The quotative ‘he/she says’ in interpreted doctor-patient interaction¹

Dorien Van De Mierop
University of Leuven

Abstract

This article examines the different functions of the quotative ‘he/she says’ in an interpreter’s renderings during four medical interviews (Dutch / Russian). First, the quotative is typically used for renderings of doctors’ turns, where it serves to signal a switch in the participation framework and to segment long discourse units by the doctor. Second, in some renderings of the patients’ turns, the quotative also has a disambiguating function, clarifying the status of the interpretation either as a literal one or as an addition to a previous summary translation. Finally, in both types of interpretation the quotative also has a distancing function. However, the situations in which this function occurs vary: in the case of doctors’ turns, distancing occurs when face-threatening or dispreferred information is being given, while in the case of patients’ turns, it serves to co-construct the typical asymmetrical doctor-patient relation.

Keywords: discourse analysis, medical interaction, quotative, asymmetry

1. Introduction

Our globalized world is characterized by ever-increasing migration, which implies that societies now consist of a mix of people from different ethnic origins, who are often not proficient in the region’s majority language. Due to this trend, the importance of community interpreters cannot be overestimated, and the relevance of research into this field ‘cannot be overemphasized’ (Bolden 2000: 387). Ever since Wadensjö’s (1998) influential study, which took a crucial step from a normative to a descriptive research angle, the community interpreter is no longer regarded as a ‘linguistic parrot’ (Davidson 2002: 1275). Rather, s/he is seen as somebody who has several roles (see e.g. Leanza 2005 for different interpreter roles in healthcare settings) and who exerts a crucial influence both on the interactional situation and on the construction of meaning.

A number of studies have adopted this perspective and have critically investigated the role of interpreters in a variety of contexts, ranging from TV interviews (Wadensjö 2008) to commercial (Gavioli & Maxwell 2007), legal (Wadensjö 1998) and medical settings (Bolden 2000, Davidson 2000, Bot & Wadensjö 2004; for an overview see Pöhhacker & Shlesinger 2005). I focus on the latter and, drawing on the findings of these previous studies, look into the way in which the interpreter influences the interaction. More specifically, I examine the role of the quotative – or ‘pronoun and a *verbum dicendi*’ (Clift & Holt 2007: 5) – ‘he/she says’ in the interpreter’s renditions.

In the data set under review here (see data description below for more details), the quotative appears quite regularly (cf. Bot 2005), in the renderings of both the doctors’ and the patients’ turns. This is interesting since it deviates from the advised ‘direct translation’ in the sense described by Bot (2005: 260), namely the assumption that there should be a ‘zero quotative’ (cf. Mathis & Yule 1994) and that ‘the perspective of person’² should not be altered (Bot 2005: 238), which is regarded as (1)

the canonical form (Merlini & Favaron 2005: 279), (2) ‘*the* sign of professionalism’ (Bot 2005: 239; emphasis in the original) and (3) ‘superior to the indirect’ mode of interpreting (Dubslaff & Martinsen 2005: 212). It also goes against the Flemish deontological code of social interpreting as laid out by the *Centrale OndersteuningsCel Sociaal Tolken en Vertalen* (COC – Central Supporting Team Social Interpreting and Translating), founded by the Flemish Government in 2004 to encourage and support the professionalization of interpreting and translating in social contexts. The deontological code (COC 2008) explicitly states that everything must be translated as literally and completely as possible and that an interpreter’s professional introduction to an interpreting session will typically include a statement about the perspective to be used in the translations, namely ‘I will translate in the first person’ (De Keyser 2009: 62). However, De Keyser adds that it may be quite difficult to follow this rule. She suggests using a quotative when interpreting offensive statements (De Keyser 2009: 64). And yet, even though the norm is quite clear regarding the recommended stance of the interpreter, a grey area emerges during some situations in real-life interpreting.

From a linguistic vantage point, the quotative is particularly interesting in the types of interactional situations described here, since it explicitly draws the listener’s attention to the speaker’s different roles. As Goffman (1979) indicated, one may discern three main roles within one speaker: that of the ‘animator’, who is ‘the sounding box’; that of the ‘author’, who is ‘the agent who scripts the lines’; and finally, that of the ‘principal’, who may be described as ‘the party to whose position the words attest’ (Goffman 1979: 17). Building on this, Wadensjö (1998) developed a parallel ‘reception format’ for the interpreting context in which the ‘animator’ becomes the ‘reporter,’ the ‘author’ becomes the ‘recapitulator’ and the ‘principal’ becomes the ‘responder.’ Although it is clear from the interactional roles that the interpreter has to be viewed as merely ‘animating’ or ‘reporting’ the words of the speaker in another language³, the use of direct speech further draws attention to the interpreter’s ‘reduced personal responsibility’ (cf. Goffman 1979). As has been described in the context of media interviews, such a shift in footing is a typical way of remaining neutral, particularly when controversial viewpoints are being voiced (Clayman 1992). The question that I aim to address here is whether these quotatives serve a similar distancing function in interpreted doctor-patient interaction, or whether there are other reasons for the insertion of a quotative.

Furthermore, I aim to link these findings to the more general observations that have been made on doctor-patient interaction, such as the importance of the ‘voice of medicine’ (Mishler 1984), the specific ways of delivering bad news (e.g. Maynard & Frankel 2006) and the asymmetrical nature of medical interactions and how deviations from the dominant pattern, as observed, for instance, by Ten Have (1991), are dealt with by the different participants of the interaction.

A final remark before going into the data description and analyses concerns the interactional complexity of an interpreted conversation. Drawing again on Goffman (1981), the notion of participation framework is particularly interesting here. A participation framework may be defined as follows: ‘When a word is spoken, all those who happen to be in perceptual range of the event will have some sort of participation status relative to it’ (Goffman 1981: 3). In ‘regular’ interaction, the participation framework is usually quite straightforward and Goffman differentiates speaker and hearer, the latter being divided further into primary addressees and overhearers. In interpreted interaction, however, two participation frameworks are constantly alternating and can never be fully active simultaneously. Due to the linguistic limitations of most of the participants, the interpreter is the only participant with access

to the two frameworks, which gives him/her a certain amount of interactional power (as will be shown below, see for example extract 3). In this sense, one can think of the interpreter as an active ‘go-between’ between the two interlocutors, namely the doctor and the patient, as illustrated in Figure 1.

Figure 1. Two participation frameworks in an interpreted doctor-patient interaction

2. Data description⁴

The data of this study consist of four interpreted doctor-patient interactions audio-recorded at a Flemish hospital in 2008. The two languages used were Russian and Dutch: all the doctors were native speakers of Dutch, while the patients’ knowledge of Dutch was insufficient to conduct such a medical interaction. All the patients understood and spoke Russian, though it was not necessarily their native language. During the four interactions, it was the same interpreter, an intercultural mediator who worked at the hospital full-time, who consecutively interpreted from Dutch into Russian and vice versa. Her native language was Russian. She had not been professionally trained as an interpreter but, having taken several courses in community interpreting, could be regarded as a semi-professional interpreter. Also when looking at the data and comparing these with the descriptions of ad hoc versus professional interpreters in healthcare settings, as presented by Valero Garcés (2005), it is clear that notwithstanding her limited training this interpreter had gained considerable professional experience. This was particularly evident in her lexical choices, her use of perspective and her use of direct one-to-one communication.

The four interactions took place at a hospital and consisted of consultations with medical specialists. Table 1 gives an overview of the theme and length of each consultation, the physician’s specialization and a brief description of the content of the talk.

Table 1. Overview of the themes and topics of the four medical interviews

Theme	Length (in min.)	Specialization of the doctor	Topic of the interaction
Liver	18	Liver specialist	The patient has a serious liver problem and he is even taken into consideration for a liver transplant. In this interview, the results of previous tests are being discussed and it is being decided how to proceed with the patient’s treatment.
Kidney	29	Nephrologist	The patient has a high blood pressure and suffers from various problems because of that. The interview is diagnostically oriented and leads to the admission of the patient into the hospital for further tests.
Rheumatism	14	Rheumatologist	The patient’s cholesterol is too high and she suffers from weakness and pain in her arms and

literally, but instead moves to a – sometimes indirect – second-person reference, explicitly putting herself in the interpreter-patient participation framework and orienting to the patient as primary addressee of the interaction. An example of such a shift in perspective in the interpretation may be seen in the example below, in which the interpreter first takes an impersonal perspective and then directly addresses the patient.

Extract 2: Kidney

- 1 Dr: heeft-em braakneigingen soms ook °of ↓ni°
does he sometimes also have qualms °or ↓not°
 2 I: порывы к рв- ко рвоте тоже бывает у вас
inclinations to v- vomit does that also happen with you

This way of shifting perspective (from an impersonal to a more personal one) along with a shift in the participation framework is the prevalent pattern in my data. The division between personal perspective in the patients' turns and impersonal perspective in the doctors' turns is hardly surprising, since the patients are responding to questions about their health or discussing their physical condition and such a personally oriented discussion typically entails a personal perspective. Of course, the doctors do not have this content-based criterion and thus adjust their perspective to the specific situation in which two participation frameworks come together and in which an outsider (the interpreter) is – linguistically speaking – the only potential addressee.

Remarkably, this impersonal address of the doctor can change quite abruptly, as the example below demonstrates:

Extract 3: Muscle

- 1 I: 't begint pijn vanzelf, °en die gaat over ook van↓zelf.°
it begins pain of itself °and it also goes away of ↓itself. °
 2 2.0
 3 Pat: ночью бывает то что ([)
at night it happens that ([)
 4 Dr: -> [en slAA:pt ze goed?
[and does she slEE:p well?
 5 I: en 's nAch:ts, (.) zegt ze, h [dat euh-
and at nIgh:t, (.) she says, h [that erm-
 6 Dr: [jah
[yes
 7 I: >ik kan me precies niet bewegen. °zegt ze.°<
>I do not seem to be able to move. °she says. °<
 8 1.2
 9 Pat: ноч[ью-
at n[ight
 10 Dr: -> [en slAapt ge goe. of ↑ni:?
[and do you sleep well. or ↑no:t?
 11 0.3
 12 I: спите хорошо?
do you sleep well?
 13 0.8
 14 Pat: я нормально сплю если мне боль не меша[ет
I sleep normally if the pain does not bother m[e
 15 I: [als ik
[if I am

16 geen pijn heb, (0.5) dan:: (.) slaap ik goed.
 not in pain, (0.5) then:: (.) I sleep well.

After the interpreter's translation of the patient's turn in line 1, there is a pause (line 2). This is a typical moment for self-selection by the next speaker, which happens almost simultaneously in the case of the two potential *first* speakers, namely the patient and, a mere few seconds later, the doctor. The interpreter, who, mediating between the two participation frameworks, has the power to decide which turn is ratified, interprets the turn that started first, namely the patient's continuation (line 5), and this choice is then ratified by the doctor's affirmation (line 6). After the patient's turn has been interpreted, a similar pattern occurs: following a pause, both the patient and, again a mere few seconds later, the doctor self-select. This time, the patient ends her turn abruptly and the interpreter then renders the doctor's question (line 12), which is then answered by the patient (line 14) and interpreted (line 15-16). Interestingly, in this example the doctor's two questions (lines 4 and 10) occur at similar situations of overlap with the patient. The doctor asks identical questions, but shifts perspective. After initially opting for a third person reference to the patient, he addresses the patient directly, and adds a tag question. Together with the intonational stress, these two elements lend the question an imperative overtone, which then triggers a switch in the participation framework, since the interpreter now ratifies the doctor's question instead of the patient's words (which have also been broken off). This shift in perspective clearly shows that the doctor is orienting himself directly towards the patient, even though the latter cannot understand him. As such, this shift in perspective may be regarded as functioning as a content trigger for shifting from the patient-centered participation framework to the doctor-centered one.

3.2 *The quotative 'he/she says' in the interpreter's translations*

While there are various ways to shift perspective in the interactions described here (see Bot 2005 for a general description of four different strategies), this study will be confined to the 65 cases in which the interpreter uses the quotative 'he/she says.' This fairly high amount is not surprising and is in line with the frequencies found by Bot (2005: 250-251). The cases are distributed unequally over the doctors' and the patients' turns: more than two thirds (47 quotatives) occur in renderings of the doctors' turns, while less than one third (18 quotatives) are found in renderings of the patients' turns. This is in line with a tendency described by Bot (2005: 244) as accounting for the interpreter's interactive role towards the patient, who is assumed not to be as aware of this as is the professional. However, these numbers need to be considered critically and to be linked to the specific interactional context in which they appear. As remarked earlier, the goals of these four interactions differ quite significantly: while one concerned the results of a battery of tests, giving the doctor a more extensive prerogative to hold the floor (e.g. interaction 1, 'liver'), another concerns a discussion of potential treatments, which entails much more interactive work (e.g. interaction 3, 'rheumatism'). Thus it is not surprising that the distribution of turns varies quite significantly between the four interactions, as is reflected in the distribution of quotatives. This is shown in Table 2, which gives the number of quotatives in the interpretations of both the doctor's and the patient's turns in each interaction.

Table 2. Performatives in renderings of the doctor's and the patient's turns in each interaction

Interaction	Number of performatives in renderings of doctor's turns	Number of performatives in renderings of patient's turns
1. Liver	30	2
2. Kidney	11	4
3. Rheumatism	3	8
4. Muscle	3	4
Total	47	18

As we can see, in the first and the second interaction, most quotatives occur in the interpretation of the doctors' turns, while the opposite is true of the third interaction. In the fourth interaction, a minimal number of quotatives occur and the distribution is similar. Furthermore, most quotatives appear in the interpretation – into Russian – of the doctors' turns. Since Russian is the interpreter's mother tongue, this is presumably the easier part of her task and one would expect her to use fewer quotatives (cf. Bot 2005: 256). The fact that the reverse is true appears to indicate that 'difficulty of the translation' is not a decisive factor in opting for the use of the quotative (cf. Bot 2005: 256). It appears, moreover, that these distributions are not very telling in themselves and it is through a qualitative analysis that potential differences between the use of this quotative in the interpretation of the doctors' turns and of the patients' turns may be uncovered. In what follows, I will discuss these cases, beginning with the interpretation of the doctors' and the patients' turns separately, after which I will attempt to draw some comparisons.

3.2.1 *Interpretation of the doctors' turns with he/she says*

The quotative in interpretations of the doctor's turns generally occurs at the start of the translation of a multi-unit turn or discourse unit, and comprises more than one turn-constructional unit; e.g. jokes and anecdotes which transcend the turn-taking level (Houtkoop & Mazeland 1985). These units are topically, rather than sequentially, structured (Mazeland 2003), and since they typically entail quite long turns, they pose a cognitive challenge for the interpreter, who must remember all of the medical information provided by the doctor. For instance in the 'liver' consultation, the doctor is discussing the results of a whole series of tests. If this were a monolingual situation, the doctor would probably hold the floor throughout most of the discussion of the results, while the patient's contribution would probably be limited to the production of continuers and possibly some requests for further explanation. However, in this case, the need for segmenting the doctor's turn is due to the presence of the interpreter and to her limited – although at times quite impressive – cognitive capacity. This is something the doctors in this data set are not always aware of or at least they do not show many explicit signs of attempting to provide the information in manageable chunks. This is in contrast to, for example, the data set described by Merlini and Favaron, in which the doctor pauses so that the interpreter may take the floor (2005: 276). Thus in these interactions, it is up to the interpreter to segment the information in her rendering, which usually entails an overlap. Because this type of overlap is also a switch in participation framework, however, the interlocutors need some time in which to adjust to the switch: the doctor needs to break his turn into chunks and to become a passive overhearer, while the patient needs to switch from passive overhearer to active addressee. It is exactly at

these points that we often see the use of a quotative as a turn-entry device (cf. Streeck & Hartge 1992) to the translation of a discourse unit.

Extract 4: Liver

- 1 Dr: =we moeten goed Afwegen (.) en zorgen dat (.) als
= *we have to weigh it well (.) and make sure that (.) if*
- 2 we iets doen (.) hij daar bE:ter van wordt
we do something (.) that he benefits from it
- 3 I: mm
- 4 Dr: en tis ni van (.) [bwaa
and it is not of (.) [well
- 5 [(*snap of the fingers*)
- 6 ne keer rap transplanteren en 't proble[em is opgelost
quickly transplant it once and the problem is solved
- 7 I: [°mm°
- 8 Dr: [(°bja dan°)
[(°yes then°)
- 9 I: -> [то есть говорит я с двумя профессорами ваши
[*so he says I have discussed your problems with two*
- 10 проблемы обсуждал
professors

In the example above, the discourse unit of the doctor, which lasts for 128 words (most words precede the fragment above), ends with the interpreter's overlap in line 9. The interpreter starts her turn with the discourse marker 'то есть' (so) and the quotative 'говорит' (he says), neither of which is crucial for understanding the turn. Rather, they give the interlocutors time to orient to the switch in participation framework. The use of the quotative as a facilitator in the intricate interactional situation becomes even clearer in the following example, where the quotative is used to introduce a second attempt to switch participation framework.

Extract 5: Liver

- 1 Dr: en tis ni de bedoeling da wem van dialyse kunne
and it is not the intention that we are able to get him ↑off
- 2 Af↑helpen (.) maar ondertussen vastzitten met ander p[roblemen
dialysis (.) but in the mean time are stuck with other problems
- 3 I: [uhum
- 4 Dr: die zijn gezondheid kosten dus 't is eunneu:h moeilijk °evenwicht°
that cost him his health so it is a:ner:m difficult °balance°
- 5 I: -> °uhum° [то есть
[*so*
- 6 Dr: [ma die lEver lijkt voorlopig
[*but that liver for the time seems*
- 7 [goe genoeg te z[ijn (ma wa)
[*to be well enough (but what)*
- 8 I: -> [°uhum° [этот это говорит решение которое вы
[*this he says that the decision that you take*
- 9 принимаете насчёт трансплантации очень серьёзное
concerning the transplant is very serious

In line 8, as the interpreter already attempts to start a translation (with the same discourse marker ‘то есть’ as in the example above), the doctor interrupts and continues his own discourse unit (line 6). This turn is again interrupted by the interpreter to re-introduce the translation and switch participation frameworks.⁸ This time, the overlap (line 8) is successful and the doctor completes his turn. Again, the overlap is introduced by means of the quotative ‘говорит’ (he says).

This turn-initial use of the quotative thus projects a ‘quotation format’ (Schegloff 1987: 72), immediately qualifying the turn as a quotation, which is generally the unmarked form in interpreted interaction. On the other hand, since the quotative solves the potential difficulty of hearing the utterance, due to overlap, by postponing the actual content,⁹ it also works as an ‘overlap absorption technique’ (Schegloff 1987: 80).

Furthermore, within discourse units, quotatives serve to provide additional support for the interpreter’s floor-holding rights. Sometimes they mark the introduction of a new subtopic within the discourse unit, but they are also used within the same topic discussion. We see an example of the former in line 8 and of the latter in line 3 of the extract below.

Extract 6: Liver – part of the interpreter’s turn (the entire discourse unit consists of 105 words)

1	то есть что касается печени самой говорит
<i>so concerning the liver itself he says that</i>
2	сам орган работает как
<i>the organ itself functions as</i>
3	-> ему надо работать сама печень говорит
<i>the organ should be functioning he says that the liver itself</i>
4	справляется с своей задачей работает нормально
<i>can handle its task and that it functions normally</i>
5	да чт- вот но есть серьезное отклонение в том что
<i>but that there is a serious defect in the fact that</i>
6	вот эти есть клетки вот эти следы как шрамы
<i>there are cells that there are traces such as scars</i>
7	как утолщение твердение этот ()
<i>such as a thickening a callosity ()</i>
8	-> самой это говорит да то есть в данный момент вы можете
<i>self he says yes at this moment he says you can</i>
[lines omitted – discourse unit continues for 46 additional words]

When new subtopics are being introduced, as in line 8, these quotatives are particularly relevant to the interaction, since they account for the extensive length of the interpreter’s turn and explicitly frame it again as a rendering of the doctor’s turn, and as a repetition of the initial framing by the quotative in line 1.

As shown above, quotatives occur very regularly within discourse units. They may serve an interactional function, as described above, but content-related functions often come into play as well.

Extract 7: Liver – turn by the interpreter

1	-> то есть нигде говорит в книжках написано ah об этом случае
<i>so nowhere he says it is written in the books ah about this case</i>
2	-> делаем так в этом делаем так это всегда говорит
<i>we do like this in this, we do it always like this he says</i>

- 3 -> надо смотреть какое ваше качество жизни говорит
it is necessary to look at your quality of life he says
- 4 то есть как вы сможете функционировать понимаете
so how you can function do you understand
- 5 от этого зависит что мы это можем трансплантировать
it depends upon that if we can transplant
- 6 и вы будете как труп лежать понимаете
and you shall only be lying here as a corpse do you understand
- 7 -> то есть это говорит мы всё должно говорит взвешивать
so he says we have to weigh everything he says

This relatively brief fragment is a case of ‘multiple representation’ (Bot 2005: 254), with five quotatives. These may be related to the kind of information the interpreter is giving: on the one hand, she is delivering bad news and on the other hand, the information is as yet vague and somewhat intuitive (see line 1). Clearly, delivering bad news about somebody’s health is a very face-threatening activity, and thus it is not surprising that the interpreter stresses her role as that of the animator/reporter of the words, rather than as the author or the principal. Interestingly, her choice of words (труп, ‘corpse’ in line 6) is very bold on record and absolutely not a literal translation of the doctor’s words, which entirely avoided such an explicit statement and which was much more in line with Lutfey and Maynard’s (1998) findings about the way physicians avoid talking about death or dying in a straightforward way. It seems then that the animator role somehow gives the interpreter additional freedom to formulate her words rather directly and in quite a face-threatening way.

Secondly, since the information is rather intuitive, it may be perceived as not conforming to the ‘particular normative order’ of the ‘biomedical model’ (Mishler 1984: 90), also referred to as the ‘voice of medicine’ (Mishler 1984). This concept points at ‘the technical-scientific assumptions of medicine,’ as opposed to the ‘voice of the lifeworld,’ which represents ‘the natural attitude of everyday life’ (Mishler 1984: 14). As observed by Mishler, the ‘voice of medicine’ may lead to the ‘objectification’ of the patient (Mishler 1984: 128) by the doctor, but I argue that it may also impose certain demands of ‘objectivity’ on the doctor’s own words, since the ‘voice of medicine’ governs the entire conversation. Furthermore, as has been observed by Bolden (2000), interpreters have been attested to explicitly orient to the ‘voice of medicine’ in the interpretation of the patients’ turns, which may result in ‘the exclusion of the patients’ perspective from the medical interaction’ (Bolden 2000: 414). In such a case, however, the interpreter seems to implicitly apply the norm of the ‘voice of medicine’ to the doctor’s words as well, thereby creating a distance between her role of animator/reporter, on the one hand, and the content of the words she is interpreting, on the other.

Quotatives also occur in sequentially organized turns. In interpretations of the doctors’ turns, they are usually situated in the dispreferred responses of the doctors to patients’ questions. Preceding the following example, the patient initiated a request for weight-reduction surgery. This request was then interpreted rather hesitantly by the interpreter, which is where the extract starts:

Extract 8: Muscle

- 1 I: dus: (.) ist ↑mogelijk van u:- >in 'n attesje,< (maar) dat
so: (.) is it ↑possible for you:- >in a little certificate,< (but) that
- 2 dat eigenlijk e:h zo'n vermA:gerings euh (0.5) euh kuur-

- that actually er:m such a sllimming erm (0.5) erm regime-
 3 de ingreep voor mij aangewe:zen
the surgery is appropriate for me
 4 1.4
 5 Dr: o:h da moet z'aan mij: ni vragen hè? .h euhm: (.)
o:h she does not have to ask me: that hey? .h erm: (.)
 6 da's- ze zou 'n Ingreep willen doen. vo te vermageren.
that's- she would like to undergo sUrgery for losing weight
 7 1.0
 8 dan zou ze: (daar) moete doen e:h dokter [X] ofzo gaan hè?
then she: would have to do (there) er:m go to doctor [X] or so hey?
 9 0.5
 10 naar de obesitasraadpleging hè?
to the obesity consultation hey?
 11 [.h (en dan moet zij:)
 [.h (and then she: has to)
 12 I: -> [вы говорит хотите от меня аттест чтобы операцию сделать
 [you he says want a certificate from me for a surgery to
 13 значит по худении но это ни ко мне это надо к доктор [X]
lose weight but for that you don't have to be with me but with doctor [X]

After the interpreter's hesitant translation of the patient's question, the doctor responds in a dispreferred way: he says that he is not the right doctor for this kind of problem, thus threatening the patient's face by rejecting her request for a prescription. The interpreter then introduces the translation of this dispreferred response by means of the quotative 'говорит' (he says). In the data under study, quotatives frequently occur in situations where a dispreferred response is given.

Quotatives are also used while interpreting other face-threatening situations which do not qualify as dispreferred responses because they are not direct responses to questions. A good example occurs in the 'rheumatism' interaction, in which the patient states that she has considerable pain due to a stomach ulcer. She uses this as an explanation for failing to take the medication prescribed by the rheumatologist to control her high cholesterol levels. The doctor then looks into her file to investigate the progress of the treatment of this ulcer by another doctor. Since no information can be found in the file, the doctor asks the patient which drug she is taking for the ulcer. Then the following interaction occurs:

Extract 9: Rheumatism

- 1 Pat: нет у меня нечего не не дарить для язвы нечего не дарил
no they have not given me anything for the ulcer he has not given me anything
- 2 I: niks werd gegeven tegen de maagzweer
nothing was given for the ulcer
- 3 Dr: hoe zegdu?
what do you say?
- 4 I: dat werd geen medicament gegeven tegen [de maagzweer
that was no medication given against [the stomach ulcer
- 5 Dr: [tegen de maagzweer
[against the stomach ulcer
- 6 en ge zijt bij dokter [X] juist geweest
and you have just been at doctor [X] 's
- 7 dus ik veronderstel da ge geen maagzweer hebt

- 8 so I suppose that you don't have a stomach ulcer
want anders [() medicatie ()
because otherwise [() medication ()
- 9 I: -> [тогда может нет вы были у доктора [X] говорит
 [it is not possible then you were with doctor [X] he says]

In line 1, the patient states that she has not received any medication for her ulcer. When the interpreter translates this, the doctor initiates a general repair (line 3) to check the correctness of the utterance. When the interpreter reformulates her translation, the doctor repeats the final part, which may function here as an understanding check (line 5). After double checking the answer, the doctor then concludes that the patient's assertion of having an ulcer must be wrong. This is of course highly face-threatening, since it directly attacks the patient's words about her own physical condition. The interpreter omits the hedged formulation by the doctor (line 7: 'ik veronderstel', *I suppose*), and factually states that it is not possible for the patient to have an ulcer, but she adds a quotative at the end of this statement. Although the interpretation is provided in overlap with the doctor's turn, the place of the quotative at the end of the sentence clearly rules out an interaction-related function, and points to a distancing one. After this fragment, the doctor continues to provide additional arguments to support his conclusion, thus reinforcing the face-threatening nature of his assertion.

3.2.2 Translation of the patients' turns with he/she says

There are fewer examples of the quotative 'he/she says' in the interpretation of the patients' turns, but it is clear from the data that the most important group of quotatives occurs in the interpreting of topics initiated by the patient. These are often accompanied by other elements that suggest a distance from the statement. In the first example of this group of quotatives, the addition of the tag question 'kan da?' (*is that possible*, line 9) actually rephrases the statement initiated by the patient into a question that probes for clarification by the doctor:

Extract 10: Rheumatism

- 1 Pat: вот этот euh холестерин () как как можно сказать
look that erm cholesterol () how shall I put it
- 2 () как будто
() as if
- 3 I: опухает у вас ()
it bloats ()
- 4 Pat: да да да да да
yes yes yes yes yes
- 5 I: чувство что надуто ()
it gives a swollen feeling ()
- 6 Pat: да да да
yes yes yes
- 7 I: -> die medicament zegt ze dat ik neem tegen de cholesterol
that drug she says that I take against the cholesterol
- 8 Dr: ja:
ye:s
- 9 I: dat geeft me opgezwollen gevoel zo opgeblazen buik kan ↑da
that gives me bloated feeling so swollen belly is that ↑possible

The content (in the Russian participation framework) is co-constructed by the patient, who hesitates and reformulates (lines 1-2), and the interpreter, who provides a slightly more fluent description of the feeling of the patient (line 3) and checks her understanding further (line 5), which is then affirmed by the patient (eight times in total: lines 4 and 6). The interpreter starts her translation of this co-constructed utterance by initiating the topic in two parts: the first part ('die medicament', *that drug*, line 7) is accompanied by the quotative. After the doctor's affirmation, the interpreter provides the second part of the utterance and adds a tag, which questions the effect of the medication and actually rephrases the entire statement into a request for further explanation by the doctor. On the one hand, then, insertion of the quotative, possibly due to the co-constructed nature of this statement, increases the distance between the interpreter and the content of her translation. On the other hand, the question in line 9 now invites the doctor to provide a clarification regarding the effect of the medication, and as such, the quotative also serves to cover up the interpreter's involvement in the construction of meaning.

In the following example, the interpreter renders a question initiated by the patient:

Extract 11: Muscle

1	Pat:	() мои весы () и может ли он мне помочь ()
() <i>my scales</i> () <i>and whether he can help me</i> ()
2	I:	d'r is nog 'n eu:h (.) 'n vraag:,
<i>there is another er:m (.) question:,</i>
3		0.5
4	Dr:	ja[h,
ye[s,
5	I: ->	[ze zegt ik heb 't gemerkt, natuurlijk mijn gewicht
<i>[she says I have noticed, of course my weight</i>
6		die heeft e:h ook allé die speelt ook 'n grote
<i>that also er:m has well that also plays a big</i>
7		rol [>in mijn gewrichtsklachten. en al die sp[ieren en ↑zo,<
<i>role[>in my joint complaints. and all these m[uscles and ↑so,<</i>
8	Dr:	[jah, [ja
[yes, [yes

The Russian question was not entirely understandable, the doctor had been on the phone and it was at this point that the patient started her question. Line 1 presents the final part of the Russian source text; i.e. the part that could be understood (the doctor had put down the phone right before). The interpreter starts her translation in line 2 with a preliminary to the question. After a short pause, the doctor grants her floor rights in his affirmation (line 4), after which she starts introducing the patient's question. She uses a quotative to introduce the topic (line 5), and this is followed by quite a long-winded introduction to the question. This question is not shown here, since it takes an additional four lines by the interpreter (after the last line of this fragment) before it is actually formulated (the question can be seen in extract 8, line 1). The interpreter quite hesitantly and circuitously initiates the patient's question, but due to the overlap with the doctor's phone call, it is unclear to what extent this formulation is a literal translation of the patient's words. However, the preliminary to the question in line 2 shows clearly that the interpreter is taking the floor cautiously by asking the doctor's permission to translate the patient's question, which is again introduced by a quotative.

In short, the function of this quotative in topics initiated by the patient seems to be twofold:

1. It creates a distance between the interpreter and the patient's words. This function is supported by the other distancing elements such as the rephrasing of a statement into a question by means of a tag in extract 10 or the careful introduction to the question in extract 11. Thus in these cases, the quotative also draws attention to the animator/reporter role of the interpreter, as was also the case in some of the translations of the doctor's turns. This distancing function can be related to two other elements:
 - a. Since the rest of the interaction demonstrated that these utterances were always followed by a dispreferred response from the doctor, this distancing function can be viewed as interactionally anticipatory and based on the interpreter's experience with particular questions and particular doctors.
 - b. Since it has been observed that the physician is in control and dominates the entire interaction (Mishler 1984: 71), which becomes particularly clear from the fact that it is typically the doctor who 'opens and terminates each cycle of discourse' (Mishler 1984: 71), these topics initiated by the patient can be viewed as disrupting this overall pattern and undermining the doctor's dominant conversational position. As originally observed by Frankel (1990), there is a general dispreference for patient-initiated questions in doctor-patient interaction. The interpreter may therefore be viewed as distancing herself from the patient's 'deviant behavior' and as confirming the typical roles and preferences associated with a medical interview. However, it is important to remark that the patients themselves also orient to this asymmetrical relation between doctor and patient: the most frequent point at which topics are initiated by the patient is the one at which the doctor-interpreter participation framework is not available; e.g. when the doctor is making phone calls to arrange a patient's admission to the hospital or writing prescriptions for medication or tests. At such points, for a patient to initiate a topic is hardly disrupting anything, because of the 'frozen' nature of the doctor-interpreter participation framework, which also illustrates the patient's role in co-constructing the asymmetrical doctor-patient relationship. Thus the interpreter is merely confirming this co-construction, instead of initiating it.
2. The addition of the quotative may be viewed as serving a disambiguating function. Since the interpreter herself sometimes initiates topics in these data, the use of the quotative clearly shows that these topics are actually initiated by the patient rather than by the interpreter. Another example of such a disambiguating function occurs when the interpreter is required to convey the patient's lack of knowledge: in these cases, she makes it clear that the lack of an efficient answer is a literal translation and not due to problems of understanding or translation on her part.

Extract 12: Rheumatism

1 Dr: de cholesterol is veel te hoog eh

- 2 I: *the cholesterol is much too high hey*
холестерин опять высокий
the cholesterol [is] high again
- 3 Pat: не знаю
I don't know
- 4 I: -> ik weet 't niet zegt ze
I don't know she says

Finally, another example of such a disambiguating function of the quotative occurs when the interpreter provides two translations of the patient's and her own turns. This occurs when the interpreter deviates from the normal pattern of translating turns, and starts initiating questions herself. This pattern was described by Bolden (2000) and the following fragment, a good example of this pattern, has already been discussed in Van De Mierop and Mazeland (2009) in terms of its deviation from the regular pattern. Here, I focus only on the function of the quotative in line 12.

Extract 13: Kidney

- 1 I: кто-нибудь к вам приходил ?
did somebody visit you?
- 2 Pat: этот молодой парень.=
that young guy =
- 3 I: =это невролог.=
that is the neurologist =
- 4 Pat: = a:h =
- 5 I: = а нефролог
= *but a nefro[logist*
- 6 Pat: [не не
[no no
- 7 1.5
- 8 Pat? [(° °)
- 9 I: [niemand is ↓langsgewe[est
[nobody came [↓by
- 10 Dr: [nee:h.
[no:
- 11 0.3
- 12 I: -> °(hij zegt)° alleen over de dokter [x]
°(he says)° only about doctor [x]
- 13 (.)
- 14 die jonge: (.) dokter.
that young (.) doctor.
- 15 Dr: °mm ↑hm°

By means of a series of repair initiations, the interpreter co-constructs the patient's answer to the question initiated by the doctor a few lines earlier, but the translation of which can be seen in line 1. After the negotiation of this answer, the interpreter initially provides no more than a summary translation of the monolingual interaction, which goes unquestioned by the doctor, who simply registers the answer (line 10). However, after a short pause, the interpreter self-initiates a more detailed rendering of the interaction, introduced by means of a quotative. This quotative clearly serves a disambiguating function, since the second part of the the interpreter's translation comes after the doctor has registered the first part. Without the quotative, the interactional goal of lines 12-14 would have been unclear and might have been understood by the doctor

as a new topic initiation. The quotative, however, makes it clear that the interpreter is still ‘looking back’ to the prior talk and is providing an additional translation that accounts for the monolingual interaction in the patient-interpreter participation framework.

3.2.3 Summary comparison of the quotatives in the translation of the doctors’ and the patients’ turns

When looking at the use of quotatives in the translations of the doctors’ turns, we observe two different functions:

1. an interaction-related function which
 - (a) facilitates the switch in participation frameworks and the segmentation of information;
 - (b) accounts for the interpreter’s extensive floor-holding rights when she is translating a long discourse unit;
2. a content-related function in which distance is created between the interpreter and the words she is interpreting. By explicitly stressing that she is merely animating the words, she effectively absolves herself of the responsibility for the content and indicates that the responsibility lies with the doctor. These quotatives occur in face-threatening situations, such as delivering bad news, providing information that does not conform with the ‘voice of medicine’, giving dispreferred responses, or refuting the patients’ words.

The translation of the patient’s turns also reveals two functions

1. a content-related function in which distance is created between the interpreter and the topics initiated by the patient, thus emphasizing the animator/reporter role of the interpreter as a mere ‘sounding box’ (Goffman 1979) of the words, which may be related to:
 - (a) the interpreter’s anticipation of the following dispreferred response by the doctor;
 - (b) the interpreter’s confirmation of the doctor’s dominant conversational position;
2. a disambiguating function aimed at identifying the principal of the words, and the status of a translation as:
 - (a) a literal translation of a patient’s lack of knowledge;
 - (b) an additional, more detailed rendering of a previous monolingual interaction.

4. Conclusions

A critical study of the above summary of the use of quotatives may lead to the conclusion that there are a number of differences between the interpretation of the doctors’ and the patients’ turns. First, the interactional function present in the case of the doctors’ discourse units is absent in the renderings of the patients’ turns. I argue that the reason for this is practical rather than content-related: this article presents a case study of four interactions, in which there are no discourse units by the patients. In itself, this is not surprising, given the nature of the four interviews and the asymmetry in doctor-patient interaction which makes it less likely to find discourse units in patients’ turns. However, this in itself offers no further insights into the use of the quotative in the interpretation of either the doctors’ or the patients’ turns.

Secondly, the disambiguating function could not be found in the renderings of the doctors' turns. Two reasons for this may be suggested:

(a) It may be related to the typical roles of doctors and patients in such medical interviews: doctors usually ask fairly clear questions, while the patients' answers frequently contain displays of vagueness or lack of knowledge. The differing nature of these questions versus answers entails a different need for disambiguation: while factual questions do not generally require any disambiguation, vague answers may.

(b) Secondly, the distribution of the disambiguating function in the additional interpretation of a previous monolingual interaction is different: when they occur in the doctor-interpreter participation framework, no detailed renderings of these additional turns are provided for the patient. Yet, as extract 13 has shown, the reverse is true when the interpreting is directed at the doctor. Further research would be needed before concluding that this example represents a disparity in actual access to interpretation.

Finally, and most importantly, we reach the comparison of the content-related function that is present in the interpretation of both the doctors' and the patients' turns. At first sight, this function seems quite similar, since it establishes a distance between the interpreter and the words she utters. Similar to Clayman's (1992) discussion, the use of such a quotative differentiates the three components of the speaker's production format; namely, the interpreter as a mere animator/reporter of the translated words and the doctor or patient as the principal of the utterance. However, when looking more closely at the specific contexts in which quotatives with a distancing function occur, a clear difference between the interpretation of the doctors' and the patients' turns may be discerned:

1. in the case of the doctor, the creation of distance may be directly related to the content of the message being translated, which is typically face-threatening or dispreferred. For example, as has also been described in the delivery of bad news in non-interpreted interactions, doctors adopt various strategies to construct a certain distance between themselves and the message:

Bad news is *shrouded* — deliverers preface the news with neutral terms (or even positive evaluations) rather than negative assessments, often delay the delivery until the third turn of the NDS [News Delivery Sequence; own addition], produce the news after hesitations and other disfluencies in a turn of talk, or otherwise position it last in the turn. (Maynard & Frankel 2006: 250)

Interestingly, when the interpreter has created a distance by adding the quotative and assuming the animator role, the news is usually delivered in quite a straightforward way, such that even rather explicit formulations (see for example the use of the word 'corpse' in extract 7) are used. The translation is thus stripped of most of the delaying and hesitating elements typical of bad news as identified by, for example, Maynard and Frankel (2006) and as such, the bad news is delivered in quite a confrontational way.

2. in the interpretation of the patients' turns, the creation of distance is related to the asymmetrical doctor-patient relation. As Frankel (1990) has put it, due to this asymmetry, topic initiations by the patient are dispreferred. The interpreter co-constructs this asymmetry by distancing herself from the translations, but, as I

have indicated earlier, patients also orient to this asymmetrical relation by hardly ever initiating topics at times when the doctor-interpreter participation framework is available. As such, patients initiate their topics almost as byplay to the dominant doctor-centered participation framework, and interpreters further confirm and co-establish this asymmetry.

As shown in the previous discussion, the difference in the occurrence of content-related quotatives is clearly linked to the typical asymmetrical relation that is constructed in medical interviews. In the interpretation of doctors' turns, a quotative's presence directly depends on the dispreferred character of the message itself, while in the translation of the patients' turns, it relates to the powerless position of the patient.

Thus, in conclusion, the discussion of a single element in the interpreter's renderings points to several findings:

1. the interpreter makes use of the quotative 'he/she says' (together with discourse markers) as a 'meaningless' element in this complex interactional situation in order to facilitate the switch in participation framework when there is a threat of cognitive overload;
2. the interpreter can disambiguate the status of her words as translations by means of the quotative 'he/she says';
3. the interpreter distances herself from her words when these words are face-threatening, either because of the message itself (e.g. bad news) or because it may undermine the doctor's dominant position in the medical interview (e.g. when the patient initiates a topic).

Clearly then, the interpreter is sensitive to the nature of the message or to the asymmetry of the interactional situation, and plays the role of a participant in the interaction, contributing to the construction of meaning and co-establishing the power relation typical of the medical interview. As observed by Merlini and Favaron (2005), then, an interpreter does indeed adopt the 'voice of interpreting' which is proposed 'as a polyphonic and shifting variable, which [is] locally determined by the interpreters' perception of their own and the other participants' needs and orientations to the unfolding activity' (2005: 294).

As a final point, I need to emphasize the limitations of this study: since I had access to no more than four interactions, all of which were rendered by the same interpreter, no definite or general conclusions may be drawn regarding the overall use of quotatives in interpreted healthcare interactions. However, the fact that certain tendencies have been observed in other studies, using both interpreted and non-interpreted data (such as the frequent use of the quotative (cf. Bot 2005) or the asymmetrical power relation in doctor-patient interaction (cf. Ten Have 1991)), supports the findings of this exploratory study and points to their potential generalizability.

Notes

1. A shorter version of this article was presented at the Critical Link 6 Conference in Birmingham, United Kingdom (26-30 July 2010).
2. The term perspective refers to a speaker's viewpoint and is thus related to Goffman's concept of footing (Goffman 1979, 1981). See Bot (2005: 241-243) for an interesting discussion of perspective in interpreted interaction.

3. Of course, the change of language excludes a purely ‘animating’ or ‘reporting’ role in a strict sense, but I use the terminology here since it most explicitly points to the role of the interpreter as a ‘linguistic parrot’.
4. The data were collected by Joke Van Den Bulck and Elien Stappaerts. They also translated the Russian into Dutch and transcribed the interactions. These translations were corrected and further completed by Karen Van de Cruys and Natalia Egorova. The transcription of the Dutch lines was further refined by Harrie Mazeland and myself for a joint publication (see Van De Mierop & Mazeland 2009). Karen Van de Cruys then corrected the final translations from Russian into English. I am very grateful to all these people for their important contribution to this study.
5. By ‘direct translation’ I refer only to the perspective that is being used. I do not wish to make any statements on either the content or the quality of the interpreter’s translation.
6. The fragments contain quite a lot of non-grammatical or non-idiomatic phrases, both in Russian and in Dutch. This is quite often due to the fact that on both sides, non-native speakers were producing these languages. The translation into English is as close as possible to the source text, which sometimes also results in odd formulations.
7. The transcription notation is based on the Jefferson system as described by Antaki (2002).
8. A caveat is in place here: since the data were only audio-recorded, no definite conclusions can be drawn on all the elements that contribute to a switch in participation frameworks. Evidently, an aspect such as eye gaze is very important in establishing, maintaining and switching participation frameworks, but due to the lack of video recordings, this aspect could not be included in the analyses.
9. The discourse markers in the fragments serve similar functions, but a discussion of these markers falls outside the scope of this article.

References

- Antaki, C. (2002). An introductory tutorial in conversation analysis. <http://www-staff.lboro.ac.uk/~ssca1/intro1.htm> (accessed 31 May 2010).
- Bolden, G. B. (2000). Toward understanding practices of medical interpreting: Interpreters’ involvement in history taking. *Discourse Studies* 2 (4), 387-419.
- Bot, H. (2005). Dialogue interpreting as a specific case of reported speech. *Interpreting* 7 (2), 237-261.
- Bot, H. & Wadensjö, C. (2004). The presence of a third party: A dialogical view on interpreter-assisted treatment. In J. P. Wilson & B. Drozdek (Eds.), *Broken spirits*. Hove: Brunner Routledge, 355-378.
- Clayman, S. E. (1992). Footing in the achievement of neutrality: The case of news-interview discourse. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings*. Cambridge: Cambridge University Press, 163-198.

- Clift, R. & Holt, E. (2007). Introduction. In E. Holt & R. Clift (Eds.), *Reporting talk: Reported speech in interaction*. Cambridge: Cambridge University Press, 1-15.
- COC. (2008). Pedagogisch dossier sociaal tolken en vertalen [Pedagogic file social interpreting and translating]. [Online] June 2010.
http://www.sociaaltolkenenvertalen.be/uploads/pedagogisch_dossier_website.pdf
 (accessed 8 June 2010).
- Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics* 4 (3), 379-405.
- Davidson, B. (2002). A model for the construction of conversational common ground in interpreted discourse. *Journal of Pragmatics* 34, 1273-1300.
- De Keyser, R. (2009). Grensoverschrijdend gedrag. Nieuwe uitdagingen voor de sociaal tolk [Cross-border behavior. New challenges for the social interpreter]. In J. Jaspers (Ed.), *De klank van de stad; stedelijke meertaligheid en interculturele communicatie* [The sound of the city; urban multilingualism and intercultural communication]. Leuven: Acco, 57-78.
- Dubslaff, F. & Martinsen, B. (2005). Exploring untrained interpreters' use of direct versus indirect speech. *Interpreting* 7 (2), 211-236.
- Frankel, R. M. (1990). Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In G. Psathas (Ed.), *Interaction competence*. Washington, DC: University Press of America, 231-262.
- Gavioli, L. & Maxwell, N. (2007). Interpreter intervention in mediated business talk. In H. Bowles & P. Seedhouse (Eds.), *Conversation analysis and language for specific purposes*. Frankfurt: Peter Lang, 141-182.
- Goffman, E. (1979). Footing. *Semiotica* 25, 1-29.
- Goffman, E. (1981). *Forms of talk*. Oxford: Basil Blackwell.
- Houtkoop, H. & Mazeland, H. (1985). Turns and discourse units in everyday conversation. *Journal of Pragmatics* 9, 595-619.
- Leanza, Y. (2005). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. *Interpreting* 7 (2), 167-192.
- Lutfe, K. & Maynard, D. W. (1998). Bad news in oncology: How doctor and patient talk about death and dying without using those words. *Social Psychology Quarterly* 31, 301-320.
- Mathis, T. & Yule, G. (1994). Zero quotatives. *Discourse Processes* 18 (1), 63-76.
- Maynard, D. W. (1991). The perspective-display series and the delivery and receipt of diagnostic news. In D. Boden & D. H. Zimmerman (Eds.), *Talk and social structure*. Cambridge: Polity Press, 164-192.
- Maynard, D. W. & Frankel, R. M. (2006). On diagnostic rationality: Bad news, good news, and the symptom residue. In J. Heritage & D. W. Maynard (Eds.), *Communication in medical care: Interaction between physicians and patients*. Cambridge: Cambridge University Press, 248-278.
- Mazeland, H. (2003). *Inleiding in de conversatieanalyse* [An introduction to conversation analysis]. Bussum: Coutinho.
- Merlini, R. & Favaron, R. (2005). Examining the "voice of interpreting" in speech pathology. *Interpreting* 7 (2), 263-302.
- Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Pöchhacker, F. & Shlesinger, M. (2005). Introduction: Discourse-based research on healthcare interpreting. *Interpreting* 7 (2), 157-162.

- Schegloff, E. A. (1987). Recycled turn beginnings: A precise repair mechanism in conversation's turn-taking organization. In G. Button & J. R. E. Lee (Eds.), *Talk and social organization*. Philadelphia: Multilingual Matters, 70-85.
- Streeck, J. & Hartge, U. (1992). Previews: Gestures at the transition place. In P. Auer & A. di Luzio (Eds.), *The contextualisation of language*. Amsterdam: John Benjamins, 135-158.
- Ten Have, P. (1991). Talk and institution: A reconsideration of the “asymmetry” of doctor-patient interaction. In D. Boden & D. H. Zimmerman (Eds.), *Talk and social structure*. Cambridge: Polity Press, 138-163.
- Valero Garcés, C. (2005). Doctor–patient consultations in dyadic and triadic exchanges. *Interpreting* 7 (2), 193-210.
- Van De Mieroop, D. & Mazeland, H. (2009). Modificaties van vraag-antwoordsequenties in getolkte arts-patiëntgesprekken [Modifications of question-answer sequences in interpreted doctor-patient interactions]. *Tijdschrift voor Taalbeheersing* 31 (2), 124-141.
- Wadensjö, C. (1998). *Interpreting as interaction*. London/New York: Longman.
- Wadensjö, C. (2008). The shaping of Gorbachev: On framing in an interpreter-mediated talk-show Interview. *Text & Talk* 28 (1), 119-146.

Author's address

Dorien Van De Mieroop
 Faculty of Arts, Department of Linguistics
 University of Leuven
 Blijde Inkomststraat 21, P.O. Box 3308
 B-3000 Leuven
 Belgium

Dorien.VanDeMieroop@arts.kuleuven.be

About the author

Dorien Van De Mieroop is a discourse analyst whose research focuses mainly on identity construction, both in institutional contexts (e.g. speeches, social work interactions) and in narratives and life stories. She has published a number of articles on this topic (e.g. in *Discourse Studies*, *Journal of Pragmatics*, *Research on Language and Social Interaction*, *Discourse & Society* and the *Journal of Sociolinguistics*).