives on interpreter-mediated bilingual health communication.

After the interviews were transcribed, the authors used constant comparative analysis for the data analysis,<sup>32</sup> coding the data for dominant themes and categories. The authors and two research assistants examined

interpreters' and health care providers' management of communicative strategies in the process of co-constructing meanings in medical encounters. Rather than focusing on how the participants understand their roles, we focused on the participants' utilization and interpretation of the communicative strategies in interpreter-mediated interactions.

The transcription includes two primary types of notation. The texts are capitalized when they are the speakers' emphasis and italicized when they are the authors' emphasis. Each participant is assigned a pseudonym. In the following sections, we denote interpreters with a superscript I (i.e., <sup>I</sup>) and health care providers with a superscript H (i.e., <sup>H</sup>) after their pseudonyms.<sup>33</sup>

## RESULTS

### Interpreters' Construction of an Invisible Role

In an earlier article, Hsieh explored how interpreters manipulate the communicative contexts to resolve conflicts. For example, interpreters were found to justify 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 covert and overt communicative strategies to manipulate communicative contexts.<sup>34</sup> In this chapter, we focus on interpreters' construction of the invisible role, a prevalent language ideology that has been identified in translators' and interpreters' practices.<sup>35</sup>

Interpreters' training in interpreter-mediated interactions often requires them to interact with speakers who are not familiar with this particular type of speech activity. These strategies provide interpreters with the tools and resources to construct meanings of the interactions. Although several researchers have argued that the invisible conduit is an ideological myth, this does not mean that interpreters do not try to portray an image of neutrality or invisibility. In fact, this chapter finds that, by far, conduit was the role identified most explicitly and frequently by interpreters (i.e., 21 of 26 interpreters of this study claimed various forms of a conduit role). This finding supports Dysart-Gale's argument that the invisible conduit role often is perceived as the default role for interpreters.<sup>36</sup>

Interpreter-mediated interaction requires interpreters to speak in a way that situates itself as a specialized speech genre. Interpreters are trained to adopt a first-person speech style. Sophia<sup>I</sup> explained, "For example, 'I believe you have hepatitis.' I just repeat. I don't say the doctor said that he believes that. I just said, 'Creo que usted tiene hepatitis.' I don't use third-person." The use of a first-person style is important. It implicates interpreters in an invisible role. The interpreters' management of the textual

transformation is hidden, and the interpreters appear to be neutral as they relay the voices of others. Sara<sup>I</sup> explained, "When I'm interpreting, I speak in first person. *I am not there*. I'm the doctor, I'm the patient." By using this interpreting style, interpreters in this study believe they are able to effectively mute their voice in the interpreting process, eliminating all bias from textual messages and allowing their interpretation to appear as if the provider and patient are directly speaking to each other.

Typically, in health care settings, interpreters use consecutive interpreting—meaning that the interpreter and speakers take turns after each others' talk.<sup>37</sup> Some interpreters in this study, however, talked about adopting simultaneous interpreting (i.e., interpreting while the speaker is speaking). Simultaneous interpreting often is adopted in international conferences, with interpreters performing their tasks in booths, and the audiences listen to the headphones (i.e., the interpreters listen to the speaker *and* interpret at the same time). Because there is minimal time lag between the speech, such interpreting style creates an illusion of monolingual talk and creates smoother transitions between speakers (e.g., the length of speech in simultaneous interpretation is closer to that of monolingual talk). Sara<sup>I</sup> explained, "[with consecutive interpreting,] it's harder for people to interact with each other and forget that I'm there. Because they have to wait, and they are looking at someone and they are listening to someone else's talk." Roger<sup>I</sup> echoed, "I found that simultaneous interpreting is very helpful. [The other speakers] don't stop. They don't waste the energy to stop, wait, and then focus again on what he was trying to say. *It just flows*. It goes with the flow."

In this study, interpreters also reported adopting other verbal and non-verbal strategies to create the role of an invisible conduit. For example, Sally<sup>I</sup> said, "We are advised to just look at the floor or just look down and just be as out of the conversation as possible, to just be a voice." Stella<sup>I</sup> commented, "[Once the interpretation begins,] I detach myself emotionally from many things that's going on there, and I look at the floor, and I look at the ceiling or something. And I make sure that they talk to each other. [...] I am just the voice. Without my opinion." Rachel<sup>I</sup> mentioned that she positioned herself in the room in a way that made her invisible to others: "What I do is I stay a little bit behind [the doctor and the patient].... When I take that position, [...] I know that I am at the back side, like I'm not in the room, so they just look at each other and they talk to each other." From this perspective, interpreters utilize not only verbal and nonverbal messages but also their positioning in the space to construct meanings (i.e., the invisible conduit) in the health care settings.

Although the interpreters' concern to adopt an invisible role mostly is tied to the provider-patient interactions, their desire to maintain the invisible presence may extend beyond the medical encounter. For example,

that because some of the words are the same in English, but they mean something totally different?

Norma's concern is not unfounded because at times interpreters adopt problematic strategies to bridge provider-patient differences. For example, Ulysses<sup>1</sup> said,

I try to avoid blunt questions. I ask it in little different ways. Same thing, you should not hurt the patient. I try to give patients some background about the question. Why is this question being asked? What is the necessity, if you explain properly, it helps with the diagnosis. That is the way I ask. I do not ask any blunt questions. *Even if the doctor says bluntly, I try to avoid that way.*

When interpreters take these attitudes, they can be justified to make drastic changes to the forms and content of the speakers' messages to a point that other speakers can lose significant control over the interactions.<sup>40</sup>

Many providers regain control over the interaction by finding access to evaluate the content of information exchanged. Some providers used the length of original versus the interpreted messages as a way to measure the interpreters' faithfulness. Others reported that they listen for the key words that they have learned the equivalent terms for in the other language and monitor whether the interpreters were doing a good job in using those terms. For example, Cory<sup>H</sup> stated, "I understand enough Spanish to know if they are interpreting what I said correctly. I don't speak it fluently but I KNOW when they are not saying the right things. And I said, 'No, that's not what I said'." Candice<sup>H</sup>, a pediatric oncologist, said that she monitors the interpreters' nonverbal behaviors (e.g., body language and facial expression) to make sure that the interpreters' emotional tone (e.g., hopefulness) is consistent with what she wants to convey. From this perspective, although interpreters aim to be a voice box for others in medical encounters, providers do monitor interpreters' verbal and nonverbal behaviors (i.e., not treating interpreters as invisible) to ensure their control over the medical exchange.

In addition, because of their institutional hierarchy, providers commented that if they suspect that interpreters fail to convey the information in the way that was intended by the provider, they would not hesitate to ask the interpreter to reinterpret the same information again. Some providers said they would simply rephrase what they had said earlier, and the interpreter would be obligated to interpret what he or she said anyway (i.e., the interpreter is the voice of others). Others said they would confront the interpreter (e.g., "I did not hear glaucoma," "No, you and the patient were laughing. You said more than that"), ask them to explicitly explain

what they had said to the patient (e.g., "What did you just say?"), and give specific instructions about how they expect the interpretation to be done (e.g., "I want to hear everything that the patient said, not just a 'yes' to my question").

*Differences in the Knowledge of the Specialized Speech Genre.* It is important to note that interpreters are aware of and frustrated by their dilemma. On the one hand, they are the linguistic experts who are trained and expected to adopt a specialized form of speaking in interpreter-mediated talk. However, their performances are not the norm in monolingual, multiparty conversations. Individuals who are not familiar with the speech genre of interpreter-mediated interactions would have a hard time anticipating or understanding the role performances of a medical interpreter. Steve<sup>1</sup> explained,

From the providers' perspective, if a patient needs an interpreter, they would get an interpreter for them, but beyond that, *they don't really understand our role. It's not a very well-defined profession, I suppose.* It's not really like an official position, like a nurse or a doctor, or one of the health providers. We almost could have just been the family members, as far as they are concerned.

In addition, the communicative contexts that interpreters carefully construct often are interrupted by other speakers' behaviors. Claire<sup>1</sup> explained,

[For interpreters,] it's like a daily job, they know how [the interaction] goes, between the two parties. But *always, the patient or the health care providers they are not familiar with working with interpreters, they are not familiar with how it goes.* Sometimes, they just need some kind of hints from the interpreter, like they have to stop frequently, speak in short sentences, to let the interpreter have enough time to interpret.

Working with an interpreter requires other speakers to change their speech style to ensure quality interpretation. Several interpreters mentioned that when others fail to talk in an appropriate way (e.g., lengthy or overlapping talk), they are forced to step out of the invisible conduit role and give explicit instructions to the speakers. In other words, others' problematic performances can disrupt the interpreters' effort to construct the image of an invisible conduit.

As discussed earlier, interpreters also use nonverbal strategies to construct meanings and to influence others' behaviors. If interpreters are to reinforce the provider-patient relationship and assume an invisible role, it

is important that the other speakers maintain direct eye contact with each other when the interpreter is speaking. Sophia<sup>1</sup> explained,

[Providers] don't know, when they are talking, who to look at, or how to do it. They probably never have done it and they get nervous too. Because they think they should be looking at the interpreter and I tell them look at your patient. I am just here to be the voice.... We tried to tell them to make that eye contact with the patient.

Sometimes interpreters' first-person style can create confusion for others. For example, Sara<sup>1</sup> talked about an incident when a patient's father was frustrated by the two doctors who were discussing possible treatments for the child.

[The father said], "If they don't know what they are doing, why don't they look for another doctor? Bring someone who knows." I'm just saying it the same way. "BRING SOMEONE who knows, why don't you do that?" And the doctors kept looking at me, but kept talking to the other doctor. And all of a sudden, when I said, "If you don't know what you are doing, why don't you look for someone else?" And I said that and I go like [pointing to the father]. And the doctor went and looked at the patient and *realized that it wasn't me.*

The health care providers were confused about who was the actual speaker of the statements, and the interpreter eventually resorted to non-verbal gestures to provide additional information to the communicative contexts. The problem here is that in interpreter-mediated talk, the interpreter often is the only person who is trained and familiar with the specific speech style and role performances of this speech activity. Such confusion is common when the participants are not familiar with this speech genre as it projects specific expectations for the performance of different speakers (e.g., the interpreter should be invisible, and the provider and patient should interact with each other directly). Interpreters often commented on their frustration about others' failures to maintain appropriate performances in interpreter-mediated interactions.

From other speakers' perspectives, however, they may not be aware of the lack of knowledge about the genre of interpreter-mediated interaction, which can cause problematic interactions. Researchers of speech acts have pointed out that individuals interpret the meanings and functions of speech acts through conventions and cultural norms.<sup>41</sup> The conventionalized use of language can be culture- and language-specific.<sup>42</sup> Failure to recognize the cultural or linguistic aspects of speech acts may lead to miscommunication as the speakers use their cultural and linguistic conventions to interpret others' speech acts.<sup>43</sup>

*Differences in the Frames of References for Meanings.* Some interpreters noted that, at times, other participants have interpreted their performances incorrectly. For example, Stella<sup>1</sup> mentioned that one of her patients once told her, "You get shy. You get embarrassed when you interpret. Because you always close your eyes and look away. Like you get shy." Stella's effort to assume an invisible role in the medical encounter was interpreted in the conventions of monolingual interactions. Even interpreters have doubts about the training they receive:

Vicky<sup>1</sup>: They wanted us to be sitting or standing by the patient, not even looking at the doctor. Not even looking at the patient. But just translating what we were hearing. Spacing us out. And the doctor is talking and we should simultaneously interpret. It would not work. We have done it but we think *it's so impersonal.*

Claire<sup>1</sup>: They said, when you arrive at the clinic, do not speak with the patient. Stay away from the patient, until the nurse calls. This is HARD! [...] I mean, for Chinese culture, it is very rude if you don't talk to people, if you just sit at a separate place. *Patients would find you rude.* You know, if you don't talk to them. I don't know. It's hard. It's hard.

Interpreters recognized that the specialized speech genre and the role expectations of medical interpreting can often be understood differently by other laymen who are not familiar with the purposes of these behaviors. In fact, our interviews with health care providers suggest that interpreters' concerns are not unfounded.

Some health care providers suggested that they find the interpreters' invisible conduit role counterproductive to the treatment process because it appears to be impersonal to the patient. Gillian<sup>H</sup>, an OB/GYN resident, explained,

You know, you've got somebody on the bed, naked, and the legs opened. And everything right there in front of everybody. And there's this strange interpreter, who has said nothing but blah, blah, blah [dull tone] ... as opposed to somebody who is willing to laugh with you, kind of gets that you are trying to bond while doing all of these.

Several health care providers also commented on how the interpreters' behaviors made them uncomfortable even when they suspected that interpreters were trained to adopt these behaviors. For example, because simultaneous interpreting requires the interpreter and the other speaker (e.g., the

doctor or patient) to speak at the same time, the continuous overlapping talk can be hard to understand, if not annoying or disrespectful, for some people who are not familiar with that particular type of speech activity. Cory<sup>H</sup> noted,

Before you finish your sentence, they are already speaking. That really bugs the tar out of me. Okay. But maybe they are supposed to do it that way.... And not looking at the person and not looking at me. And like looking straight ahead like they are inanimate objects, just rotate, you know those kinds of things. *It is distracting to everybody in the room.*

Right after Cory's comment about the interpreter's style, Cleo<sup>H</sup> concluded, "Because she's kind of like a robot. Language robot." Cara<sup>H</sup> echoed, "Because the translator is a PERSON, for better or worse there, a person. And *for them to act like they are not. It just doesn't work.* I mean, it just doesn't work." Claudia<sup>H</sup> concluded, "It's a *human interaction* that you are having with the patient."

The challenge here is that the interpreters are imposing a particular type of context on provider-patient interactions. Essentially, the providers and patients use the conventions that are familiar to them to understand the interpreters' effort, which can be problematic. For most people, lack of eye contact does not mean professionalism but uncaring (if not deceiving).<sup>44</sup> In our interviews, health care providers consistently pointed out that the quality of care is their utmost concern, and interpreters' behaviors should be flexible and adaptive to accomplish such goals. As Camila<sup>H</sup> put it, "I don't think patients are really thinking about the interpreter. I think they are thinking about their health care." In contrast to interpreters, health care providers do not put much thought into the communicative contexts that are carefully and meticulously constructed by the interpreters. In addition, because such communicative contexts can be so foreign to laymen, health care providers (and patients) may feel more confused by, rather than appreciative of, interpreters' communicative strategies.

Finally, it is important to note that as providers in our study became more acquainted with the style of interpreter-mediated encounters, some became more appreciative of the functions and values of these particular forms of speech. For example, Candice<sup>H</sup>, an oncologist, said, "[The interpreter] would be talking AS I was talking and there was NO emotional reaction. Once *I got used to that style*, I kind of liked it. Because the parents are looking at ME and reading MY nonverbal and MY emotions." Camila<sup>H</sup> said, "[With simultaneous interpreting,] you are actually having a conversation with that person." From this perspective, one can argue that if providers learn to use the frames that are consistent with that of inter-

preters' style, they can interpret the meanings of interpreters' behaviors better and become more appreciative of interpreters' management of contexts.

*Different Attitudes Toward Verbal Versus Nonverbal Information.* It is not uncommon to find providers feeling distrustful of interpreters' performances.<sup>45</sup> Although some providers in our study viewed interpreters as professionals and commented that they never questioned interpreters' abilities to assume a neutral and faithful role, other providers reported that they have serious distrust of the information conveyed by interpreters. However, as providers and interpreters talk about how they manage and interpret information in provider-patient interactions, an interesting folk belief emerges: Whereas verbal information requires interpretation, nonverbal information is universal and can be communicated directly between the provider and patient.

When asked how they manage negative emotions in health care settings (e.g., providers who appeared to be annoyed or patients who look frustrated), interpreters often mentioned that they do not interpret the negative emotions because those would be visibly evident to the providers.

Sharon<sup>I</sup>: [If a doctor is annoyed or upset], *patients can see that for themselves.* So, I would not add to the situation by, sort of stressing myself out and reacting to the way the physician is. I would try to stay *as calm as possible, kind of just interpret what is being said.*

Steve<sup>I</sup>: I think a *patient is able to interpret the emotions without having me to do it.* I would have felt very uncomfortable in that situation conveying sort of what I would see as a condescending doctor or attitude. I cannot do that. Maybe that's just my personal opinion that I have to add in there. I do interpret what the doctor says and I think the patient has ample ability to interpret the emotions.

Sally<sup>I</sup>: When the doctor says, with the gestures she made and her intonation, I think the patient understood anyways. *A patient is going to understand the energy regardless.*

Selena<sup>I</sup>: [To interpret the nonverbal information when the speakers are upset] would be helping to stir the pot, you know what I mean? So, the best thing you can do is just to stay calm and stay focused [on the textual information]. You have to stay focused.

One can argue that by *not* interpreting emotions, interpreters are intervening and manipulating the content of information as they try to present the verbal information without the emotional contexts. In addition,

provider-patient interactions are not just intellectual exchanges of medical information. Providers, at times, aim to develop rapport and trust with their patients as an effort to improve the patients' quality of care. Grace<sup>H</sup>, an OB/GYN resident, said,

If I walk in and I like my patient's shoes, I'd say, "OH, I LOVE your shoes! They are so cute" [high cheery tone]. And I have some interpreters that'd say "¡oh! ¡Amo sus zapatos!" [in a dramatic tone] or whatever. And some of them go like, "Yeah, haha." I'm like, "NO! Tell her! I like her shoes!!"

From the providers' perspective, their interactions with patients also involve identity and relational management. Past literature has suggested that interpreters tend to ignore information that is not medically related.<sup>46</sup> The arguments that interpreters presented here about not interpreting negative emotions, however, were interventions of muting problematic nonverbal information. In addition, they justified their behaviors by claiming that nonverbal information is visible and universal. In other words, there is a presumption that individuals across different cultures can understand nonverbal messages without an interpreter. In fact, physicians' interviews also suggested similar beliefs. For example,

Claudia<sup>H</sup>: [I don't think interpreters need to translate my emotions,] *cause I think that they hear that in my voice. Like music whatever.* They know that I care for them. Even though I speak a different language, I still talk to them anyways.

Ginger<sup>H</sup>: I can tell from the patient's voice that they are angry or upset or that I can see them crying or getting mad or whatever. Then, I don't necessarily need the interpreter to be yelling and screaming as well.

Although interpreters' training as a conduit implies that they are also responsible for transferring emotional messages (i.e., verbal and nonverbal information) that are embedded in the medical encounter, both providers and interpreters in this study seemed to agree that emotions, negative emotions in particular, are apparent to other speakers, and that for interpreters to transfer that is to make the situations worse. From this perspective, verbal and nonverbal information is perceived differently by our participants. Interpreters' neutrality and invisibility can be maintained when they are transferring the verbal information from one language to another. However, because nonverbal information is visibly apparent to others, interpreters who transfer that information (e.g., emotions) create redundancy of information and lose their neutrality (by exacerbating the situation).

*Challenges in Defining the Meanings of Patients' Talk.* A fundamental challenge faced by providers and interpreters in resolving the clashes between their management and control over the medical dialogue is to have a defined boundary for their expertise so that the linguistically and culturally knowledgeable interpreter and the medically knowledgeable physician can collaborate effectively. However, in everyday practice, the boundary is not always clear. For example, Yetta<sup>1</sup> talked about her effort in helping Nigerian patients to understand U.S. providers' use of drug names:

[For] patients from Nigeria, we don't use the medical terms [in the US]. So, mentioning [those drug names], don't mean anything to the patient. So, what I always do is explain, I try to tell them, Dulcolax is like water pills. Okay, because [laxatives over there] is not Dulcolax in Nigeria. They are from Europe, from Germany, from London. So, being bicultural, I can always tell them this kind of medicine, this is what it does.

The problem here is that Dulcolax is *not* like water pills and laxatives are *not* the same as water pills. More important, Yetta<sup>1</sup> viewed this as information that requires her cultural expertise to facilitate provider-patient interaction, when in fact she has overstepped the boundary that separates interpreting medical information and dispensing medical knowledge. Vicky<sup>1</sup>, a Vietnamese interpreter, also commented on how American physicians often provide too many options for the patients (e.g., various treatments available and their corresponding risks), which often confuses Asian patients even more. As a result, rather than giving patients the option to hear various treatment options, she asked the doctor,

"So, according to your expertise, doctor, if this patient would be your own flesh and blood, what would your decision be?" He said, "Oh, this. If I were her, I would do that." I said, "Good. That's okay. So, why don't you choose this option then."

Clearly, Vicky's cultural intervention has a direct impact on the content and process of provider-patient interaction. Although her judgment was based on her cultural understanding of Asian patients, it is unclear whether these strategies may have legal consequences (e.g., informed consent) or may ignore individual differences (e.g., some Asian patients may still desire patient autonomy).

Interpreters are in a difficult position because any talk can be perceived as medically *meaningful*. Gloria<sup>H</sup>, an OB/GYN physician, mentioned an incident she had with an English-speaking patient:

I had a patient walk in one day, who had 40 complaints and always wanted to tell me *they are turning off the husband from the ventilator that night and that he's going to die*. And we spent time on that. I got her into a psychiatrist after that too. *But that's not a pap smear*.

Gloria<sup>H</sup> used this example to illustrate how patients may go off track during a medical encounter and concluded,

The interpreter needs to know how to *keep the patient focused* if the patient is not focusing. So that the time management in the interaction is efficient as well. [...] If the interpreter is going to sit there and tell me all about the dog and the cat and the everything else, no, I don't need to know those things. And they are really irrelevant. *What we need to stay focused on is the PROBLEM*.

The challenge presented by Gloria is that for interpreters to keep the patient focused, the interpreter needs to make an active judgment about whether certain information is medically relevant to the encounter at hand. As a result, comments such as “turning off the husband from the ventilator” may be medically meaningful in a psychiatric appointment but not an OB/GYN appointment. However, Gloria<sup>H</sup> also mentioned that she referred the patient to a psychiatrist, which is a medical intervention. Had the interpreter kept the patient focused, these issues would not have been brought up and a needed medical intervention may not have been provided.

Another challenge faced by interpreters is that the provider–patient relationship is perceived as a relationship that is bonded for therapeutic objectives, and interpreters' interactions with the patient may interfere with those objectives. For example, Mira<sup>H</sup>, a psychologist, commented, “If the patient opens up so much to the interpreter that they become so emotional or have an emotional breakdown, that can interfere with the treatment process tremendously.” Michael<sup>H</sup>, a psychologist, also indicated that he would rather interpreters not have interactions with patients without his presence. He explained,

'Cause I'm not there to participate in guiding that interaction. Should the family or the patient have a lot of angst or anxiety about seeing us. The interpreter won't be able to regulate that as well as if I was there. So that may impact patient care cause they are not gonna talk with us. Or they'll become too anxious and they'll kick us out or they're paranoid or afraid or angry.

From Michael's perspective, even everyday talk may lead to issues that need to be dealt with in the medical encounter. As a result, although in ear-

lier discussions some interpreters have argued that not greeting or chitchatting with patients may be perceived as being rude in their cultures, these behaviors risk compromising the therapeutic process in provider–patient interactions.

As medicine becomes increasingly specialized and each physician has his or her area of expertise, the health care providers learn to focus their patients on what is medically relevant *and* also what is relevant to their area of specialty. In other words, physicians have learned to filter patients' talk through their areas of specialty for what is medically relevant (i.e., not anything medically relevant would do). This is what Heidegger called *enframing*: Even being “objective” is a subjective bias. In contrast, medical interpreters' frame to understand a patient's talk in health care settings is holistic because they are involved in all aspects of the patient's talk in health care settings (e.g., the medical talk with health care providers and the financial talk with social workers).

## CONSTRUCTING MEANINGS IN BILINGUAL MEDICAL ENCOUNTERS

Although the meanings of a bilingual medical encounter may first appear to be constructed by the interpreter through his or her faithful and neutral relay of others' voices, our study has demonstrated that the communicative process is far more complicated. Individuals exercise various semiotic, institutional, and cultural resources to assert authority in controlling and constructing meanings in the bilingual medical encounter. Kramer proposed, “Legitimate power (such as ‘expertise’) is manifested as the act of granting voice or agency to a particular person, literature, or institution. One might well argue that the ‘real power’ is in those who do the granting of voice.”<sup>47</sup>

In bilingual medical encounters, medical interpreters are the ones who give voice to others. Does that mean that interpreters have the “real power” to grant voice to others? Interpreters' concerns for an invisible role and their strategies to manage the communicative processes (while drawing minimal attention to their manipulation of the contexts) suggest that interpreters do not wish to be perceived as having real power in the interpreter-mediated interactions. Nevertheless, interpreters' construction of an invisible role allows them to grant voice to others and establish legitimacy and authority to the voices of others.<sup>48</sup> In fact, if others perceive interpreters to be actively manipulating the content and process of the interpreter-mediated medical encounters, interpreters may risk the legitimacy of their servic-

es and the credibility of others' voices. For example, providers in this study have talked explicitly about their strategies to ensure an interpreter's faithful and neutral relay of information and to rectify situations where they believe the interpreter may have misrepresented their voices. Does that mean that the providers are the ones who grant voice to interpreters? That they are the ones who have the "real power"?

The institutional hierarchy provides more status and legitimacy to providers' authority in managing the content and process of the medical encounter. In other words, in health care settings, providers' voices prevail over others' voices. However, we have documented several issues that are critical to the construction of meanings 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 the communicative contexts. Second, the frames of references (i.e., frames that are used to derive meanings) 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 in bilingual medical encounters 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 the providers' voices are told or heard. Through 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.

The challenge in an interpreter-mediated encounter is that no one has the sole authorship to his or her own voice. 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. This is *polivocality* or, as Bakhtin calls it, *heteroglossia*.<sup>49</sup> Within the one message/channel, at least

two voices exist. One voice is content, and the other is a sort of carrier wave that is being modulated and thus also adding content. Content/form and message/channel dualisms fail to accurately describe this phenomenon. This is complex. In fact, it is multiplex. It is a form of intertextuality articulated in a single message. It is a fusal phenomenon. The interpreter only appears invisible but is in fact fundamental. It is like seeing language, such as mathematics, as "innocent," as not biasing the semantic dimension as it is encoded. However, the encoding process relies on the code. The code has an influence on the semantic dimension. Translation always changes the meaning a bit. And so the interpreter is hardly invisible except in a naïve sense, which doctors and patients may exhibit as they believe the interpreter can simply say what he or she means. But this is their naïveté. The effort to appear invisible actually foregrounds or belies the obvious (essential) presence of the interpreter. Also there is the issue of suspicion as to the accuracy of the translation, a meta-communicative issue that is always lurking and involves meta-communicative inquires such as, "Did you translate me exactly? Don't say anything different."

Heteroglossia is distinct from monoglossia. Monoglossia is normalized or presumed to be unproblematic meaning within a discourse (what Husserl called the bias of the natural attitude or the unquestioned faith that reality is naturally so).<sup>50</sup> Heteroglossia has to do with the coexistence of voices and the confounding of reality. It is living parole as opposed to institutionalized language. Speech versus canon. Speech is jazzy. It is filled with floating signifiers and multiple meanings. It is in time, and therefore meaning is contingent, constructed, conflicted, and negotiated. Derrida makes much of this in his notions of deferral, difference, and deference.<sup>51</sup> Heteroglossia is dialogical, meaning debatable, and in process. For Bakhtin, it meant the conflict between voices through their adscription to different elements in a novel.<sup>52</sup> Joyce does it in *Ulysses* as conversations between people and conversations between real and imagined conversations in one person's world.<sup>53</sup> Two or more people can look at or hear the "same" thing, but it is not the same. Again, Derrida goes into this throughout his works. The issue of not being able to nail down, once and for all, THE meaning of a discourse undercuts the idea of discursive authority (positivity). All participate in the play of the process. Hierarchy and center/margin statuses are in play.

Now in the medical setting, the participants try hard to eliminate difference and the play of signification, but they cannot entirely eliminate interpretation, the temporal aspect of difference and contingency (frames). But even the frames are not fixed. They too are in play, which is where Heidegger<sup>54</sup> and Derrida<sup>55</sup> blow past the frame theorists such as Snow<sup>56</sup> before they even picked up a pen to write. The two other classic sources on the inevitable impact of subjectivity (horizon) on perception are Goffman<sup>57</sup>

and Lakoff.<sup>58</sup> All derives from Nietzsche<sup>59</sup> and Husserl.<sup>60</sup> They highlighted the complexity of the issue when they insisted that the subject is a text that is constantly being rewritten: The horizon, the frame, is dynamic.

The once integrated voice diverged into multiple voices. Individuals *differentiate* their understanding of and response to (a) meanings across various semiotic resources, such as verbal, nonverbal, spatial, and emotional information; and (b) functions of the provider-patient conversations, such as relationship building, therapeutic purposes, and identity management. 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).

From this perspective, to improve the quality of an interpreter-mediated medical encounter, it is important for researchers to understand how different individuals (a) utilize multiple semiotic resources in constructing meanings, (b) use various frames of references to interpret meanings, and (c) negotiate control over issues of (a) and (b). Findings in these areas will allow researchers as well as educators to develop effective training programs for interpreters, health care providers, and even patients to better understand the processes and challenges of bilingual health communication and to develop effective and appropriate strategies to ensure quality health care.

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## 3

## THE POETRY OF DOGEN ILLUSTRATING GEBSERIAN POETICS

Ian Mills

"Poetry is a writing of history of the dateless; it is the record and declaration about the invisible events and happenings that are effective from origin, and become present in the poetic word." Seven hundred years apart, the concordant subject matter of Dogen and Gebser is that the effective way of being in the world ("a-waring") has to do with emphasizing the a-egoic, the a-perspectival, the a-chronic, as the poetic "way" of emancipation from the self, from perspective, from time—diaphany of "a-waring" via systasis and synairesis. In Dogen's poetry we have expressed, as only the poetic can, an exemplification of Gebser's contention: "The synairesis which systasis makes possible integrates phenomena, freeing us in the diaphany of 'a-waring' or perceiving truth from space and time." The perfection of Dogen's aesthetic expression of reality arises from the diaphanous impact of those elements that transform rational language into a poetic presentation of origin. He intertwines the *intensity* of an integrating of *feeling-thought* within a synaeretic *rhythm* of systatic *metaphors* that shatter perspectival space in an eruption of a-chronicity. Dogen's poetry leaves us with the "no trace of realization," that is, with the "ever-present origin." His legacy is a diaphanous illustration of what Gebser terms "verition" via a systa-