Communicating in medical settings

Strategies & challenges for effective cross-cultural interpreting

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Abstract

This thesis examines ways in which interpreting practice in healthcare settings can be enhanced in order to better facilitate communication with Aboriginal and Torres Strait Islander patients. This study is based on 17 audio-recordings of semi-structured interviews with interpreters of Aboriginal languages and Aboriginal Liaison Officers (ALOs) in metropolitan, regional and remote sites in Australia. This thesis is built around two major research questions. The first focuses on how interpreters and ALOs talk about how they do their work. The findings illustrate that the interpreters and ALOs use storytelling to talk about their professional practice. A small story and narrative positioning analysis framework is used to analyse these stories. The resultant analysis foregrounds the positions that the interpreters and ALOs adopt as they tell their stories and highlights the Discourses that they invoke to frame their professional identity. The second research question explores the strategies and actions the interpreters and ALOs report they use to resolve potential communication differences that may confound the interpreting process. The findings suggest that provisions need to be made for cultural differences. Interpreters report they have to 'unpack' medical terminology pertaining to biomedical concepts such as cancer, fungus infection and diabetes. They explain such terminology and related concepts in tangible terms to ensure patient understanding. Other strategies include talking about sensitive topics such as private body parts, sexually transmitted infection and death and dying using culturally appropriate terms; avoiding certain question-answer routines typical in western communicative interaction and being aware of non-verbal aspects of communication.

Declaration

I declare that:

a) This thesis comprises only my original work towards the Doctor of Philosophy degree;

b) Due acknowledgement has been made in the text to all other material used;

c) Full ethics procedures and guidelines have been followed; and

d) The thesis is fewer than 100,000 words in length exclusive of tables, maps, figures, and foreign language examples.

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List of Acronyms and Transcription Conventions

Acronyms

Abbreviation	Definition
ALO	Aboriginal Liaison Officer
AIS	Aboriginal Interpreter Service
AIWA	Aboriginal Interpreting Western Australia
ASDW	Aboriginal Service Development Worker
AUSIT	Australian Institute of Interpreters and Translators
CALD	Culturally and Linguistically Diverse
NAATI	National Accreditation Authority for Translator and Interpreters
SAE	Standard Australian English
SL	Source language
ST	Source text
TIS	Translating and Interpreter Service
TL	Target language
TT	Target textssssss

Transcription Conventions

Notation	Meaning
###	Unintelligible (syllables)
Annie	Pseudograph (fake name, address etc.)
@@@	Laughter during speech
[ ]	Overlap
<MISC> </MISC>	Manner/quality
Word truncation	word—
..	Pause short (< 150 milliseconds)
...	Pause long (> 150 milliseconds)
Appeal	?
ANNIE;	Speaker label

Chapter 1 Introduction

1.1 Overview of the study

How does an interpreter or an Aboriginal Liaison Officer (ALO) position themselves with respect to the health institution, other health professionals and the patient? How do interpreters and ALOs interpret medical terminology and concepts that appear to be absent in the target language? How do they interpret for people who come to the interaction with markedly different worldviews and knowledge systems? These questions among many others sparked my interest and served as the motivation for the research in this study. This thesis brings together several key topics related to health interpreting: how the professional identities of interpreters and ALOs emerge through the stories they tell; the challenges interpreters and ALOs face as they contend with culturally distinct communication patterns; and finally, the communication strategies they use to navigate these challenges.

The overall aim of this thesis is to investigate ways in which interpreting practice in healthcare settings can be enhanced so as to better facilitate communication with Aboriginal and Torres Strait Islander patients. The research is based on data collected over the period of one year. It includes 15 hours of transcribed audio recording conducted with 10 interpreters of Aboriginal languages and 9 ALOs in metropolitan, regional and remote sites in Australia. Aboriginal Liaison Officers are responsible for the delivery of culturally responsive services for all Aboriginal and Torres Strait Islander patients and are often employed to interpret for them; however, they are not certified as interpreters by interpreting bodies such as National Accreditation Authority for Translators and Interpreters (NAATI). Interpreters, on the other hand, have NAATI certification. Two types of data were used; narrative data that consists of 25 stories; and non-narrative data that contains central themes pertaining to interpreting in medical settings. The narrative data was analysed using Bamberg and Georgakopoulou's (2008)

three level positioning analysis to investigate how the interpreters and ALOs use stories to talk about how they do their work and in doing so discursively construct a sense of who they are professionally. The non-narrative data was analysed using a thematic analysis to identify central themes pertaining to interpreting strategies used to resolve potential communication differences that may confound the interpreting process in medical settings.

In approaching the topic of interpreting in medical settings, several key issues arise with respect to how the professional identities of interpreters of Aboriginal languages and ALOs emerge through the stories they narrate. One question that arises is how interpreters and ALOs actually perceive and report on their own experiences in the field of their professional practice. Other questions concern: how the interpreters and ALOs position themselves with respect to the health institution, other health practitioners, and the patient; and how and why interpreters and ALOs shift from one positioning to another. A final question raised, is how the interpreters and ALOs position their sense of self with respect to broader Discourses[1] – or ways of being in the world. These questions are investigated in Chapter 5 'Narrative Positioning Analysis', in which I present the stories the interpreters and ALOs exchange as they offer their interpretation of the complexities of their respective roles and in doing so demonstrate the construction of multiple, shifting identities.

These multiple, shifting positions that interpreters and ALOs adopt as they interpret for Aboriginal patients, bring to the fore culturally distinct communication patterns. When analysing these culturally distinct ways of talking, several key questions arise: How do structural and institutional barriers impact the interpreter-mediated encounter? Another question pertains to how interpreters and ALOs navigate different

[1] Gee (1999) states that Discourses with a capital D characterise "ways of being in the world, or forms of life which integrate words, acts, values, beliefs, attitudes, and social identities …" (p. 127).

communication norms as they converse with Western medical practitioners and Aboriginal patients. For instance, how do interpreters offer single-word equivalents to words such as *risk*, when *risk* as an abstract notion, is absent in the patient's worldview? A related question concerns, how interpreters navigate between Western medical knowledge systems and Aboriginal ways of knowing to convey meaning. For example, how do they interpret the microscopic world of disease including key biomedical health concepts such as cancer, fungus infection and diabetes. A further concern raised is the interpreting of taboo topics, such as private body parts, sexually transmitted infection and the concept of death and dying. When commissioned to interpret such culturally sensitive topics, how does the interpreter strike a balance between their professional roles as stipulated in the AUSIT (2012) Code of Ethics and Code of Conduct, and the responsibilities and restrictions placed on them by customary law? Finally, how do interpreters and ALOs deal with the cultural specificity of verbal and non-verbal conversational behaviours? These questions are addressed in Chapter 6, 'Interpreting in medical contexts', which explores the strategies interpreters and ALOs report they use to deal with potential communication differences during the interpreter-mediated encounter.

In Chapter 7, 'Discussion and Conclusion' I discuss the significance of the findings from Chapter 5 and 6. For instance, I illustrate how the Discourses the interpreters and ALOs construct, highlight the multifarious positions they take on as they navigate the challenges they encounter. I then show how the interpreters and ALOs engage with these Discourses to construct a sense of their professional identity. Finally, I illustrate how these Discourses and the related positions the interpreters and ALOs adopt are invoked when discussing the strategies used when interpreting for Aboriginal patients.

Throughout the course of this thesis, I will examine each of these questions in light of the following research questions:

1) How do interpreters of Aboriginal languages and Aboriginal Liaison Officers talk about how they do their work, when they interpret or advocate for their clients?
2) What strategies and actions do interpreters and Aboriginal Liaison Officers report they use to resolve potential communication differences that may confound the interpreting process?

In the following Chapters, Chapter 2 'Narrative Research', and Chapter 3 'Translation and Interpreting theories' I establish the theoretical groundwork for the analysis of stories and argumentative sequences offered by the interpreters and Aboriginal Liaison Officers. First, I examine the history of narrative research in the social sciences and then proceed to situate this study in relation to the small story research approach and narrative positioning analysis, which form the analytical lens I employ to analyse the stories offered by the participants (Bamberg, 2006; Bamberg et al., 2011; Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2006, 2007). I then discuss theoretical approaches to translation and interpreting and explore the extent to which paradigms from translation have influenced the development of interpreting theories. I also draw on this research to identify implications for interpreting practice.

Chapter 2 Narrative research

2.1 Introduction

Storytelling is one of the primary vehicles we use to talk about our lived experiences whether they be past, present or imagined futures (McAdams, 2008). It is well-attested that stories often emerge during the course of a research interview either fortuitously or following the interviewer's deliberate elicitation of a specific narrative performance (Slembrouck, 2015). In the former case, a participant's response to a particular question may produce a narrative that revolves around some "human, social, professional, institutional, or personal experience," (Slembrouck, 2015, p. 241). Slembrouk (2015) observes that interview participants often interrupt the question-answer format that is characteristic of research interviews; they adopt the role of narrator and subsequently, the interviewer takes on the role of "recipient of the narrative performance" (p. 241). At other times there is co-construction of the narrative. This indeed is the case with stories that the interpreters of Aboriginal languages and ALOs spontaneously produce in this study, as they talk about the work they do, and it is through the narration of these stories and the positions they adopt, that they construct a sense of their professional identity.

In Aboriginal societies, telling stories is a way of knowing that emanates from a strong oral tradition of sharing knowledge in this way (Green, 2014; Iseke, 2013). Ober (2017) asserts that storytelling "is used to inform past histories, kinship structures, beliefs, values, morals, expected behaviour and attitudes" and thus storytelling constitutes a habitual practice in the lives of Australian Aboriginal people (p.10). In the context of research, Archibald (2008) and Kovach (2010) use storytelling as a research tool. Kovach (2010) notes that story telling involves "a dialogic participation that holds a deep purpose of sharing story as a means to assist others" (p. 40).

When it comes to the terms *narrative* and *story*, they are often used interchangeably in the literature and this is something that Wierzbicka (2010) and Linde (1993) query. Wierzbicka (2010) asserts that the word *story* is an "English cultural

keyword and a key interpretive tool of modern Anglo culture" (p. 153). This cultural specificity is not translatable in languages where the word may also carry the senses of *history* (as can be seen with the Greek work *ιστορία* /ɪstorɪa/ which may be used to refer to *history* or a personal *story*). Wierzbicka (2010) explains that the Anglo-Saxon *story* "suggests a well-defined shape and a kind of internal logic of (well-chosen) events …[it] suggests something … many people want to hear or to read (as if it were, a 'good story'), whereas a *history* does not" (p. 158). In this study I use *story* to refer to stories offered by the participants in the sense of the small story approach that sees stories as fragmentary or unfinished texts that may allude to past experiences, but also habitual or hypothetical or unfinished stories (Georgakopoulou, 2006; see section 2.3).

In this Chapter, I examine the history of narrative research in the social sciences and then situate this study in relation to the small story research approach and narrative positioning analysis (Bamberg, 2006; Bamberg et al., 2011; Bamberg & Georgakopoulou, 2008; Georgakopoulou, 2006, 2007). This forms the basis of Chapter 5, 'narrative positioning analysis' where I analyse the stories offered by the interpreters and ALOs to identify how these stories are used to determine the participants' sense of professional identity.

2.2 Narrative research in the social sciences

The use of narratives in the social sciences is a long-standing tradition with a recurring interest in narrative research at different times. Hyvärinen (2008) identifies three "narrative turns and attitudes" in the social sciences that are distinct but not "straightforwardly successive moments":

> At the first stage, narratives were used as *factual resources*. The second moment was characterised by the study of *narratives as texts* as a particular form. The third moment includes a movement beyond a separate narrative text, into the study of *narratives and storytelling* as polymorphous phenomena *in context* (p. 447, emphasis in the original).

As Hyvärinen (2008) and Spector-Mersel (2010) explain, narratives have been employed as factual resources since the 19th century; at the beginning of the 1900s, sociologists from the Chicago school collected life histories to examine social change, and anthropologists used narrative as a means of recording cultural data (Chase, 2005). Riessman (2008) also points to the use of narratives during the liberation movements in the 1960s; particularly with reference to feminist, civil rights and gay and lesbian identity movements. The study and analysis of narratives as texts developed firstly, within literary studies in the 1960s and "signified a structuralist, scientific and descriptive rhetoric in the study of narrative" (Hyvärinen, 2008, p. 449). In the mid-1960s, research into the structure of narratives concerning past, personal experiences developed in the context of Labov's (1966/2006) research into linguistic variation and language change. Seeking to closely approximate the vernacular of spontaneous speech, Labov (1966/2006) conducted interviews to elicit personal stories as they were found to reduce the impact of the effects of observation or the observer's paradox to a minimum (Labov, 1972). His resulting analysis identified that such narratives contain a similar organisation. In their collaborative work Labov and Waletzky (1967) sketched out the core components of the structure of a narrative. Their model offered criteria that helped distinguish narrative from other forms of discourse.

Beyond the structural model of narrative, there is also a functional element to Labov and Waletsky's classic narrative model, whereby narratives are "one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events that actually occurred" (Labov & Waletsky, 1967, p. 12). This analysis of narrative structure begins with "an orientation, proceeds to the complication action, is suspended at the focus of evaluation before the resolution, concludes with the resolution and returns the listener to the present time with the coda" (Labov & Waletsky, 1967, p. 369). Labov and Waletsky's work highlights the systematicity and structure present in narratives and has resulted in the description of what is now classified as 'classic

narrative'. Most importantly, it foregrounded the oral narrative as a form of discourse and this motivated other scholars to pursue this line of research (Chase, 2005).

Although having wide-ranging reach beyond linguistics into social science disciplines, the Labovian model has also been criticised for its "idealization, essentialization and homogenization of narrative" (Georgakopoulou, 2007, p. 3). Drawing on work conducted in "intensive life interviews", Mishler (1997) observes that "respondents rarely provided chronological accounts" and the close attention to clause level narrative structure in the Labovian model does not capture the complex narration that is characteristic in interview settings (p. 72). Mishler (1997) also points to "its relative inattention to the interview context in the production of narratives" (p. 71). In a similar vein, Schegloff (1997) takes issue with the way the model portrays stories as independent and fully formed texts, and "appears to take the story or narrative as already formed, as waiting to be delivered" (p. 100). Rather than being detached from their immediate context, "in the natural social world, narrative –in the form of the telling of stories in ordinary talk-in-interaction– is an organic part of its interactional environment" (Schegloff, 1997, p. 107).

Within the social sciences, in the early 1980s, researchers explored narrative as a mode of thought. This was in contrast with the "logico-scientific mode" of understanding, which compares two modes for interpreting the world (Bruner, 1986, p. 12; De Fina & Georgakopoulou, 2012). The first, the paradigmatic or logico-scientific mode of thought, "attempts to fulfil the ideal of a formal, mathematical system of description and explanation. It employs categorization or conceptualization and the operations by which categories are established, instantiated [and] idealized" (Bruner, 1986, p. 12). The second, the narrative mode, seeks to establish meaning by interpreting people's intention and action. Sarbin (1986), Bruner (1986) and Werstch (1985, 1998) perceived of narrative as a way of knowing about the world and more specifically "a mode of thought, communication, and apprehension of reality" (as cited in De Fina &

Georgakopoulou, 2012, p. 15). In essence, through narratives individuals assign meaning to their lives, reconstruct and interpret experience through the telling of their stories.

At the same time, during the 1980s, there was an epistemological shift away from a structural focus, where the focus was on the study of narratives "as separate complete and self-sufficient texts", towards a discourse-centred focus to narrative study, where the focus was on "narratives *in context* and interaction, and the study of *narrative practices*" (Gubrium & Holstein, 2008; Hyvärinen, 2008, p. 452). The work of Schegloff (1997), Duranti (1986), Goodwin (1986), Norrick (2000) and Ochs and Capps (2001) foreground the co-constructedness of storytelling in conversation. For instance, Ochs and Capps (2001) focus on conversational exchanges in which interlocutors produce spontaneous "accounts of life events" and often do so "without knowing where they will lead". These narratives "are shaped and reshaped turn by turn in the course of conversation" (p. 2). Ochs and Capps's (2001) *dimensional model* describes narrative in terms of five narrative dimensions which are presented along a continuum: 1) The dimension of *tellership* can be perceived as the social organisation of who tells the story (e.g., whether there is one central teller or multiple co-tellers); 2) *tellability* refers to both "the significance of the narrated experience and the rhetorical style in which it was related"; 3) *embeddedness* refers to the extent to which a narrative is "detached" or embedded in conversation, for instance, whether the interactants ask questions or interrupt the narrative; 4) *linearity* points to the way the sequence of events in the narrative is organised and the extent to which narratives depict events as emerging in a "single, closed, temporal and causal path" or not; and finally, 5) *moral stance* refers to the perspective for interpreting the moral meanings associated with events in the narrative (Ochs & Capps, 2001, p. 33).

Vásquez (2007) supports the view that that moral stance is related to the construction of identity and a "professional self" (p. 656) and that the moral stance is

not static but may shift during the telling of a narrative, "as the teller – or listener – makes revisions to earlier interpretations" (p. 657). This is particularly evident in Vásquez's (2007) study of ESL teachers in a professional setting, in the context of mentoring conversations where the teachers "used language to position themselves within their narratives as variously reflective, certain, uncertain, and even doubtful" (Vásquez, 2011, p. 541). Vásquez (2011) illustrates how those positionings were at times, co-constructed by the teacher's interlocutors.

Studies in Conversation Analysis have shown that narrative is embedded in surrounding talk. It sees stories as talk-in-interaction, as activities that are sequential and co-constructed between the story-teller and audience (Goodwin, 2015). Jefferson (1978) underscored the importance of prefaces and closing or end points in a story and illustrated how narratives display links with preceding and following talk. Other CA analysts have highlighted the role of "participation frameworks", particularly in the "design, management and reception of stories" (De Fina & Johnstone, 2015, p. 156). These studies reveal the diverse role conversational participants play during the telling of a narrative, for instance, by negotiating evaluations (Ochs & Capps, 2001) or acting as co-tellers (Lerner, 1992; Page, 2018; Reissner & Pagan, 2013).

Research within the interactional framework has also demonstrated the diversity of narrative genres in informal contexts such as everyday conversations and more formal contexts such as workplace interactions. Riessman (1990) describes habitual narratives "which tell of the general course of events over a period of time, with the verb phrases and adverbs marking repetition and routinization" and hypothetical narratives describing events that did not happen (p. 1197). Baynham (2003) discusses generic narratives and shows how they were used by Moroccan immigrants to the UK to construct a gendered representation of the process of migration. Labov and Fought (2004) and Norrick (2000, 2013) analyse vicarious narratives, or "third-person stories" whose protagonists are not the actual teller or the

"central affected participant" (Norrick, 2000, p. 149). More recent theories, such as small story research and narrative positioning analysis, offer new insights to stories that are "incomplete or foreground mental events (of observation, feeling, and cognition) instead of physical action" (Bamberg & Georgakopoulou, 2008; Hyvärinen, 2008, p. 457). Small story research and narrative positioning analysis have been used to go beyond accounting for past experiences to exploring social identity as it emerges in situated talk (Bamberg & Georgakopoulou, 2008 see sections 2.3-2.5).

This section sets the theoretical groundwork for this study by tracing developments in narrative research in the social sciences and making reference to what has commonly been called *three narrative turns*. As we have seen, these include: narratives used as factual resources, the study of narrative as texts and finally narrative as situated talk-in-interaction.

Section 2.3 elaborates on narratives as situated talk-in-interaction and illustrates how efforts have been made to combine two different perspectives to narrative analysis research. The first, narrative inquiry, focuses on the content of a narrative, and the second, narrative analysis, explores the form a narrative takes in situated talk. In light of current definitions of fundamental taxonomies of narrative research such as the distinction between big and small stories, I discuss the small story approach to narrative analysis and illustrate how positioning analysis is employed to consider issues of identity (Bamberg & Georgakopoulou, 2008). This forms the basis for my own analytical focus in Chapter 5, narrative positioning analysis, where I have adopted the small story approach and narrative positioning analysis to study how the interpreters and ALOs construct a sense of their professional identity.

2.3 Small story approach

Narrative research has traditionally explored narratives from two perspectives; the first, narrative inquiry, focuses on the content of the narrative and examines the content of people's narratives in terms of their experiences. It explores how these past experiences are represented and how they are interpreted during the course of their telling (Georgakopoulou, 2006; Rugen, 2013). The second, narrative analysis, places focus on the form the narrative takes as it emerges in situated talk. It requires a closer examination of the language used in the telling of a narrative, how that language is expressed in its turn by turn account and how the participants interact and oftentimes co-construct their narratives (Georgakopoulou, 2006). Efforts have been made to bridge the gap between these two approaches to analysing narratives; Bamberg and Georgakopoulou's (2008) work is indicative of these efforts; they have combined analytical approaches that perceive narratives as situated talk-in-interaction that have a focus on the here and now, with analytical approaches that take into account the broader socio-cultural context and the Discourses in which these narratives emerge. Here I adopt Gee's (1999) distinction between small-*d* discourses and capital-*D* discourses. The former refers to "connected stretches of language that make sense, like conversation …" and the latter is used to characterise "ways of being in the world, or forms of life which integrate words, acts, values, beliefs, attitudes, and social identities." (p. 127). Bamberg (2014) reinforces Gee's (1999) differentiation between capital-*D* discourses, which are likened to *dominant discourses* or *master narratives*, and small-*d* discourses, which are used to refer to the everyday form of talk. This distinction facilitates an understanding of different ways of analysing identity in discourse (Bamberg et al., 2011). Studies drawing on *D*-Discourses perceive identity as being determined by societal macro conditions such as communal and institutional contexts, while studies examining *d*-Discourses make use of the in situ context or the actual choices speakers make "in the form of performed in vivo utterances … [to understand] how speakers present a sense of who they are (Bamberg et al., 2011, pp.

181–182). The connection between small-*d* discourses and capital-*D* discourses is taken up in narrative positioning analysis, which is elaborated on in section 2.5.

Building on the *dimensional approach* to narrative, Bamberg and Georgakopoulou developed the small story "functionalist-informed" approach to narrative and identity analysis (Bamberg, 2006; Bamberg & Georgakopoulou, 2008, p. 382; Georgakopoulou, 2006, 2007; Ochs & Capps, 2001). Small story research emerged as a counter response to prevailing models of narrative studies that:

> (a) defined narrative restrictively and on the basis of textual criteria;
> (b) privileged a specific type of narrative, in particular the long, relatively uninterrupted, teller-led accounts of past events or of one's life story, typically elicited in research interview situations (Georgakopoulou, 2015, p. 255).

A distinction was initially drawn between big and small stories; the former refers to "the grander narratives we tell ourselves, the big retrospectives [or life stories] elicited form interviews" (Watson, 2007, p. 371); and the latter, small stories, are those that "present fragmentation and open-endedness of tellings, exceeding the confines of a single speech event and resisting a neat categorization of beginning–middle–end" (Georgakopoulou, 2016, p. 3). As such, small stories involve the analysis of "a gamut of under-represented and a-typical narrative activities, such as tellings of ongoing events, future or hypothetical events, or shared (known) events, but also allusions to tellings, deferrals of tellings, and refusals to tell" (Georgakopoulou, 2006, p. 130). Small stories emerge within talk-in-interaction and are often co-constructed between tellers and audience who share some common knowledge and experience. It is important to note that Bamberg and Georgakopoulou did not set out to establish a rigid dichotomy between big and small stories but recognise "the pluralism, heterogeneity, and productive coexistence of narrative activities, big and small, in the same event, by the same teller, and so on" (Georgakopoulou, 2015, p. 256). As such, the small story approach enables research that explores "how people use small stories in their

interactive engagements to construct a sense of who they are, while big story research analyses the stories as representations of world and identities" (Bamberg & Georgakopoulou, 2008, p. 382).

Small story research is an eclectic approach to narrative analysis that draws on "various modes of interactional sociolinguistic and linguistic anthropological analysis", as well as principles of linguistic ethnography (Georgakopoulou, 2017, p. 37). Beyond insights drawn from conversation analysis that see stories as talk-in interaction, small story studies have also drawn on "biographical research" (Freeman, 2006; Wengraf, 2001), "practice-based approaches" to language and identities, which view language as "performing specific actions in specific environments and as being part of social practices, shaping and being shaped by them" (Georgakopoulou, 2015, p. 257). The process of making meaning in narrative is contextualised but has the potential to be re-contextualised and acquires meaning in new contexts (Bauman & Briggs, 1990). Therefore, narrative is not conceptualised as a single homogeneous genre but as multiple genres closely intertwined in routine ways of narrating a story in a wide range of contexts (Hyvärinen, 2015).

As Georgakopoulou (2015) explains, small story research is an eclectic synthesis of different approaches that has been developed into a method of narrative analysis comprising three levels of analysis: *ways of telling*, *sites*, and *tellers*, which are presented below: (Georgakopoulou, 2015, p. 258):

1) *Ways of telling* refers to the communicative how: the socioculturally shaped and more or less conventionalized semiotic and, in particular, verbal choices of a story:
   e.g.,
   a) how stories are introduced into and exited from conversations
   b) the stories' plots
   c) the types of events and experiences that they narrate
   d) the ways in which they are interactionally managed during the telling
   e) the intertextual links of the current story with other, previous and anticipated, stories

2) *Sites* refers to the social spaces in which narrative activities take place and captures the conglomerate of situational context factors ranging from physical (e.g., seating) arrangements to mediational tools that the participants may employ.
    a) social spaces in the here-and-now
    b) setting of the taleworld
    c) mediational tools

3) *Tellers*, as participants of a communicative activity and as complex entities:
    a) tellers as here-and-now communicators
    b) tellers as characters in their stories
    c) tellers as members of social and cultural groups
    d) tellers as individuals

By documenting the kinds of small stories that have been researched, Georgakopoulou (2015) suggests ways of identifying small stories:

- **Non- or multi-linear unfolding events sequenced in further narrative-making,** not linear sequencing of past events
- Emphasis on **world-making, i.e., telling of mundane, ordinary, everyday events**, not world-disruption and narration of complications.
- Emphasis on **detachability and recontextualization** of a story, not its situatedness in a specific environment
- **Co-construction of a story's point, events, and characters between teller and audiences**, rather than sole responsibility resting on the teller (emphasis in the original, p. 260).

Underlying this approach of working with small stories is the premise that constructions of identity are "dialogical and relational, fashioned and refashioned in local interactive practices" (Bamberg & Georgakopoulou, 2008, p. 393). Beyond identity work, small stories performs rhetorical work: interlocutors "put forth arguments, challenge their interlocutors' views and generally attune their stories to various local, interpersonal purposes, sequentially orienting them to prior and up-coming talk" (Bamberg & Georgakopoulou, 2008, p. 393).

Studies utilising the small story approach have foregrounded the role of the interviewer or researcher and their investment in the research process. Early and Norton's (2013) study into researcher reflexivity illustrated how the researchers

exploring identity formation of teachers partaking in a digital literacy project in Uganda impacted the process of educating teachers. Focusing on small stories helped uncover the complex identities the researchers adopted throughout the study, which ranged from teacher to team leader to international guest. The teachers also produced small stories when narrating their experiences of teaching English as an additional language in a rural school in Uganda. Overall, the study revealed negotiation of identities between researcher and participants and highlighted the role of researchers as stakeholders in studies into language education research as well. Small story research has been effectively utilised in studies of identity claims that emerge in interview and conversational data (Georgakopoulou-Nunes, 2009). It has been used in studies of ethnic identities among migrants (Galasińska, 2009); for instance, Barkhuizen (2010) analyses a small story that shows the construction of an "imagined 'better life' of a migrant, pre-service teacher" (p. 282). Small stories have also been used to explore the presentation of hybrid and emergent identities in intercultural encounters (Lee, 2015); and more recently in social media, as a salient aspect of online communication practices (Georgakopoulou, 2017; Georgakopoulou, 2016; Georgakopoulou-Nunes, 2017; Page, 2018).

Other studies have found small story research to lend itself to the critical analysis of professional practice; for instance, Juzwik and Ives (2010) employ small story research as "resources for performing teacher identity" as do Barkhuizen (2010), Rugen (2013) and Pomerantz and Kearney (2012). Oostendorp and Jones (2015) make use of small story analysis to explore "workplace identity in discourses on organizational processes in one workplace in South Africa" (p. 25); Ehrlich (2015) investigates "recasting and reformations of "original" narratives in what De Fina and Georgakopoulou (2012) call "their [original] occasions of production", which in this study refers to courtroom trials (p. 295). Ehrlich (2015) illustrates that these recasts of the original narratives tend to be reproduced in written documents or by participants not

present in the original interaction and during this process, may "undergo significant transformations in meaning" (p. 295). Finally, Runcieman (2018) uses a small story framework to examine how higher education institutions "appear to construct the identity of the professional interpreter from a student perspective" (p. 5). Although the small story framework has been used in a wide range of contexts, to my knowledge it has not been utilised to analyse stories told by interpreters of Aboriginal languages and ALOs, who shift into story mode to talk about how they do their work.

2.4 Identity construction

In this section, I explore identity construction through a social constructionist and interactionist paradigm. First, I differentiate between the concepts of identity and self or sense of self, then I outline why narratives are pertinent for the construction of identity by describing some of the relevant discursive processes that are involved, namely: indexicality, local occasioning and dialogism.

The task of defining the concepts of 'identity' and 'self' is formidable given the diversity in the terminology and alternate conceptualisations that have emerged in the numerous publications on the topic. However, overall it seems that there has been a move away from the traditional perception of "the self as an isolated, self-contained entity" (De Fina, 2011, p. 264) and a shift towards a more non-essentialist view of the self that sees the self as situated in the social world (Mead, 1934). This view of identity as a social construction is espoused by such feminists as Butler (1990) whose work on gender performativity proposes that gender identity is not something a person 'has' but something that they 'do'; she explains: "gender proves to be performance—that is, constituting the identity it is purported to be. In this sense, gender is always a doing …" (p. 25). This notion of performativity has been widely adopted in identity work "due to its ability to evoke the concrete and communicative aspects of the construction and communication of identity" (De Fina, 2011, p. 266).

How identity is enacted and communicated has been the focus of much work that examines identity processes such as *indexicality* (Silverstein, 1976/1980), for instance, the use of indexicals such as deictics and personal pronouns; and processes such as *local occasioning* (Antaki & Widdicombe, 1998). Antaki and Widdicombe (1998) argue that "for a person to 'have an identity' is to be cast into a category with associated characteristics or features" (p. 3). The notion of local occasioning encapsulates the idea that the way that identity is presented or ascribed is dependent on the context in which the interaction takes place but also functions to shape that context. In this way, identities are made relevant for subsequent talk (Van Dijk, 2011). As Johnstone (2008) explains, indexicality "can point to pre-existing social meaning, but the use of an indexical can also create social meaning" (p. 133). In this sense, on one level, the local construction of the self can be traced in the turn-by-turn interaction and on another level, broader assumptions about identity can be drawn by examining how the participant in an interaction indexes the social world in their talk. Zienkowski (2012) describes indexicality as a semiotic process of:

> generating meaning by means of contextualisation cues that point to spatial, temporal, social, and/or (inter)textual coordinates of reality. Indexicals may be linguistic or non-linguistic. [...] For instance, through marked transitions in register or dialect, a speaker may index a shift in relevant aspects of his or her identity within the context of a conversation (p. 515).

With respect to narrative analysis, narrators animate the voices of characters and such animations are locally indexed prosodically and or lexically and often align the characters with a specific social group or assign specific social roles or positions to them (Wortham, 2001). Wortham (2001) illustrates that due to the "socio-indexical" nature of language, narrators do not have to "explicitly represent their points, but instead they adopt positions by juxtaposing and inflecting the voices of various characters" (p. 63).

Antaki and Widdicombe (1998) highlight the importance of drawing attention to the fine details of local talk when making reference to the processes of "indexicality and occasionedness" (p. 4). They explain that "any utterance (and its constituent parts) comes up indexically, in a here and now … [therefore] a good part of the meaning of an utterance (including … one that ascribes or displays identity) is to be found in the occasion of its production" (p. 4). It follows then that the manner in which people project their identity or assign identity categories to other people is not only dependent on the context in which the talk emerges but is also instrumental in shaping this context.

Apart from being socially situated, identity is also a "relational and dialogical process" (De Fina, 2011, p. 271). De Fina (2011) elaborates on these processes by pointing out that "[i]ndividuals and collectivities express and negotiate their identities by occupying social and verbal spaces that are charted in oppositions or complementarities with others" (p. 271). Bamberg (2011) builds on this idea by illustrating that the process of active engagement in the construction of self and identity is navigated or managed between what he calls three *dilemmatic spaces* or challenges that storytellers are faced with: firstly, the dilemma of constructing *sameness of a sense of self across time in the face of constant change*; secondly, *the establishment of a synchronic connection between sameness and difference (between self and other)*; and thirdly, *the management of agency of the self in the world.* Each of these dilemmatic spaces seeks to provide an answer to the question "who am I?" and poses some challenge for identity work. The first dilemmatic space is negotiated by "sorting out what events qualify as formative or transformative for the emergence of identity" (p. 6). In this way, we can examine diachronically how an individual's identity evolves by negotiating between *constancy and change* (p. 3). The second dilemmatic space is negotiated by synchronically differentiating between sameness and differences in relation to self and others (Bamberg, 2011). In a narrative, this is the space where tellers position themselves vis-à-vis other characters and through the act of juxtaposing their

selves with others, tellers are able to showcase their uniqueness. The third dilemmatic space relates to the management of agency in terms of whether it rests within the self or within contextual and social forces (Bamberg, 2011).

Bamberg (2011) asserts that these dilemmatic spaces are closely related to both identity and the self in that "identity takes off from the continuity/change dilemma, and from here ventures into issues of uniqueness (self/other differentiation) and agency" (p. 6). Bamberg then contrasts the construction of identity with "notions of self and sense of self, [which] start from the self/other and agency differentiation and from here can filter into diachronicity of continuity and change" (p. 6). These dilemmatic spaces of continuity and change, sameness and difference, and agency, echo Bakhtin and Holquist's (1981) dialogical approach to interaction. The authors acknowledge the multiplicity of different voices and perspectives, in that an utterance acquires meaning partly by drawing on the voices it indexes (Bakhtin & Holquist, 1981). Bakhtin and Holquist (1981) explain that:

> All words have the "taste" of a profession, a genre, a tendency, a party, a particular work, a particular person, a generation, an age group, the day and hour. Each word tastes of the context and contexts in which it has lived its socially charged life; all words and forms are populated by intentions (p.293).

In other words, when interacting we use words that have been used by others and these are tinted with the social locations and ideological stances held by others. Bakhtin and Holquist (1981) goes on to describe that "the word in language is half someone else's. It becomes 'one's own' only when the speaker populates it with [their] own intention, [their] own accent, when [they] appropriate the word adapting it to [their] own semantic and expressive intention" (p. 294). What becomes evident, is that we are in a continuous dialogue between the words we are given, "shot through with [others'] intentions and accents" and our efforts to assign meaning to them (Bakhtin & Holquist, 1981, p. 293). In a similar way, narratives have the potential to 'dialogue' with

alternative perspectives and create novel meanings (Brockmeier, 2009).This is achieved through what Bakhtin calls double-voiced discourse; the process through which narrators "represent voices, as well as the process through which voices develop through contact with others" (Wortham, 1998, p. 5). Tannen (2007) elaborates on this process by arguing that the representation of characters' voices is not a reiteration of a character's utterances but instances of constructed dialogue. Tannen (2007) contends that "ideas cast as dialogue rather than statements is a discourse strategy for framing information in a way that actively creates involvement" (p. 112). Clark and Gerrig (1990) and Holt (1996) construe constructed dialogue as serving as a "type of demonstration". As Clark and Gerrig (1990) illustrate demonstrations "depict their referents – what is being demonstrated" and provide interlocutors with direct access to the interaction under discussion so that they are able to assess it for themselves (p. 764). Thus, voice in narrative becomes a means of positioning characters in the story world and the social world but also a means by which a narrator positions himself with respect to other characters and in relation to these worlds.

This concept of dialogism is reflected in the analytical framework of positioning analysis as applied to the small stories that emerged in this study. In Chapter 5, we see how interpreters and ALOs animate the voices of the characters to create a particular persona, or attribute an affective quality to a particular character. I now look at how positioning analysis allows for the exploration of a person's identity as it emerges dialogically in talk-in-interaction.

2.5 Narrative Positioning Analysis

The analytical framework employed in this study is based on narrative positioning analysis which draws primarily on Bamberg (1997) and Bamberg and Georgakopoulou (2008). In this section, I examine some theoretical approaches to positioning to illustrate how identities are adopted and negotiated in narratives and then discuss the three levels of positioning proposed by Bamberg and Georgakopoulou focusing on the strengths and limitations of the theory.

The origins of the term *positioning* can be found in Foucault's (1984) conceptualisation of the notion of *subject positions*, which postulates that a subject is constructed within a certain discourse. In Foucault's (1984) view, language emerges within historically competing discourses and these discourses present alternative versions of reality and serve differing and conflicting power interests. Baxter (2016) argues that such power interests originate in institutional systems that promote institutional discourses and these institutional discourses are the sites where:

> individual identities are recognised, constructed and regulated. This process of identity construction is reciprocally achieved through the agency of individual language users who are subjectively motivated to take up particular positions within multiple discourses and through the ways they are variously positioned as subjects by the social, normalising power of discourses (p. 37).

One of the first studies to use positioning in conversational interactions was Davies and Harré (1990). Here the term is used as a different way of conceptualising the notions of personhood and role. Within this perspective, positioning activities are the primary site for the discursive construction of selves; "whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines" (p. 48). For Davies and Harré (1990) positioning is understood in terms of three interrelated concepts, which they have termed the *positioning triangle*: storyline, positions and social acts. The *storyline* refers to the narrative which is being acted out and "can be taken from a cultural repertoire or can be invented" (Harré & Lagenhove,

1999, p. 30). People are located within discursive storylines in the form of the subject *positions* they adopt. Every position has a "moral quality" so that it is associated with a set of rights and duties that are attributed to an actor or interlocutor. These positions are organised along socio-categorial relationships such as doctor, nurse or patient or leader and disciples for example. Davies and Harré (1990) explain that:

> Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned (p. 35).

The final part of the triangle involves the actions and utterances produced by the interactants which acquire meaning through the storyline and the positioning of those involved in the co-construction of the narrative; having been given meaning, the actions and utterances become *social acts* (Harré & Lagenhove, 1999). Positioning theory also regards the *other* as being central to the positioning process, as positionings are perceived to be co-constructed and relational, therefore the adoption of a position (self-positioning) invariably assumes a position for the interlocutor (other positioning) (Harré & Lagenhove, 1999).

More recently, Slocum-Bradley (2010) has extended the positioning triangle to a positioning diamond that draws a distinction between identities and rights and duties. Identity is seen as a discursive construct and relates to the ascription of moral and social characteristics to an actor. On the other hand, rights and duties refer to the moral order linked to this position. This distinction allows for the explanation of self-other relations and the consideration of power dynamics and norms in shaping identity categories such as "illegal alien" in discourses about illegal immigration from Mexico to the USA (Slocum-Bradley, 2008).

Bamberg (1997) and Bamberg and Georgakopoulou (2008) refined and developed positioning theory in relation to stories told in interaction. Here positioning theory is used to conduct a fine-grained analysis of "separable yet interrelated positioning processes" in small stories (Bamberg & Georgakopoulou, 2008, p. 385). Bamberg and Georgakopoulou (2008) proposed the notion that the narrator can position themselves at three levels: the story (level 1), the interaction (level 2), and finally, with regards to the "Who am I question" – or how narrators position themselves with regards to capital-*D* discourses (level iii). The first two levels place emphasis on small-*d* discourses; where "the way the referential world is put together [i.e., at the level of the talked about] points to how tellers index their sense of self in the here and now [at the level of tellership and performance]" (Bamberg et al., 2011, p. 186). Bamberg, De Fina, and Schiffrin (2011), explain that a focus on content, tellership and performance allows for a "more or less implicit or indirect referencing and orientation to social positions and discourses about and beyond the here and now" (p. 186). Therefore, level i and level ii positioning feed into capital-*D* discourses, "or the general societal contextual conditions" that speakers invoke to make sense of who they are (level iii) (p. 181).

The processes involved in conducting a positioning analysis for levels i to iii are presented in detail below:

Level i: how characters are positioned within the story

a) includes relational positioning of characters vis-à-vis one another

Level ii: how the speaker/narrator positions himself (and is positioned) within the interactive situation. Level ii positioning is subdivided into sub-steps:

a) how the characters in the story are positioned in relation to each other and in space and time (positioning level 1)
b) then [the researcher] turns to the interactional accomplishment of narrating as the activity under construction (positioning level 2)
c) [the researcher] analyses more closely the research setting in which the moderator has asked a question, how it was answered in the form of telling a story, and what we can conclude from that (positioning level 2)
d) [the researcher] turns to the joint interaction engagement between all participants (positioning level 2)

Level iii: how participants construct each other and themselves in terms of teller roles and in doing so establish a sense of self/identity

a) how the speaker/narrator positions a sense of self/identity with regards to dominant discourses or master narratives by which the teller establishes himself as a particular kind of person (Bamberg & Georgakopoulou, 2008, pp. 385; 391)

Georgakopoulou (2013) discusses the strengths of Bamberg's model in that the analysis illustrates the "inextricability of the two worlds involved in any storytelling: that of the told world (level i) and of the telling world, i.e. the here-and-now of storytelling (level ii)" (p. 91). In this way, narrators can position themselves in the story world and the here-and-now of the interaction and at the same time "draw strategically on the opportunities for self-presentation afforded by their deictic separation/separability on the one hand and, on the other hand, by the possibilities for the teller to stress and maximize their interconnections" (p. 91). Narrative positioning analysis has been adopted and adapted in numerous studies including stories derived from conversational and interview data: Watson (2007) uses positioning analysis to examine the construction of the professional identities of two student teachers and also explores the framework's "ability to link locally produced identities to wider discourses" (p. 371); De Fina (2013) focuses on level 3 positioning to illustrate the connection of "local identity displays to macro social processes" (p. 42); and Bamberg (2011) uses positioning analysis to link "the creative act of storytelling with the construction of story content … [and] to the act of constructing identities" (p. 2).

As we have seen, Bamberg's model presents an analytical tool-kit for "linking local telling choices to larger identities" (De Fina & Georgakopoulou, 2012, p. 164). However, it has also been critiqued with respect to some of the assumptions underlying positioning analysis. Hall (2004) argues that positioning at level 3 "pursues inferences about dominant or master narratives that are not demonstrably relevant for participants in the ongoing conversation" (p. 355). This echoes Conversation Analysis researchers who argue that dominant discourse or *D-discourse* should explicitly be oriented to by the participants in an interaction to be considered relevant (Heritage & Clayman, 2010).

Recent work, however, has attempted to address this disparity in methodological approaches by suggesting a middle ground between CA approaches that "centre exclusively on participant orientations at a local level and approaches that regard identity as basically determined by macro social processes" (De Fina, 2013, p. 40). In their respective work, Georgakopoulou (2013) and De Fina (2013) have proposed ways to reach this middle ground. Georgakopoulou (2013) has suggested conducting an analysis that involves "iterativity", that is locating repeated types of story-lines, and De Fina (2013) proposes looking for "patterns" which she describes as "general tendencies in the way issues are viewed and dealt with by the communities to which individuals belong". These patterns often reveal "collective representations and inventories" which can be "related to wider social processes" (p. 45). Georgakopoulou (2013) also suggests the use of linguistic ethnography which enables the researcher to explore how the participants reflect on their narrative practices and also provides insights as to what capital-*D* discourses or master narratives "may be operative in a given storytelling context through the analyst's attention to the participants' sense-making devices both in local interactions and outside of them" (p. 93). In this way, the researcher can gain a more in-depth understanding of the communities that they are studying.

2.6 Summary

In this study, I have adopted the small story approach and narrative positioning analysis to explore how spontaneously produced stories are embedded within the professional practice of interpreters of Aboriginal languages and ALOs. These stories emerged as the participants stepped outside the prototypical question-answer format of research interviews to make a particular point more salient. Such stories have the potential to show how identities are constructed in situ and "are extremely valuable for showing how identity gets renegotiated and reconstructed in and through social interaction" (Freeman, 2006, p. 156). This study also uses narrative positioning analysis in order to explore how interpreters and ALOs perform and co-construct their professional

identities in narrative activities. The multiple, shifting positions the interpreters and ALOs adopt as they construct various identities, brings to the fore a range of Discourses pertaining to communication differences and challenges that medical interpreters and ALOs encounter as they interpret for Aboriginal patients or facilitate communication during the medical encounter.

The following Chapter discusses theoretical approaches to translation and interpreting that are drawn upon in Chapter 6. Chapter 6 explores interpreting in medical contexts and the difficulties that ensue when medical terminology and concepts have no one-on-one equivalent in Aboriginal languages and vice versa.

Chapter 3 Translation and interpreting theory

3.1 Introduction

This Chapter explores theoretical approaches pertaining to translation and interpreting and outlines their strengths and weaknesses to identify implications for interpreting practice that are drawn upon in Chapter 6. This study explores the interpreting strategies interpreters and Aboriginal liaison officers report they employ when interpreting for Aboriginal and Torres Strait Islander peoples in medical contexts. This is primarily because there are clear difficulties communicating and accommodating into English the diverse conceptualisations of health that are found in the multiple and diverse Australian Indigenous languages that are spoken today.

There are several contextual factors that need to be addressed when considering interpreting of Aboriginal languages in health settings. Firstly, health communication tends to be conducted in English, which is the first language of the health practitioners and the second, third or fourth language of the patient (McGrath, 2010); thus if communication is to be successful, all parties need to be privy to and have access to a common conceptual framework which allows for meaning to be negotiated. Secondly, when health communication takes place with the aid of an interpreter or ALO,

successful communication is dependent on translatability; in other words, that what is said in English can be translated into the language/s of the Aboriginal patient and vice versa. Thus, the issue of intertranslatability comes to the fore; "whether it is possible to provide an account of meaning as something shared between two language users, including those who believe they are using the same language" (Davidson, 1984/1991, p. 124). This is particularly relevant in the context of communication between speakers of diverse languages reflecting divergent worldviews.

While intertranslatability has been theorised extensively due to the varied ways of conceptualising translation, this Chapter focuses on only those paradigms that have a direct impact on interpreting in institutional settings. The discussion begins with classical theories of translation including early linguistic approaches that promote equivalence-oriented translation or analyse translation as a linguistic product. It moves on to functionalist and purpose-oriented approaches and then ties translation theories with interpreting theories, demonstrating the extent to which the former facilitate the latter. It concludes with more recent discourse-based approaches that are better suited to understanding community interpreting in medical settings. This discussion helps to establish the difficulties associated with locating a one-on-one equivalent between the source text (ST) and the target text (TT) and is drawn on to show how interpreters and ALOs attempt to resolve such difficulties by employing approaches that focus on the intended function of a translation.

3.2 Translation theory

3.2.1 Studies in translation before the 20th century

Although there has been work on the subject of translation since antiquity, translation has been studied in an academic context roughly since the second half of the twentieth century (Munday, 2016). Prior to this, studies in translation tended to co-occur with language learning and teaching, or as part of "comparative literature, translation 'workshops' and contrastive linguistic courses" (Munday, 2016, p. 15). Newmark

(1981) discusses Western translation theory prior to the twentieth century, during the period he calls the "pre-linguistic period of translation" (p. 4). Stemming from the work of Cicero (104-43 AC) and St Jerome (347-420 AC) early debate centred around the polar views of whether translation is literal (word-for-word) or free (sense-for-sense) (as cited in Munday, 2016, p. 17). It was not until the late seventeenth century that Dryden (1680/1992) proposed three categories of translation, including: metaphrase, which corresponds to literal translation, paraphrase or sense-for-sense translation, and imitation, which more or less resembles free translation (p. 25). However, it is Holmes (1988b/2004) who is widely credited with proposing an overall framework that delineated *pure* areas of research in the field of translation, including: "(1) description of the phenomena of translation; and (2) the establishment of general principles to explain and predict such phenomena (translation theory)" (as cited in Munday, 2016, p. 8). The result was that studies in translation theory moved away from the polar opposites of literal versus free translation and attempts were made to conduct more systematic analyses of translation, as is evidenced in the following section that discusses equivalence-oriented translation.

3.2.2 Equivalence-oriented translation

Early systematic analyses of translation fell under the subfield of applied linguistics, in which translation was primarily perceived in linguistic terms and served the practical purpose of training translators and producing better translations (Newmark, 1981; Schäffner, 2004). During the 1950s and 1960s equivalence became the aim of translation activity, the object of research into translation, and the benchmark for assessing quality. According to Krein-Kühle (2014), the etymology of the term *equivalence* potentially provides us with a "useful understanding of the concept in translation context" (p. 17). The adjective has come into English via "Old French from late Latin *æquivalent-em* 'being of equal worth', from the present particle *æquivalēre*, from *æquus* - 'equal' + *valēre* 'to be powerful, to be worth' to be 'equal in value'"

(Oxford English Dictionary, 2018b). Albrecht (2005) has rightfully pointed to the definition's emphasis on "similar use, function, size or value, or about having an equal effect" (as cited in Krein-Kühle, 2014, p. 17).

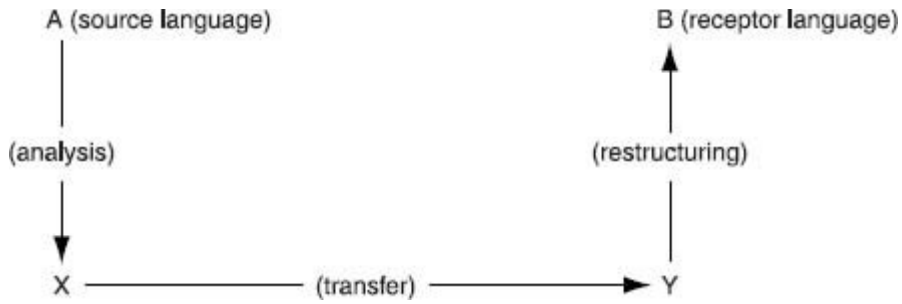
Krein-Kühle (2014) usefully summarises different conceptualisations of equivalence by noting that some theorists have conceived equivalence as being fundamental to their discipline and have defined or redefined the concept, albeit in different ways (Catford 1965; Neubert 1970, 1988; Willis 1982, 1996a, 1996b; Koller, 1995, 2011; Pym 1995, 2010; House 1997; Nida, 2003 [1964]; Zybatow, 2010). Other theorists call into question the universality of the term (Hatim and Mason 1990; Reiss and Vermeer, 1991; Nord 2009) or reject its usefulness altogether (Holz-Mänttäri 1984; Hönig and Kußmaul, 1984; Vermeer 1984; Snell- Hornby 1988 [1995], 2006; Prunč 2007) (as cited in Krein-Kühle, 2014, p. 15).

The problem of equivalence in meaning was discussed by Jakobson (1959/1992) by drawing on Saussure's notions of *langue* (the linguistic system) and *parole* (specific individual utterances). He considers equivalence in meaning between lexis in different languages and asserts that "there is ordinarily no full equivalence between code-units … however, translation from one language into another substitutes messages in one language not for separate code units but for entire messages in some other language" (Jakobson, 1959/1992, p. 233). Jakobson (1959/1992) advocated seeking equivalence in meaning by determining differences in grammatical categories and lexical forms of languages. He concedes that although differences between languages exist at the level of gender, aspect and semantic fields, "all cognitive experience and its classification is conveyable in any existing language" (p. 147), therefore when there is a lack of expression in a given language, it may be qualified in a translation.

This issue of equivalence in meaning was also taken up in the 1960s, where attempts were made to tackle the question of translatability by developing a more

scientific approach to translation. There was a growing awareness that theories of translation had to move away from perceiving lexis as having static meaning. Nida and Taber's (1969) work shifted the focus from the individual sentence to the study of text in context, where meaning is essentially negotiated between interlocutors (Hatim & Mason, 1990; Nida, 1964/2003; Nida & Taber, 1969). Chomsky's (1965/2015) theory, Generative Transformational Grammar, was appropriated by Nida as it purported that there is a universal pattern underlying different grammatical structures (Nida, 1964/2003; Nida & Taber, 1969). As such, it could provide the translator with a means of decoding the original written text (the source text or ST) in the original verbal language, and encoding it into a written text (the target text or TT) in a different verbal language (Nida, 1964/2003). He proposed the following three-stage process of translation that involves analysis, transfer and restructuring (Nida & Taber, 1969, p. 33).

Figure 1. The three-stage system of translation



Nida (1964/2003) demonstrates that the traditional attention to *formal equivalence* focuses on the form of the message and not on the response of the receptor. With this in mind, Nida and Taber (1969) define *dynamic equivalence* as the "principle of equivalent effect" which is "the degree to which the receptors of the message in the receptor language respond to it in substantially the same manner as the receptors in the source language" (p. 24). By placing prominence on the response of the receptor, Nida positions translation as a multifunctional means of communication that has expressive, imperative as well as informative functions; however, he prioritises the former by

asserting that “one of the most essential, and yet often neglected, elements is the expressive factor, for people must also feel as well as understand what is said” (p. 25).

Nida’s contribution to translation theory is widely acknowledged for moving away from traditional debates on literal versus free translation to introducing a new focus on receptor-driven translation that ensures comprehension of intent and enhances the general efficacy of the communicative process (Nida, 1964/2003). However, it has also been criticised. With respect to the equivalent effect, there are three main arguments that contest the soundness of the principle; firstly, that it is unfeasible in practice – Newmark (1988) attests that the equivalent effect should be the “desirable result” and not the “aim of the translation” (p. 48). Secondly, aiming for receptor-driven translation the translator runs the risk of using “domesticating translation” strategies — which denote “an ethnocentric reduction of the foreign text to target-language cultural values” (Venuti, 1995, p. 20). Hu (1992) questions the plausibility of the equivalent effect by pointing out that it is not attainable when meaning is attached to form. She discusses the translation of literary words in languages such as Chinese or English and the difficulty in finding equivalent words. Finally, the equivalence effect has also been deemed impossible to measure (van den Broeck, 1978).

Despite this critique, Nida’s contribution has exerted considerable influence on other translation scholars, many of whom have alternatively conceived of equivalence in terms of the text as a whole, rather than on the sentence or word level, as is the case with more linguistic-oriented approaches. Vinay and Darbelnet (1958/2000; 1995) advocate equivalence-oriented translation and make the distinction between *direct* and *oblique* translation. The former involves literal translation, the latter free translation (Vinay & Darbelnet, 1995, p. 84). Strategies pertaining to direct translation include: borrowing, calque, and literal translation, and strategies that fall under oblique translation include modulation (“a variation of the form of the message, obtained by a change in the point of view”) and transposition (“a switching of word classes”). The

remaining two oblique strategies involve cultural adjustments: adaption ("where the type of situation being referred to by the source language (SL) message is unknown in the target language (TL) culture") and equivalence or correspondence (the use of corresponding idioms, clichés, proverbs, nominal or adjectival phrases) (pp. 31-39). With respect to equivalence, Vinay and Darbelnet posit that it entails "creating a new situation that can be considered as being equivalent" (p. 39). They assert that this procedure enables the translator to maintain the stylistic impact of the SL text in the TL text and is particularly effective when dealing with idioms, clichés, proverbs and adjectival or adverbial phrases and onomatopoeic animal sounds. They postulate that for equivalent language pairs of words or phrases to be acceptable, it is a necessary and sufficient condition that they be listed in bilingual dictionaries as 'full equivalents' (p. 255). However, this is pragmatically impossible and even if the semantic equivalent to the SL text is rendered in a dictionary, it does not suffice, nor guarantee an appropriate translation. Vinay and Darbelnet (1995) acknowledge this and admit that it is "in the situation of the source-language text that translators have to look for a solution" thus the surrounding context determines the translation strategy employed (p. 255).

Similarly, for Catford (1965) the central concern of translation theory is that of "defining the nature and conditions of translation equivalence" (p. 21). Translating consists of " the 'replacement' of SL lexical and grammatical elements with 'equivalent' TL lexical and grammatical elements, coupled with the concurrent exchange of SL graphological and/or phonological elements for TL graphological and/or phonological elements" (Catford, 1965, pp. 20–24). Drawing on Ferdinand de Saussure's distinction between *langue* and *parole*, Catford's (1965) most notable contributions consist of his distinction between *textual equivalence* and *formal correspondence*; where the former seeks for correspondence at the level of individual utterances, and the latter at the level of linguistic principles such as syntax, phonetics and lexis. Catford (1965) defines textual equivalence as "any target language text or

portion of text which is observed on a particular occasion to be equivalent to a given SL text or portion of text" and a formal correspondent is "any TL category (unit, class, structure) which can be said to occupy as nearly as possible the same place in the economy of the TL as the SL given category occupied in the SL" (Catford, 1965, p. 27). Like Vinay and Darbelnet (1958/2000), he concludes that the underlying conditions of translational equivalence are "situational" (Catford, 1965, p. 36). Importantly, Catford's work highlights the problems of equivalence between languages even at the word-level and stresses the centrality of context in the determination of linguistic meaning.

In a similar fashion, other theorists provide solution-type lists which translators employ when the default procedure of literal translation does not suffice. Pym's (2014) overview of equivalence in translation illustrates other formulations of this polar categorisation. While not exhaustive it includes: Newmark's (1988) distinction between *semantic* and *communicative* translation, where the former has the ST as the starting point and retains its semantic properties as much as possible, while the latter takes into consideration the needs of the addressee; a distinction between Levý's (1963/2011) *illusory* and *anti-illusory* translation; House's (1997) *overt* and *covert* translations. Nord (1997) presents an opposition between *documentary* and *instrumental* translation; Toury (1980, 1995, 2012) distinguishes between *adequate* and *acceptable* translation; and Venuti (1995) delineates this opposition with *fluent* and *resistant* translations (as cited in Anthony Pym, 2014). As Pym (2014) observes, what these binary categorisations have in common is that they represent "some aspect or function of the start text" albeit in varied ways (p. 32). One limitation of such categorisation of translation solutions is that the "terms for the solutions have clearly not been standardised" and it is often the case that several categories overlap or do not "fit comfortably into any category" (Pym, 2014, p. 15). The latter is especially true for translation of languages that are not cognate (Pym, 2014). Another limitation of these linguistic approaches lies in the dearth of "robust theoretical and methodological

frameworks to account for all aspects relevant to translation and equivalence" (Krein-Kühle, 2014, p. 19). Although Pym (2008; 2014) points out limitations, he also proposes that equivalence theories can be categorised into two types of theories; one type are theories of natural equivalence where equivalents exist prior to and independently of the translator's actions and are in effect discovered, not created, by the translator in the ST. The other are theories of directional equivalence, which stem from the translator making active choices and taking actions that are not necessarily determined by the ST. This however, does not imply that the outcome is not equivalent; but that there are several kinds of equivalence from which to select. Essentially, the theories that discuss different kinds or levels of equivalence are directional as translators choose an approach that lies along the cline of the literal versus free translation dichotomy, but as Pym (2014) points out this does not have to be an either-or choice as translators tend to combine both literal and free strategies.

The following section discusses theories that shift away from the search for equivalence between ST and TT and focus on the intended function of a translation.

3.2.3 Functionalist-pragmatic theories[2]

The 1980s saw a paradigm shift away from binary understandings of equivalence and the centrality of the ST towards a more functionalist-pragmatic turn in translation studies that brought the target text to centre stage. For instance, Reiss (1981/2004), in striving to achieve equivalence at the level of the text, categorises texts in accordance with their primary function (informative, expressive, operative or audio-medal) and advocates "specific translation methods according to text type" (Reiss, 1981/2004, p. 20). This however, has been seen as a rather restrictive categorisation. Alternatively, Nord (1997) incorporates a more complex textual analysis model and Snell-Hornby

[2] The term 'functionalist' is used to refer to an approach where the intended *function* of a given translation decides what the relationship between the source and target text should be. Functionalist approaches draw inspiration from action theory, communication theory and cultural theory and should not be confused with Halliday's systemic functional grammar.

(1988) includes an all-encompassing 'integrated' approach that categorises text-types in an attempt to represent diverse areas of translation. However, Munday (2016) questions the viability of "incorporate[ing] all genres and text types into such a detailed single overarching analytical framework" (p. 79).

Purpose-driven approaches, particularly Skopos theory (Reiss & Vermeer, 1984/2014) reinforce the notion that the *σκοπός*- skopos – purpose (Greek), is the central principle in any translation and not striving for equivalence between a ST and TT. The ST is regarded as an "Informationsangebot (offer of information)" (Reiss & Vermeer, 1984/2014, p. 18). Thus, the product of translation, 'the translatum' may be considered a text offering information in a particular way about another [text]" (p.18). Drawing on action theory, the underlying principles of Skopos theory include:

1. A translatum is determined by its skopos.
2. A translatum is an offer of information in a target culture and language about an offer of information in a source culture and language.
3. A translatum is a unique, irreversible mapping of a source-culture offer of information.
4. A translatum must be coherent in itself.
5. A translatum must be coherent with the source text.

(Reiss & Vermeer, 1984/2014, p. 107).

These principles or rules are hierarchical, so the translator is advised to first and foremost abide by the *skopos* or purpose, rule (1), and ensure that the target text fulfils its designated purpose. The translator then determines whether the target text is coherent and as a final step seeks for coherence with the source text (Reiss & Vermeer, 1984/2014). Essentially, "the target text will strive for adequacy, i.e. the selection of linguistic material with regard to syntax, semantics, pragmatics should be appropriate for a different audience" (Reiss & Vermeer, 1984/2014, p. 126). Thus, if the TT fulfils the purpose set out by the commission, it is "functionally and communicatively adequate" (Munday, 2016, p. 84).

Skopos theory has afforded the translator the agency to translate one text in different ways depending on the purpose set out in the commission. Vermeer (1989/2000) highlights this in: “What the skopos states is that one must translate consciously and consistently, in accordance with some principle respecting the target text. The theory does not state what the principle is: this must be decided separately in each specific case” (p. 228).

Like Reiss and Vermeer, Holz-Mänttäri’s (1984) takes the notion of text functions and conceives of the process of translation as a *Model of translational action*, which aims to produce a TT that is functionally communicative for the receiver. This means, for instance, that genre and the structure of the TT need not necessarily replicate the ST, rather it should conform to what is functionally appropriate or permissible in the TT culture. Holz-Manttari's (1984) work places translation within its sociocultural context, including the interaction between the translator and the initiating institution. However, Nord (1997) criticises the Model of translational action and Skopos theory for their disregard of the ST. She stresses that, while 'functionality is the most important criterion for a translation, [it is] certainly not the only one”, and as such “the translator is expected not to falsify the author’s intention (Nord, 2005, p. 32). She points out that the nature of the relationship between the ST and the TT is determined by the purpose or skopos.

To compensate for the unchecked freedom afforded to the translator, Nord (2006) introduces the concept of *loyalty*:

> ... translators, in their role as mediators between two cultures, have a special responsibility with regard to their partners, i.e. the source text author, the client or commissioner of the translation, and the target text receivers, and towards themselves, precisely in those cases where there are differing views as to what a ‘good’ translation is or should be (p. 33).

Loyalty differs from the concept of equivalence or, in Nord's terminology, 'fidelity' in that equivalence seeks for similarity between the ST and the TT while loyalty refers to an interpersonal relationship between the translator and their "partners" (Nord, 2001, p. 185). Nord's (1997) work has highlighted the primacy of the "translation brief", reinstated the importance of the "role of ST analysis" prior to embarking on any translation, and has provided a detailed model for text analysis that serves as a guide for translator training (p. 59). While Nord's text analysis approach is conducive to identifying problematic features in the ST, as discussed with solution-type lists produced by linguistic-oriented theorists, these features cannot be easily categorised.

Other key paradigms are beyond the scope of this thesis but have made a significant contribution in furthering translation theory. One such paradigm includes *Descriptive Translation Studies* which "made equivalence a quality of all translations, no matter how good or bad, and set about describing the shifts and transformations that translators produce" (Pym, 2014, 118). Another paradigm, *the indeterminist paradigm*, "particularly deconstruction … sets about undoing illusions of equivalence as a stable semantic relation" (Pym, 2014, 118). Given the rapid advances in technology *Localization* coupled with *Internationalisation* enables "one to many patterns of translation" and alters the way texts are translated to cater for simultaneous translation into multiple languages (Pym, 2014). Finally, within the field of translation studies developments in *Cultural translation* have stemmed from the recognition that translation includes the language and culture in which the text is constituted (Bassnett & Lefevere, 1990). This incorporates the interaction between culture and translation, particularly the way cultural constraints impact translation and on the "larger issues of context, history and convention" (Bassnett & Lefevere, 1990, p. 11).

This Chapter has established the difficulties associated with locating a one-on-one equivalent between ST and TT and discussed other approaches that focus on the intended function of a translation. This bears on the findings in Chapter 6, which

discusses the challenges interpreters face and the strategies they report they use when interpreting medical terminology and concepts that may be absent in the target language. The next section shows how research in interpreting has in part developed out of the field of translation.

3.3 Interpreting theory

Research in interpreting has borrowed from a variety of different paradigms or disciplines. Interpreting studies are generally situated within the field of Translation Studies. I first begin by outlining the difference between translation and interpreting. As Hale (2007) points out, "[t]he word translation is the generic term for the activity of converting one language into another. More specifically, the term Translation is used to refer to written translation and the term Interpreting to oral translation." (p. 3). As Pöchhacker (2016) notes, interpreting scholars have only drawn on their translation counterparts to some degree. It is linguistic, psychological and social interactionist approaches that have shaped interpreting research more fundamentally. This section discusses linguistic and social interactionist contributions but not psychological studies as they fall outside the scope of this thesis.

3.3.1 Linguistic approaches to interpreting

Theoretical approaches to interpreting have discussed the relationship between the ST and TT not in terms of 'equivalence' but in terms of an 'ideal standard' drawing on notions of "accuracy, completeness and fidelity" (Pöchhacker, 2016, p. 135). Herbert (1952) argues that an interpretation should "fully and faithfully" express the source message (p. 4). This notion of fidelity is echoed by Gile (1992) who gives priority to the "informational content" and not the linguistic "package" of the text (p. 189). Seleskovitch's (1994) Interpretive Theory of Translation also called for "total accuracy" that could be achieved via the interpretation of meaning and not through the transcoding of words (p. 102). Other researchers have examined interpreters' output employing criteria for measuring source-target correspondence. Quantitative studies have looked at

errors and discontinuities (Gerver, 1969); omissions, substitutions and additions that may constitute errors of translation or interpretation (Barik, 1975). However, Jacobsen (2008) argues that interpreters tend to modify face-threatening utterances and Berk-Seligson (1988) found that interpreters are likely to offer renditions of the ST that are more polite in the TT. Wadensjö (2014) perceived omissions as a conscious choice on the part of the interpreter who tries to meet the communicative goal of the interaction, while Napier (2004) argued that omissions may be coping mechanisms employed by an interpreter when there is redundant or irrelevant information that could led to misunderstanding. This contrastive lexico-semantic approach to source-target correspondence, however, does not cater for pragmatic and functional considerations (Pöchhacker, 2016).

Nida's (1969) "principle of equivalent effect" has also been invoked in interpreting studies with regard to "comprehension by the target audience – and with regard to the emotive and pragmatic impact of the target text at the interpersonal level" (Pöchhacker, 2016, p. 139). The pragmatic impact of the interpreter's output has also been measured in courtroom interpreting settings. Berk-Seligson (1988) studied the impact of an interpreter's rendition or omission of politeness markers, their use of "hyperformal" register, hedging and passive versus active voice when interpreting from Spanish to English and found that their inclusion or omission skewed the way a witness was perceived. Hale (2004) also demonstrates that adjustments made by an interpreter to polish an interpretation have an impact on perceptions of intelligence, credibility and competence of a witness's testimony.

3.3.2 Target-oriented and functionalist approaches to interpreting

Target-oriented and functionalist versions of translation have to some degree been adopted in interpreting studies. The *Interpretive Theory of Translation* with its emphasis on sense making rather than transcoding foregrounds the prominence of the target message as Seleskovitch (1994) claims that the target message has to be tailored

to the recipient. This has the dual function of utilising the target audience's background knowledge and ensures that the TT is functionally appropriate in the target culture (Seleskovitch, 1994). Although initially applied to simultaneous interpreting in conference settings, functionalist and target-based approaches have proved influential in community interpreting as Pöchhacker (2016) pertinently observes:

> If what the interpreter says must make sense against the listener's horizon of socio-cultural knowledge, and if the interpreter is the only person capable of assessing that knowledge, s/he may well have to paraphrase, explain or simplify in order to achieve the communicative effect desired by the speaker (p. 60).

These theoretical approaches to interpreting are drawn upon in Chapter 6 to examine the approaches the interpreters use when interpreting for Aboriginal patients; whether they draw on linguistic, target-oriented and functionalist approaches, or discourse-oriented approaches to interpreting.

3.3.3 Discourse-oriented approaches in interpreting

Discourse-oriented approaches in interpreting have departed from text processing paradigms adopted in translation to cater for face-to-face communicative encounters in community or dialogue interpreting. The social interactionist model views language as a social activity that is connected to "different genres and layers of contexts" (Wadensjö, 1995, p. 114). This model is dialogical as meaning is co-constructed between both speakers and hearers in interaction (Wadensjö, 1995). Goffman's (1959) exploration of a social role proposes examining the normative expectations associated with a particular role. Wadensjö (1995) furthers this work, by pointing out that an interpreter's self-perceived normativity, with respect to their work, does not necessarily align with how their "social role is actually lived [or] carried out in practice" (Wadensjö, 1995, p. 115). It is important to note that individuals are "multi-performers" and as interpreters, they may be confirmed or rejected in their role (Goffman, 1961, p. 142; Wadensjö, 1995).

The interpreter's task is to relay and coordinate the interaction. It also involves speaking and listening on behalf of others and "assessing how, and by whom, interlocutors intend their utterances to be understood" (Wadensjö, 1995, p. 120). Goffman (1981) proposed that speakers use different production roles including animator, author and principal and this means that in the course of interacting speakers can display different aspects of self and assume different measures of responsibility for the content and progression of the interaction. Wadensjö (1995) foregrounded the role of the listener and proposed matching Goffman's production formats with what she labels reception formats; listening as a reporter, to be able to repeat the message verbatim; listening as a recapitulator, to summarise the message, or listening as a responder, to be able to respond adequately (p. 122). Combined these roles show that "interlocutors coordinate their speaking and listening for their mutual involvement in the discourse" (Roy, 2000a, p. 114).

3.3.4 Mediation in interpreting studies

Although the role of the medical interpreter is "complex and multifaceted due to the pressing situations and circumstances in the field" there is little consensus among interpreters, healthcare providers and patients over the role of interpreters in the context of bilingual health communication (Angelelli, 2012, p. 431; Fatahi et al., 2008; Ngo-Metzger et al., 2007). Most healthcare providers and interpreters advocate the conduit model of interpreting, which views the interpreter as a conduit "transmitting information without distortion between sender and receiver" (Shannon, 1997). More recently, researchers have called for a broader interpretation of the interpreter's role that encompasses the more complex nature of interpreting as communication including "the exchange – and transfer of multiple, interwoven layers of information" (Sleptsova, Hofer, Morina, & Langewitz, 2014, p. 168).

Professional interpreters are cognizant of the demands and expectations of their practice which involve abiding by the following codes of conduct; impartiality, accuracy or faithfulness to the message, and competence (Ko, 2006; McDonough Dolmaya, 2011). Roy (2000a) shows the expression of these codes of conduct in interpreters' self-perceived roles; including metaphors such as "a bridge, or channel through which communication happens" (p. 101). This role involves the transmission of information form one speaker to another "faithfully, accurately, and without personal or emotional bias" (p. 101). This perspective developed partially from Reddy (1979/1993) who illuminated and critiqued language as a conduit where thoughts and ideas are perceived as a commodity to be transmitted. The conduit metaphor has been brought into the field of interpreting through the conceptualisation of the interpreter as "a supposedly neutral or passive third party" (Roy, 2000a, p. 103). This metaphor is reinforced in courtroom interpreting where interpreters are instructed "not to interpret …, but to translate – a term which is defined, sometimes expressly and sometimes by implication, as rendering the speaker's words verbatim" (Morris, 1995, p. 26). Adopting this role allows an interpreter to claim impartiality and neutrality (Hale, 2004, 2007).

However, Hsieh (2016) argues that the conduit model of interpreting makes problematic assumptions about the role of the interpreter as it presumes:

> (a) all participants are competent speakers who can communicate effectively and appropriately
>
> (b) there are minimal differences between speakers' cultural knowledge and social practices
>
> (c) it is desirable to maintain the existing structure of relationships and patterns of communication
>
> (Hsieh, 2016, p. 27)

Some of these assumptions are also made explicit in The Australian Institute of Interpreters and Translators (AUSIT) Code of Ethics and Code of Conduct (2012); firstly, under section 5 *Accuracy*, where accuracy is understood to mean "optimal and

complete message transfer into the target language preserving the content and intent of the source message or text without omission or distortion". Secondly, under section 6 C*larity of role boundaries*, interpreters are instructed not to "engage in other tasks such as advocacy, guidance or advice" (AUSIT, 2012, p. 6). These specifications are driven by the necessity to avoid discrimination and the provision of unequal services (Hsieh, 2016, p. 27). Thirdly, under section 4, the related principle of *impartiality* states that "[i]nterpreters and translators observe impartiality in all professional contacts …[and] remain unbiased throughout the communication exchanged between the participants in any interpreted encounter" (p. 5). This is a stipulation that as Cooke (2009) suggests is virtually impossible to uphold given that interpreters of Aboriginal languages have "rights and obligations under customary law" (p. 90).

There are several reasons why the conduit model remains one of the preferred models for healthcare interpreting; firstly, it prescribes that interpreters adopt an invisible and passive role in the communication process, which establishes authority and credibility in the provision of services; secondly, a conduit model seems to require minimal training, and finally, the physician and patient are seemingly the only speakers who maintain full control of the content and process of the interaction (Hsieh, 2009). Sleptsova et al. (2014) reinforced the pervasiveness of the conduit model in healthcare interpreting in a narrative review that focused on the role definitions of interpreters. The researchers found that the conduit model was included in 16 out of the 34 studies that were reviewed; however, the majority of these studies underscored the importance of extending the role of the interpreter to include additional functions such as that of "a cultural broker", "a manager/clarifier", "patient advocate" or "mediator" (Sleptsova et al., 2014, p. 179).

It has been firmly established that the conduit model does not do justice to the complex role of the interpreter. As Roy (2000) asserts the task of the interpreter requires "knowledge of a discourse system that includes grammar, language use,

organization, participant relationships, contextual knowledge, and sociocultural knowledge" (p. 103). The conduit model falls short of this complex psychosocial process because it assumes a linear view of communication, and as such presumes that meaning is constructed by speakers; the physician and patient, as opposed to being co-constructed by all participants of the communication activity including the interpreters (Georgakopoulou, 2002).

Since the mid-1990s researchers have identified a diverse range of roles that medical interpreters utilise to manage the complex nature of the bilingual physician-patient interaction; the following roles have been identified: *chairperson and gatekeepers* (Fenton, 1997; Linell, 1997; Wadensjö, 2005); *co-diagnosticians and informational gatekeepers* (Angelelli, 2004; Davidson, 2000, 2001); *cultural broker* (Butow et al., 2011; Dohan & Levintova, 2007); *patient advocate* (Drennan & Swartz, 2002); *professional and manager* (Hsieh, 2008; 2016). Although research into interpreter roles has allowed researchers to examine interpreters' goals and functions, and to identify certain behaviours based on the identities that interpreters assume during the physician-patient interaction, little is known about when, how or why interpreters move from one role or function to another (Hsieh, 2016). This final point is one of the central focuses of Chapter 6, which examines the contexts in which interpreters shift from one role or function to another.

This section has reviewed literature on translation and interpreting theory and in doing so, raises the question of translatability in terms of interpreting for speakers of diverse languages. It also demonstrates the need to view health communication as a socially constructed, goal-motivated communication process. At the same time, studies in interpreting and translation highlight the complexity of language and the reality of interpreting in practice (Dysart-Gale, 2005; Hsieh, 2009). In terms of the role of the interpreter, assuming neutrality during the medical encounter undermines the interpreters' physical presence, their function in removing cultural and linguistic

barriers, their emotions and judiciousness. These findings are drawn upon in Chapter 6 to explore the different strategies available to the medical interpreter so as to be able to interpret for Aboriginal and Torres Strait Islander peoples in a culturally appropriate manner. The complexities of interpreting for Aboriginal and Torres Strait Islander peoples are discussed in the following sections, including barriers to health communication and strategies to overcome these.

3.4 Interpreting for Aboriginal and Torres Strait Islander peoples in medical contexts

The context of this thesis involves exploring health communication and more specifically interpreting for Aboriginal and Torres Strait Islander peoples in medical settings, so there is some merit in exploring different conceptualisations of health in order to raise awareness of its complexity. The word *health* may have wide or narrow applications and be positively and negatively defined (Bury, 2005). The medical model of health and illness perceives health as predominantly the absence of illness and is "as likely to emphasise the complex or unknown aetiology of disease as it is to discover its specific 'cause'" (Bury, 2005, p. 5). Lay conceptualisations of health define health negatively, as the absence of disease or illness, but also add a functional dimension, that is, "the ability to cope with everyday activities", or perceive health positively in terms of "fitness and well-being" (Blaxter, 2003, p. 14). This perception of health deviates both from biological norms, as in the medical model of health, but is also a deviation from social norms (Bury, 2005). Yet, although there are scientific and lay notions of what it means to be ill or healthy, there is no general consensus on a single definition of the term health because of the existence of manifold interpretations that draw on "individual experience and culture" (Wright, Sparks, & O'Hair, 2012, p. 5). The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(WHO, 1946). This definition of health presents a holistic and positive conceptualisation of health that goes beyond physical and psychological health to encompass aspects that pertain to quality

of life (Boddington & Räisänen, 2009). A key principle of health in the Constitution of the World Health Organisation is that it is "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO, 1946, p. 100). However, some scholars have questioned the extent to which such "a definition of health is operational, suited to actual, practical, and concrete application" (Boddington & Räisänen, 2009).

Given that the context of this thesis involves exploring Aboriginal and Torres Strait Islander health communication, it necessitates examining a commonly cited Australian Aboriginal definition of health (Jackson & Ward, 1999; Lutschini, 2005). This definition expands on the WHO definition, going beyond the physical, psychological and social dimension of health to add the concept of cultural and community wellbeing:

> Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.
>
> *Health* to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity. (A National Aboriginal Health Strategy, 1989, p. ix).

As this definition of health displays, the concepts of "life-death-life" and cyclical time are at the centre of Aboriginal notions of health. Another key concern is the concept of "determination" in terms of being granted agency over all facets of life, which delegates responsibility for health and life choices to the Aboriginal and Torres Strait Islander

person. Yet, the centrality of the community is also underscored as individual wellbeing is intricately linked to community wellness and vice versa. This is also attested by Boddington and Räisänen (2009) who contrasts the Aboriginal view of health that is "intimately bound up with something external to the individual" and the Western concept of health, where "the health of an individual is a descriptor only of that individual" (p. 13). Although this is a widely accepted definition of Aboriginal health and is included in many policy documents on Aboriginal health (Department of Health and Ageing, 2013); it is not by any means an all-encompassing definition that has been adopted by all Aboriginal communities across Australia. There are clear difficulties communicating and accommodating into English the diverse conceptualisations of health that are found in the more than 250 Australian Indigenous languages that are spoken today (Lutschini, 2005). With these stipulations in mind, it remains that there are benefits to including a cultural dimension within the definition of health as it forefronts the fact that notions of health may differ across languages, and cultures.

It is widely acknowledged that there exists a disparity in the health status of Aboriginal and Torres Strait Islander peoples and other Australians (Vanden Heuvel & Australian Institute of Health and Welfare, 2015). For the Aboriginal and Torres Strait Islander population that was born in 2010-2012, life expectancy was about 10.6 years lower for males than that of non-Indigenous males (69.1 years compared with 79.7 respectively); and 9.5 years lower for females than non-Indigenous females (73.7 years compared with 83.1 respectively (AIWH, 2018). Research has also underlined the reduced health outcomes among Aboriginal and Torres Strait Islander populations in Australia and other countries with histories of colonisation (Stephens, Porter, Nettleton, & Willis, 2006). With respect to cancer, Aboriginal and Torres Strait Islander peoples have a lower incidence of the disease, but are more likely to have poorer prognosis, and lower survival rates (Meiklejohn et al., 2016). Similar patterns have been identified for Aboriginal and Torres Strait Islander peoples suffering from kidney disease (Rix,

Barclay, Wilson, Stirling, & Tong, 2013) and cardiovascular disease (Taylor et al., 2009). Rates of self-discharge against medical advice by Aboriginal adults in Central Australia remain much higher than that of non-Aboriginal patients (Einsiedel et al., 2013); and despite higher rates of hospitalisation for mental health problems, Aboriginal and Torres Strait Islander peoples underutilise mental health services (McKenna, Fernbacher, Furness, & Hannon, 2015).

This paints a consistently bleak picture of the health of the Aboriginal and Torres Strait Islander peoples and raises the question why this segment of the population seems to be less likely to have positive outcomes, and less likely to access timely treatment and care. One hypothesis points to Aboriginal and Torres Strait Islander peoples reluctance to participate in specialised health care settings and this contrasts with their greater propensity to utilise Aboriginal community controlled health services that tailor primary care to their needs (Armstrong, 2006; Kowal, 2012). Kowal (2012) attributes this disparity to feelings of exclusion from the health system. Communication has also been identified as being central to contributing to poorer outcomes.

Cross-linguistic health interactions in Australia have become pervasive and necessitate the use of professional interpreters to address the health communication needs of culturally and linguistically diverse (CALD) communities. According to the 2016 Australian Census, about 4.8 million people reported speaking a language other than English at home, representing 20.8 percent of the entire population (ABS, 2017). With respect to Australian Indigenous languages, the 2016 Census counted about 63,750 people who speak an Indigenous language at home, representing 10% of the Aboriginal and Torres Strait Islander population; however, this proportion includes non-Indigenous people who may also speak an Indigenous language at home (ABS, 2017). This increasingly diverse population has created numerous challenges in the delivery of healthcare services as they struggle to negotiate new approaches to health

service delivery that meet the needs of this section of the population (Gill & Babacan, 2012). English competency is a significant component in health communication because it is a key determinant of the level of understanding patients have of their illness and related treatment. The Australian Charter of Healthcare Rights in Victoria mandates that clients:

> have a right to an accredited interpreter for communication needs with [their] publicly-funded healthcare service. Interpreters should be provided at important points during [their] care, such as when discussing medical history, treatments, test results, diagnoses, during admission and assessment and when [they] are required to give informed consent (Dunbar, 2009).

Despite this provision, the uptake of interpreters in Australian Hospitals varies from site to site and in terms of how frequently qualified interpreters are used. Research into emergency department's access to interpreters reflects this trend; data for New South Wales and Queensland hospitals indicate that qualified interpreters are used as little as 6 per cent to 33.3 per cent of the time (Bonacruz Kazzi & Cooper, 2003; Mahmoud et al., 2011; Garrett et al., 2008). Alternatively, health clinicians frequently make use of untrained bilingual staff, family and friends in three-way communication health consultations. In Australian hospitals untrained interpreters are reportedly used between 20 per cent and 61.5 per cent of the time when an interpreter is needed (Foundation House, 2012; Garrett et al., 2008; Zimbudzi, Thompson, & Terrill, 2010). There are also limited professional interpreter services for Aboriginal languages in Australia in comparison to other culturally and linguistically diverse populations (Devitt & McMasters, 1998). "Dedicated Indigenous language interpreter services" are currently only available in the Northern Territory and Western Australia and this is in stark contrast with the national Commonwealth funded Translating and Interpreter Service (TIS) that caters for migrant communities across Australia in more than 160 different languages (Commonwealth Ombudsman (Australia), 2016, p. 1). Where interpreters of Aboriginal languages do exist, interpreters are required to interpret

between patients and medical clinicians who share limited linguistic, conceptual and cultural common ground (Cooke, 2004). This is further attested by Commonwealth Ombudsman (2016) report which identified that there are "unique challenges" in the domain of Indigenous language interpreting and individuals and governmental agencies often are unable to access accredited interpreters even in instances when the need for an interpreter has been identified (p. 1). Ralph, Lowell, Murphy, Dias, Butler, Spain … and Cass (2017) discuss low levels of utitlisation of accredited interpreters for Aboriginal languages and note that there has been a downward trend in the number of completed assignments by interpreters for Top End Health Services clients and the most common reasons cited for non-completion were "no interpreter available" or "interpreter did not show" (p.3). Another issue interpreters contend with, is the tension between their professional role as interpreters and the impact of their restrictions and responsibilities under customary law (Cooke, 2009). This is particularly contentious when family members or relatives are used as interpreters and may lead to "miscommunication and communication breakdown" (Pauwels, 1991, pp. 156–157). As a result, the way that interpreters perform their work may have an impact on the delivery of services and the frequency of patients' access to this service (Jacobs et al., 2001).

3.5 Barriers to health communication

Barriers to health communication is a key area of research which is common to non-indigenous and Aboriginal and Torres Strait Islander populations alike. The following factors may confound communication and are common to both groups*: low literacy levels* (Ha & Longnecker, 2010); *complex medical discourse* (Andrulis & Brach, 2007; Chang & Kelly, 2007; Ha & Longnecker, 2010; McGrath & Holewa, 2007; Zanchetta & Poureslami, 2006); *non-disclosure of information* (The, Hak, Koeter, & van der Wal, 2000); *resistance by patients* (Lee & Garvin, 2003); *divergent health beliefs* (Diette & Rand, 2007); *cultural constructs* (Andrews & Boyle, 2016); *assigning a passive role to*

patients during consultations (Shaw, Zou, & Butow, 2015) and *cultural sensitivity and respect* (Willis, 1999).

However, there are communication barriers that Aboriginal and Torres Strait Islander patients encounter that tend to be more specific to this segment of the population. A number of researchers have emphasised the diversity of Indigenous language groups across Australia and point to the "distinct local patterns of cultural, religious and social life" (Devitt & McMasters, 1998). Given that the majority of Aboriginal people speak English as a second or third language (if at all), language barriers constitute a major obstacle to effective communication. Deficiency in English language skills creates a sense of fear and this is particularly prominent among elderly Indigenous Australians residing in rural communities (McGrath, 2010). What typically ensues is a communication gap that pervades every phase of health care. This communication problem in fact goes two ways as both patient and practitioner express mutual disappointment at the limited range of interaction (Devitt & McMasters, 1998). Even when interpreters are employed, it is often the case that concepts do not translate neatly into a given Indigenous language and the difficulty of comprehension goes beyond merely the translation of words and centres on interpretation difficulties (Cass et al., 2002; McGrath et al., 2005).

3.6 Linguistic choices and semantic domains

Drawing on studies in legal interpreting, Moore (2014) identifies issues pertaining to the use of different Englishes in the courtroom and explicates how and why miscommunication occurs. Cooke (2002) defines learner's English or Interlanguage as:

> "utterances of those learning a second language who, while attempting to achieve native speaker norms, fail to (consistently) do so. The errors of language learners occur as patterns, which vary according to the learner's first language, their stage of development in the second language, and the context of the conversation" (p.7)

Language-specific differences between Aboriginal languages, including Aboriginal English and Standard Australian English (SAE) often cause difficulties in interpretation of meaning. Single-word equivalents in English are particularly problematic as many words in traditional Aboriginal languages contain a range of senses that are context-dependent and resorting to a single SAE equivalent can create misunderstanding. For instance, *apure,* from Arrente, a language spoken in Central Australia, is often translated as *shame* or *shamed* in SAE; however, the Eastern and Central Arrente to English Dictionary (ECAED) provides cultural and contextual information surrounding *apure* which suggest that apart from "shyness, embarrassment shame, [and] not knowing how to behave … having a degree of *apure* is a positive and healthy attitude and that the lack of *apure* is a social problem" (Moore, 2014, p. 8; Morgan, Slade, & Morgan, 1997). Moore supports that understanding the speaker's intention and context is imperative in discerning what the correct meaning is.

Polysemy poses similar challenges as in Western Desert languages a word such as *kulini* may include "the senses of 'understand', 'hear', 'know', 'think', 'listen', 'believe' and 'obey' (Moore, 2014, p. 8). It is important to determine what sense of the word is central to the utterance to ensure appropriate translation. In addition, false friends, typically have a common origin, sound the same but have different meanings. In the legal setting, Moore (2014) describes instances where defendants relying on the meaning of their own dialect or language made use of *believe* to mean *suspect*, as in the phrase "they are just trying to believe me". The intended meaning was "they are trying to set me up, get me charged with the offence" (Moore, 2014, p. 12). The use of English expressions with non-standard meaning is potentially damaging for Aboriginal people of non-English speaking background as is illustrated with the Luritja word *punganyi* that can be translated into *hit, strike* and *kill-dead* in hunting contexts. *Punganyi* has been misinterpreted as a threat to kill somebody, an interpretation that could easily implicate a defendant into confessing a crime they did not commit. The unambiguous

term is *mirri punganyi* that has the sense "to kill someone so that they die" (Moore, 2014, p. 9). Such patterned differences reveal that an Aboriginal or Torres Strait Islander person speaking English may use false friends that have the potential of leading to misunderstandings.

The prevalence of practitioner-centred communications styles often inhibits communication between Aboriginal and Torres Strait Islander patients and physicians (Charlton, Dearing, Berry, & Johnson, 2008; Slade, Matthiessen, Lock, Pun, & Lam, 2016). Eliciting information using question-answer approaches, may be construed as impolite or confrontational (Cass et al., 2002; Lin, Green, & Bessarab, 2016; Trudgen, 2000). A common communicative routine is the use of closed-questions requiring a yes/no response. As Cass et al., explain "such routines are highly susceptible to miscommunication due to gratuitous concurrence" (p. 71). Gratuitous concurrence is prevalent when Aboriginal people tend to offer responses that they feel the staff want to hear (Eades, 1982, 1992, 2008, 2010, 2016; Liberman, 1980). In most cases Aboriginal patients tend to give an affirmative response instead of admitting to not comprehending a question or to having limited English proficiency. In these cases, an affirmative response does not always mean 'yes' but instead serve as a means of appeasing the interlocutor and terminating the conversation without causing offence (Mitchell & Hussey, 2006; Westwood, Atkinson, & Westwood, 2008; Westwood & Westwood, 2010). Devitt and Master's (1998) study of Aboriginal end-stage renal disease patients' responses to medical information found that patients were reluctant to ask questions, seek clarification or request additional information. This had two implications; firstly, indigenous patients became increasingly isolated in their decision making; and secondly, refraining from asking questions or voicing complaints reinforced the notion of patient satisfaction and smoothly-operating programs, which in reality were not always present. In the same respect, Cass et al., (2002) discuss differing modes of discourse between Aboriginal and Torres Strait Islander patients and Western staff

members. In Yolngu discourse, question-answer approaches are governed by cultural restrictions on who may request, or give specific information and therefore direct questioning is considered impolite, as is openly contradicting or responding negatively to one's interlocutor. It is best practice for the health professional to allow for negotiated agreement through the verification of information (Christie, 1994). Verbal scaffolding often masks the lack of shared understanding. This occurs in response to questions that embed multiple response options or open-ended questions, where a person repeats some or all of their interlocutor's utterance without necessarily understanding the English terms used. Analysing courtroom discourse Cooke (2002) explains that while "[scaffolding] contributes to the semblance of English conversational skills on the part of the learner, reliance upon scaffolding may easily mask insufficiency" (p. 14). Negative sentence constructions are a source of confusion due to their ambiguity. (Cooke & Australian Institute of Judicial Administration, 2002; Eades, 2010). Cooke (2002) illustrates that in *the Elcho Coronial,* Yolŋu witnesses would typically respond in the affirmative to confirm the validity of a negatively framed proposition. In the following Extract the witness's response may either mean: "*Yes, you are right, I couldn't see them*, or *Yes, I could see them*":

> CPol: And when he started running you couldn't see any of the task force men at that stage, could you?
> Witness: When he was running?
> CPol: No, when he started to run?
> Witness: Yes.
> CPol: When he started to run you couldn't see the task force?
> Witness: Yes
> (as cited in Cooke & Australian Institute of Judicial Administration, 2002)

Eades (1992) also found that the quantification of information also poses a challenge as many Aboriginal people "often tend not to use expression of quantifiable specification, or to use them vaguely, inaccurately or inconsistently" (p.29). This is also the case in the medical setting, where findings from a study of Australian Indigenous dialysis patients showed that when asked to quantify a reported food item

with “How much would you have?”, the patient would typically respond “a little” or “it depends on how much is available”. Responses to questions requiring quantifiable answers were vague and dietary history was difficult to obtain (Todd, Carroll, Gallagher, & Meade, 2013, p. 9). Eades (1991) suggests that the expression of information in non-numerical terms in respect to quantity, time and location assists in providing more accurate information.

Another communication difficulty is the conceptualisation of body parts using culturally dependent metaphors or symbols. Devitt and McMasters (1998) illustrate that for most of Australia and particularly Aboriginal Central Australia, the kidneys are perceived as both a metaphor and a symbol. Similarly, Gaby (2008) illustrates that the body is often invoked in the conceptualisation of intellect, emotion and life forces. In particular, in Kuuk Thaayorre, a Paman language of Cape York Peninsula, the belly, *ngeengk*, is conceptualised as the locus of life force. While English-derived metaphors are based on the heart, where the heart is a central vital organ, in Kuuk Thaayorre the heart holds little symbolic significance. Instead, ‘belly of the chest’ man-ngeengk, a compound formed from the lexemes man ‘chest’ and ngeengk ‘belly’ is perceived as “the core of the person overall” (p. 37). Similarly, Vass et al., (2011) found that certain “fundamental health concepts” such as circulation and digestion processes are not present in Yolngu Matha speakers’ worldview; instead their understandings of the role of the blood “are highly sacred knowledge” (p. 35). Such cultural associations between internal organs and internal experiences vary between linguistic communities. This reveals how understanding such fundamental concepts is important in Aboriginal and Torres Strait Islander patients’ decision-making process and underlies the difficulties inherent in interpreter-mediated interactions.

The concept of time belongs to “a system of broad categories” that facilitate understanding of the world (Janca & Bullen, 2003, p. 40). The Western linear perception of time compartmentalises time into units and English speakers typically

employ metaphors that are inherently spatial to visualise and talk about time and their position with respect to the past and the future and the present moment; so that "the past is 'behind us', the future is 'in front of us', and the present is 'where we are (right now)" (Janca & Bullen, 2003, p. 40). Recent studies from cognitive psychology suggest that conceptions of even such central domains as time can differ across cultures. Boroditsky and Gaby (2010) describe representations of time in Pormpuraaw, a remote Australian Aboriginal community. They show that Pormpuraawans' arrange time in accordance with cardinal directions: east to west and not a left to right orientation. Therefore, time is organized in a coordinate frame that does not reflect Western frames. This is not to say that Aboriginal and Torres Straight Islander peoples do not understand the linear concept of time as Western society applies it. However, as Stockton (1995) observed, time can alternatively be perceived with respect to the socially determined importance of events and is typically identified by the historic relevance of events or by stages in life. This distinction between priorities and time needs to be taken into consideration when scheduling doctor's appointments; non-attendance does not necessarily mean non-compliance, but the family and community's precedence over self (Janca & Bullen, 2003).

McGrath (2010) discusses the divergent perspectives that prevail on illness and death in Aboriginal contexts. There are diverse responses to different types of knowledge that come into play when medical staff and Aboriginal and Torres Strait Islander patients interact. According to Weeramanthri (1996) the latter do not perceive death as originating from purely mechanical causes; instead they tend to seek "an underlying cause, most often in the social or spiritual realm" (p. 5). McGrath (2010) broaches the subject of cancer, the etymology of which is "embedded in beliefs about curses and payback in the spirit world for perceived misgivings" (p. 61). Vass, Mitchell and Dhurrkay (2011) explain that while the biomedical concept of being *sick* is context dependent in the Western context, referring to conditions which are "acute or chronic,

infectious or non-infectious or manageable only"; for Yolngu people, *rerri-sick* has different connotations. For instance, there is a need to "feel/and/or look sick" otherwise it is difficult to employ the term. Taylor, Smith, Dimer, Wilson, Thomas and Thompson (2010) have found that Aboriginal patients are likely to construct a causal relationship between visiting a doctor and being diagnosed as sick, which may stem from continuous media coverage of Aboriginal and Torres Strait Islander peoples' poor health outcomes. Fogarty, Bulloch, McDonnell and Davis (2018) also draw a link between media and political discourses which function to reproduce negative discourse about Aboriginal and Torres Strait Islander peoples. These discourses "form a narrative that homogenises and dehumanizes Aboriginal and Torres Strait Islander people into an intractable 'problem' to be 'dealt with'" (p. xi). Fforde et al. (2013) argue that 'the prevalence and social impact of deficit discourse indicates a significant link between discourse surrounding indigeneity and outcomes for Indigenous peoples" (p. 162). This has repercussions for how the Aboriginal and Torres Strait Islander patients approach proposed treatment and also determines the range of interpretations open to Aboriginal patients and how this may confound the interpreting process.

There are also difficulties at the interface of Western and traditional medicine that arise when health practitioners and Aboriginal patients draw from their respective worldviews and knowledge systems. Health practitioners and Aboriginal patients typically draw on their own "individual, physical, social and cultural orientations, prior knowledge, experiences, verbal and non-verbal communication styles" (Shaouli Shahid, Durey, Bessarab, Aoun, & Thompson, 2013, p. 2). For instance, when seeking to make a diagnosis, health practitioners typically draw on Western medical knowledge systems and establish causation in "the context of a systematic description of the disease and its etiology" (Kalitzkus & Matthiessen, 2009). In effect, the health practitioner practises evidence-based medicine which entails integrating "individual clinical experience and the best external evidence" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p.

71). However, for Australian Aboriginal people, health beliefs tend to attribute meaning to events (Maher, 1999). This requires "explaining health, illness, and their causation, so that they are embedded in a wider context" (Boddington & Räisänen, 2009, p. 16). What becomes increasingly evident is that prevailing health models based on Anglo-Celtic worldviews tend to be alien to Aboriginal communities and these models underpin an "assumption of superiority" to Aboriginal traditions of health and care (Collis-McAnespie, Australian Rural Health Research Institute, Macquarie Area Health Service (N.S.W.), & New South Wales Aboriginal Health Resource Co-operative Inc, 1997). As noted in section 3.4, Boddington and Räisänen (2009) point out that a closely connected notion is that the health of an Aboriginal person is intricately linked with the health of their community. This very notion may become the source of some perplexity in discerning "how an individual's health status could be so intimately bound up with something external to the individual," which marks a stark contrast with prevailing Western concepts of health that perceive that "the health of an individual is a descriptor only of that individual" (p. 13).

In addition, for many Aboriginal and Torres Strait Islander peoples, medical discourse is perceived as a foreign language in itself (McGrath & Holewa, 2007). Western medical terminology or "biomedical speak" is more often than not becoming a barrier to communication. Devitt and McMasters (1998) document that a high proportion of end-stage renal disease patients had a limited to poor understanding of their illness and associated treatment procedures. This translated to an "overwhelming majority … fail[ing] to achieve maximum benefit of the medical treatments provided" (p. 137) and underscored their finding that Aboriginal people do not do as well post-kidney transplantation as non-Aboriginal transplant recipients.

The process of providing information to Aboriginal and Torres Strait Islander patients involves considering their cultural belief and practice pertaining to relationships that guide communication. This underlies the significance of talking to the

right person; for instance, understanding of the network of relationships and knowing to whom it is appropriate to dispense information is essential. Additionally, interpreters are often not in the right kinship relationship to the patients and this prevents meaningful interaction (Butcher, 2008; McGrath et al., 2005).

Finally, there is a further problem when caring relationships traverse a cultural divide (Willis, 1999). Cultural sensitivity and respect are considered key issues that promote successful communication among Aboriginal and non-Aboriginal people (Downing et al., 2011; Freeman et al., 2014; Henderson et al., 2011). This is attested by Simonds, Christopher, Sequist, Colditz and Rudd's (2011) exploration of patient-doctor interactions in a Native American community. They foregrounded building trust as central in doctor-patient communication. Williams, Hanson, Boyd, Green, Goldmon, Wright et al. (2008) discuss the importance of effective communication and decision-making as being key to sustaining overall quality of life. Kushnir, Bachner, Carmel, Flusser, and Galil (2008) illustrate that there is an important link between a doctor's interpersonal competence and skills, They explain that global trust between doctor and patient is achieved through the display of interest and collaborative communication styles. However, as McConaghy (2000) argues cultural sensitivity as a term is loaded with negative connotations: "The tolerance and intolerance binary masks the more significant underlying binary of the tolerating majority and the tolerated minority, a power-laden division which lies at the heart of Australian [and we would add Canadian] multiculturalism" (emphasis in the original, p. 41). Central to the notion of liberal tolerance is the creation of an ambivalence toward the Other (Henry & Tator, 2010). This is often externalised as either an expression of admiration or disdain for different cultural differences (Furniss, 2000).

These findings highlight that working with Aboriginal and Torres Strait Islander communities entails raising awareness of cultural differences and being sensitive to the Aboriginals' verbal and non-verbal needs and being aware of common barriers that

exist to accessing and utilising health services (Cass et al., 2002; Lorié, Reinero, Phillips, Zhang, & Riess, 2017). In the Australian context, efforts have been made to reconcile such cultural differences between Aboriginal and Torres Strait Islander peoples and health service providers as part of the Australian government's initiative to Close the Gap (Holland, 2018). The *Cultural Respect Framework 2016–2026* was developed "to support the corporate health governance, organisational management and delivery of the Australian health system to further embed safe, accessible and culturally responsive services" (Australian Health Ministers' Advisory Council's National & Aboriginal and Torres Strait Islander Health Standing Committee, 2016, p. 4). The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Health Plan) and the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023* have been developed in collaboration with the National Health Leadership Forum and envisage to improve the wellbeing and health of this segment of the population (Department of Health, 2015; Department of Health and Ageing, 2013). Approaches that are commonly adopted as part of Indigenous cultural training include: "cultural awareness, cultural competence, cultural respect, cultural security and cultural safety" (Downing & Kowal, 2011, p. 7). These programs serve two different purposes; for instance, cultural awareness training programs tend to focus on "individual behaviour change" while in a cultural security model the onus for the provision of culturally secure health care is on "the system as a whole" (Downing & Kowal, 2011, p. 7). Downing and Kowal (2011) and Thomson (2005) explain the ways in which these approaches vary with:

> While a cultural safety training program usually emphasises processes of culture and identity formation in order to understand how the effects of colonialism manifest in the health system, cultural awareness training typically aims to enhance participants' knowledge of 'cultural, social and historical factors

applying to Indigenous peoples' (Downing & Kowal, 2011, p. 7; Thomson, 2005, p. 3)

However, a review of these cultural training programs has found that they have had limited impact in changing the health professionals' attitudes and behaviours and there is scant evidence as to whether this cultural training translates to "changes in health and wellbeing that follow from improved knowledge, attitudes and/or skills" (Downing et al., 2011, p. 254).

3.7 Summary

In Chapters 2 and 3 I have reviewed literature on narrative research, translation and interpreting theory, interpreting for Aboriginal and Torres Strait Islander peoples in medical contexts and identified research concerning barriers to health communication. I draw on this literature in Chapters 5 and 6 in order to address the two primary aims of the study; firstly, in Chapter 5 to explore how interpreters and ALOs perform and co-construct their professional identities in different narrative activities; and in Chapter 6 to explore the different strategies available to the medical interpreter so as to be able to interpret for Aboriginal and Torres Strait Islander peoples in a culturally appropriate manner.

Chapter 4 Methods

4.1 Introduction

The overall aim of this thesis is to investigate ways in which interpreting practice in healthcare settings can be enhanced so as to better facilitate communication with Aboriginal and Torres Strait Islander patients. This overall aim is achieved by firstly, exploring how interpreters of Aboriginal languages and ALOs talk about how they do their work through the stories they tell. The telling of the stories is used to illustrate how the participants' professional identities are constructed in situ and also shows how their identity is negotiated or renegotiated in and through the interaction. Secondly, this thesis examines the interpreters' and ALOs' perceived experiences of interpreting in medical settings so as to gain insight into how language is used to resolve potential communication differences during interpreter-mediated interactions. The research is based on 15 hours of transcribed audio recording from semi-structured interviews conducted with 10 interpreters of Aboriginal languages and 9 ALOs in regional and remote sites in Australia. All participants were interacting with the author. Two types of data were used; narrative data that consists of 25 stories; and non-narrative data that contains central themes pertaining to interpreting in medical settings[3].

The following research questions were developed to explore interpreting in medical settings:

1. How do interpreters of Aboriginal languages and Aboriginal Liaison Officers talk about how they do their work when they interpret or advocate for their clients?

2. What strategies and actions do interpreters and Aboriginal Liaison officers report they use to resolve potential communication differences that may confound the interpreting process?

[3] In accordance with The University of Melbourne guidelines for conducting human research, this project was approved by the Humanities and Applied Sciences Human Ethics Sub-Committee, ethics ID number: 1646989.1.

In this Chapter, I present the theoretical perspective and methodology adopted in this study. In particular, in section 4.2, I present processes pertaining to the development stage of this thesis and in 4.3, I discuss data collection and data analysis processes.

4.2 Development stage

4.2.1 Qualitative Research Methods

Two qualitative research methods are used in this thesis to explore communication concerning interpreter-mediated interactions. Following Tashakkori and Creswell (2007), I conduct data triangulation of two types of data analysis: narrative positioning analysis and thematic analysis. This is primarily because triangulation permitted "convergence [and] corroboration" of research results (Bryman, 2006, p. 105). Triangulation also ensures "complementarity in which different methods are used to assess different study components or phenomena" (Greene, Caracelli, & Graham, 1989, p. 257). In terms of the former, the narrative analysis, I use Bamberg and Georgakopoulou's (2008) narrative positioning analysis to examine how the participants positioned themselves at three levels: positioning at the level of – the story, the interaction, and positioning in terms of how the speakers position a sense of self or identity with respect to broader Discourses or master narratives and by doing so establish a sense of who they are (sections 2.4 and 2.5). As for the latter, thematic analysis is used to analyse the non-narrative data by examining the micro and macro issues that emerge in the data (Nowell, Norris, White, & Moules, 2017). The thematic analysis enables the researcher, on one level, to consider interpreting for Aboriginal and Torres Strait Islander patients through the exploration of the participants' experiences and the meanings they attach to them. On a second level, it permits the exploration of the impact of the wider social context on these meanings through a cross data analysis of the themes that emerge in the stories and the non-narrative data. Thus, these two qualitative research methods complement one another; firstly, the narrative positioning analysis showcases the participants' understandings of the complexities of interpreting

for Aboriginal patients in healthcare settings. This is achieved through the multiple shifting positions the interpreters' and ALOs' attribute to themselves and other social actors in the stories they tell. Secondly, the thematic analysis of the non-narrative data also brings to the fore the challenges narrated by the interpreters and ALOs in their stories but also allows for the identification of strategies that they put forward for the framing of and dealing with culturally distinct communication patterns while interpreting for Aboriginal patients.

4.2.2 Development of interview guide

A semi-structured interview guide was developed for interviews with interpreters and ALOs by drawing upon previous literature, in consultation with the research participants and piloted during the design stage with qualitive researchers that have extensive experience in conducting semi-structured interviews (see Appendix A for interview guide). The guide included topics to be discussed that were in line with the research questions. Prompts were provided in the guide to facilitate discussion if it were deemed necessary. It is important to note that interviews were not being used to access a single, stable 'reality' but that participants and the researcher together co-constructed their version of knowledge (Holstein & Gubrium, 1995; Sandelowski, 2002).

4.2.3 Participant Sampling

There were 19 participants in this study comprising 10 interpreters of traditional Aboriginal languages, 8 Aboriginal Liaison Officers and 1 Aboriginal Service Development Worker[4]. Aboriginal Liaison Officers are often employed to interpret for

[4] The Aboriginal Liaison Officer is responsible for:

- Delivery of culturally responsive services for all Aboriginal and Torres Strait Islander patients and their families when coming to the hospital.
- Availability of appropriate health services and preventative care for Aboriginal people.
- Helping ensure the hospital meets the particular needs of ATSI patients and their families and increase the cultural sensitivity of healthcare services and providers to Aboriginal health issues.
- Building positive relationships with the Victorian Aboriginal community, other service providers, and government departments. (https://www.thermh.org.au/health-professionals/clinical-services/aboriginal-health)

Aboriginal and Torres Strait Islander people; however, they are not certified as interpreters by interpreting bodies such as National Accreditation Authority for Translators and Interpreters (NAATI). Interpreters, on the other hand, have NAATI certification. Seven of the Aboriginal Liaison Officers were female and one male; the Aboriginal Service Development worker was female. Three of the interpreters were male and seven were female. They are English speaking or bilingual/multilingual adults, aged 18 and over. Table 1 below provides an overview of the participants:

Participant names (pseudonyms)	Role	Gender	Age	Languages
Gary	Interpreter	Male	36-45	Kriol, Marra, English
Annie	Interpreter	Female	26-35	Walmajarri, Fitzroy Valley Kriol, Kimberley Valley Kriol & English
Jill	Interpreter	Female	36-45	Gooniyandi, Walmajarri, Kriol & English
Alicia	Interpreter	Female	26-35	Gooniyandi, Walmajarri, Kriol & English
Indigo	Interpreter	Female	46-55	Walmajarri, Kriol & English
Daniel	Interpreter	Male	56-65	Walmajarri, Kriol & English
Francesca	Interpreter	Female	26-35	Walmajarri, Kriol & English
Margaret	Interpreter	Female	56-65	Walmajarri, Nyangumarta, Kriol & English
Karen	Interpreter	Female	36-45	Walmajarri, Kriol & English
Robert	Interpreter	Male	46-55	Kriol & English
McDuff	Interpreter	Male	46-55	Kriol & English
Sarah	ALO	Female	36-45	English, Torres Strait Islander Kriol and Katherine Kriol
Lincoln	ALO	Male	46-55	English
Rachel	ALO	Female	46-55	English
Melanie	ALO	Female	46-55	Aboriginal English and English
Lenny	ALO	Female	36-45	Aboriginal English and English
Katrina	ALO	Female	46-55	English
Bridget	ALO	Female	36-45	English
Trudy	ASDW	Female	46-55	English

Table 1. Overview of participants

4.2.4 Participant recruitment

Recruitment of participants took place using different approaches for each participant group. For the interpreters of traditional Aboriginal languages, I contacted relevant

The Aboriginal Service Development Worker (ASDW) engages in project work and "works alongside other hospital staff to make certain patients and families receive the care and support that they need" (https://www.thermh.org.au/patients-visitors/services-clinics/aboriginal-health)

interpreting services. I first contacted the interpreting service via phone and informed them about the aim of the research and invited them to participate. Following their consent, I followed this communication up via email, where I provided the information about the study in writing, and attached ethics approval, plain language statement and consent form. The first interpreter I contacted through the interpreting service provided information about how the interpreting service operated, how interpreters were commissioned for interpreting projects and also offered input on the themes incorporated in the semi-structured interview guide that were taken into consideration when revising the interview guide. The interpreting service then identified eligible interpreters that were accredited by (NAATI) and a date and time were arranged for the interviews.

The Aboriginal Liaison Officers were initially sourced through the professional networks of the researcher and then via a snowball effect for participation in the semi-structured interview. The Aboriginal Service Development Worker (ASDW) I contacted at a metropolitan hospital in Melbourne also gave valuable input on the semi-structured interview guide so that it was revised to ensure that it was culturally appropriate for Aboriginal and Torres Strait Islander peoples. This was done for instance, by providing her with an overview of the broad topics to be discussed in the semi-structured interviews and taking into account the ASDW's input when revising the interview guide. Incorporating participatory research elements in the research design allowed the participants to enhance the data collection process; for instance, by discussing the importance of the creation of a "safe space" in which the participants can disclose their personal views of the situation, their own opinions and experiences without fear that they will be disadvantaged (Cook, 2012). A second recommendation included ensuring that ALOs were given a voice alongside that of the interpreter. This became one of the focal points of the study; the construction of the ALO and interpreter's knowledge and ability through empowerment and understanding (Cook,

2012). Potential participants were first contacted by phone, informed about the study and offered an invitation to participate. Following a positive response, I followed up this communication via email providing a written summary of the aim of the study and a description of the task (semi-structed interview) and estimated length. I also attached ethics approval, plain language statement and consent form.

4.2.5 Setting: Hospitals and Interpreting services

As the aim of this study was to explore interpreters' and Aboriginal Liaison Officers' experience of interpreting for Aboriginal and Torres Strait Islander patients across Australia, this study was conducted at multiple hospitals across Australia as well as an interpreting service in the North West of Australia. This ensured and enhanced the anonymity of the participants and also increased the relevance of findings to sites across the country. I travelled to each hospital to undertake collection of data and this afforded me additional insights into the workings of the Aboriginal Liaison Officers at the Aboriginal health services at the respective hospitals. I also met with interpreters at the interpreting service or in their homes.

Data was collected from two Metropolitan hospitals in Victoria, one Metropolitan hospital in the Northern Territory, 1 regional hospital in regional Victoria, and via an interpreting service, in Western Australia.

Interpreters were sourced from an Interpreting service in Western Australia. It has over 100 accredited interpreters that work throughout the Kimberley, who cater for more than 18 Kimberley and Central Desert languages. For many Aboriginal people in this area, English is their fourth or fifth language; the majority of young people grow up speaking Kriol and only learn English at school. Older people tend to speak traditional language(s) as well as Kriol.

4.3 Data collection, coding and data analysis

4.3.1 Data collection

This study was based on 15 hours of transcribed audio-recordings of interviews conducted with interpreters of Aboriginal languages and ALOs. The data were collected between January 2017 and January 2018. Data collection consisted of 17 semi-structured interviews with interpreters of Aboriginal languages and ALOs, lasting between 30 – 90 mins each. There were 16 one-on-one interviews with participants at different locations and 1 interview was conducted with 3 ALOs working at the same hospital. Once the participants had read the plain language statement and signed the consent form, I set up the audio-recording device and collected basic demographic information. The interview proceeded with questions that focused on the ALOs and interpreters' perceptions of the interpreter-mediated interaction. They were open-ended questions such as "Who do medical clinicians usually call to act as an interpreter?" or "How do you deal with things that are difficult to translate because of their cultural content" and close-ended questions like "Have you assisted Aboriginal and Torres Strait Islander patients whose health beliefs differ from those common in Western medicine?" (See Appendix B). I acknowledge that one limitation of using semi-structured interviews is what Labov (1972) refers to as the *observer's paradox*, where the participants in an interview setting may alter their linguistic behaviour when they become aware that they are being observed (see section 7.3).

4.3.2 Data coding and analysis

The initial process for analysis involved the transcription of the interviews. The whole dataset, 15 hours of interview data were transcribed using a broad revised Santa Barbara transcription system (DT2) (Du Bois, 2006). The narrative data, which consists of 25 stories with a total duration of approximately 50 mins, and the non-narrative data totalling approximately 14 hours, were transcribed using ELAN linguistic annotator version 4.8.1 to enable a qualitative-based result. I identified stories in the dataset by

locating story preface sequences. Following Sacks, Schegloff, and Jefferson (1974) and Schegloff and Sacks (1973) these were often explicit expressions of the speakers' intention to offer a story or were used to make reference to the recency of the reported event. In line with research into discourse analysis, I also identified stories as being prefaced by discourse markers such as the common ground discourse marker *You know* (Maschler & Schiffrin, 2015); sequential initial *So* (Bolden, 2009; Jefferson, 1978) *Oh*-prefaced tellings (Schegloff, 2007) and the discourse markers *Okay so*, to preface an extended telling (Bolden, 2009). Typical examples of such story prefaces in the dataset include those that:

a) project a forthcoming story: 'So like um, I'll give you, just a quick example, of how that happens.'; 'I remember one time,'; 'This is a good example, as well.'
b) make reference to the recency of the reported event: 'So um just recently,'

Discourse markers that signal the telling of a story include:

c) common ground preface *You know*: 'Um. You know, in most cases, I will say to them,'
d) sequential initial *So:* 'So um, down in E D um, a couple of years ago,'
e) *Oh*-prefaced tellings: 'How did .. the doctor understand, in the end?
⌉Oh so then, so then—'
f) *Okay so* to preface an extended turn: 'Okay, so we had um a fell— A a a little boy admitted—'

Prefaces were also followed by temporally related clauses; according to Labov and Waletsky (1967) a narrative consists of a sequence of past tense clauses which are sequentially ordered as in: 'I was at footy, and my auntie tol— My auntie rang me up.' However, in line with Georgakopoulou (2015) a number of stories did not exhibit a linear sequencing of past events; in this dataset these stories were often fragmentary accounts of professional experience or stories that made reference to habitual narratives "which tell of the general course of events over a period of time, with the verb phrases

and adverbs marking repetition and routinization" and hypothetical narratives describing events that did not happen (Riessman, 1990).

4.3.3 Narrative and non-narrative data

People generally look at discourses in spontaneous conversation and discourses in narrative as separate analytical domains. However, researchers have shown that they are often integrated in conversation (Bamberg & Georgakopoulou, 2008). As mentioned in section 4.2.1, I draw on Bamberg and Georgakopoulou's (2008) analytical framework for small story research and narrative positioning to analyse the stories that were produced by the interpreters and ALOs. These stories are not life histories or autobiographies in the context of research on narrative identity; rather they are narratives in interaction; at times fragmentary accounts of professional experience that emerged spontaneously as the participants stepped outside the prototypical question-answer format of research interviews to make a particular point more salient. This framework provides the potential to determine how the interpreters and ALOs perceive and position themselves within the story, the ongoing interaction, and with respect to wider Discourses that are drawn upon to frame the role, skills and attributes of the professionals in this study. The narrative positioning analysis is also used to show how the interpreters and ALOs engage with these Discourses across similar kinds of stories, to construct multiple, shifting professional identities (see sections 2.3, 2.4, 2.5).

With respect to non-narrative data, this study explores the participants' views on mediated interactions between doctors, patients and interpreters or ALOs. A rigorous thematic analysis using NVivo 12 software, allowed for the identification, analysis, organisation, description, cross data analysis and reporting of the themes that emerged in the non-narrative data (Nowell et al., 2017). This approach takes into consideration the potential varying levels of knowledge and expertise that each speaker group possesses so as to interpret meaning. These perspectives therefore provide a theoretical

framework for the design and methodology employed in this study. I now move onto discuss two different levels of data analysis.

4.3.4 Analysis of narrative data

In the first level of analysis, that of the narrative data, I used Bamberg and Georgakopoulou's (2008) three level positioning analysis to investigate how the interpreters and ALOs use stories to talk about how they do their work and in doing so discursively create a sense of who they are professionally.

Firstly, I briefly define each positioning level and then move on to provide a more detailed description of how I applied the three levels in this study.

Level i: positioning at the level of the story

Level ii: positioning at the level of the interaction

Level iii: positioning in terms of how the speakers position a sense of self or identity with respect to Discourses or master narratives and by doing so establish a sense of who they are.

Level i positioning explores the story, focusing on where the story is set, how the action develops, and how the characters are portrayed. It analyses the kinds of actions the narrators attribute to the main characters and the underlying motives for doing so. It also analyses how the narrator attributes certain characteristics to the protagonist and other characters in the story.

Level ii focuses on the interactive situation. This requires examining how the story is embedded in the surrounding talk, how the story was produced and what the motivation was for doing so. It then looks at how the speakers position themselves in the ongoing interaction and in the storyworld, how they co-construct the story or challenge or endorse other participants' tellings.

It is important to note that in level i and ii analysis, I focus on how the characters in the story and the narrators in the ongoing interaction employ indexicality

to position themselves and other characters in relation to the social world and by doing so make claims to a certain professional identity (Ochs & Capps, 2001). I also analyse the way the characters' voices are animated through constructed dialogue in the stories by examining lexical and prosodic cues, which illustrate how narrators index certain positions by aligning characters in their stories with specific social groups (Wortham, 2001).

Level iii positioning addresses the question of "Who am I?" and is where the participants' position themselves with respect to broader Discourses and identify a sense of their professional identity. These Discourses are made relevant by relating the participants' projected identity to the three dilemmatic spaces that Bamberg (2011) suggests the storytellers are faced with: firstly, the dilemma of constructing *sameness of a sense of self across time in the face of constant change*; secondly, *the establishment of a synchronic connection between sameness and difference (between self and other)*; and thirdly, *the management of agency of the self in the world.* (see section 2.4). Through the identification of repeated types of story-lines and patterns or collective representations in other stories in the dataset, I show how positioning processes are linked with "specific types of stories and types of social settings" (De Fina, 2013; Georgakopoulou, 2013, p. 92). These are subsequently analysed in relation to wider social processes that are located in the literature.

4.3.5 Analysis of non-narrative data

In the second level of analysis, that of the non-narrative data, I conducted a thematic analysis to identify central themes pertaining to interpreting in medical settings for Aboriginal and Torres Strait Islander patients. In line with Nowell, Norris, White, and Moules (2017), this involved a five-step process:

Phase 1: Familiarising myself with the data: this entailed repeated reading of the entire dataset so as to begin identifying meanings and patterns.

Phase 2 and 3: The generation of initial codes and searching for themes: I initially developed a coding framework in the form of a coding manual which included predetermined codes drawn from the literature. These deductive codes often represented main themes some of which related to the research questions. Where there was no obvious fit into the pre-existing coding frame, subthemes were formed using an inductive process.

Peer debriefing and reflexive writing throughout the course of the coding process had the dual function of firstly, documenting how ideas evolved as I engaged more closely with the data and secondly, it permitted the creation of an audit trail which helped keep a record of these emerging impressions (Cutcliffe & McKenna, 1999).

Phase 4: Reviewing themes: This involved peer-reviewing the coded data to ensure whether the themes coded were an accurate reflection of the meanings evident in the dataset. Recoding the data was a necessary step when it was deemed that there were overlapping codes; these codes were subsequently deleted. When a relevant theme was not covered by existing codes, a new code was inserted.

Phase 5: Defining and naming themes: This phase entailed writing a detailed analysis for each individual theme which included a description of the scope and content of the theme and a consideration of how the theme fit into the overall story that was emerging from the data. Peer debriefing helped to clarity certain interpretations and challenge certain assumptions made by the researcher. This process enhanced the credibility of the research findings (Cutcliffe & McKenna, 1999).

What ensues is an indicative example of this process. The following coding framework emerged during the defining and naming of themes phase which incorporate the predetermined codes drawn from the literature as well as themes that emerged inductively. Firstly, macro issues which addressed the interpreters' and ALOs' experience of interacting with Aboriginal and Torres Strait Islander patients were

identified so as to gain insight into the institutional issues that confounded communication during an interpreter-mediated encounter (see Table 2). All predetermined codes derived from the literature were identified in the dataset. An exception to this was the following code: self-management approach vs collective participation.

Pre-determined macro-level codes: Institutional level – issues	
Service availability	(Devitt & McMasters, 1998)
Low levels of utilisation	(Mahmoud et al., 2011)
Time constraints	(Mercer, Byrth, & Jordan, 2014)
Inequity in access & health outcomes	(Gill & Babacan, 2012)
Deficiency in the provision of culturally appropriate care	(Willis, 1999)
Self-management approach vs collective participation	(Barnett, L., & Kendall, E., 2011)

Table 2. Pre-determined macro-level coding categories

Secondly, an analysis of micro issues examined language-specific differences between traditional Aboriginal languages, Kriol and Aboriginal English and Standard Australian English as perceived by the interpreters and ALOs in this study. Beyond the lexical level, this included looking at differences in syntactic structures, semantic content and paralinguistic features, which may lead to difficulties in interpreting medical terminology and concepts and taboo topics. All pre-determined micro-level codes pertaining to communication challenges derived from the literature were identified in the dataset. An exception to this was communication challenges that arise from the use of parts of the body as metaphor and symbol. Table 3 includes pre-determined codes pertaining to communication challenges.

Pre-determined micro-level codes: Communication challenges	
Single-word equivalents in English	(McGrath et al., 2005)
Polysemy	(Moore, 2014)
False friends	(Moore, 2014)
Parts of the body as metaphor & symbol	(Gaby, 2008)
Syntactic question structure	(Cooke & Australian Institute of Judicial Administration, 2002; Eades, 2010)
Aboriginal perceptions of time	(Boroditsky & Gaby, 2010; Janca & Bullen, 2003)
Medical discourse	(Devitt & McMasters, 1998)

Complex health explanations	(Andrulis & Brach, 2007)
Reluctance to: ask questions, seek clarification, request additional information, voicing complaints	(Devitt & McMasters, 1998)
Lack or absence of communication	(Cass et al., 2002)
Differing modes of discourse	(McGrath & Holewa, 2007)
Gratuitous concurrence	(Eades, 1992)
Culturally accepted listening behaviours	(Lin et al., 2014)
Paralinguistic features	(Carbaugh, 2007; Carbaugh, 2005)
Written information	(Browne et al., 2011; Ha & Longnecker, 2010)

Table 3. Pre-determined micro-level coding categories

As discussed in phase 2 and 3 in the instance where there was no obvious fit into the pre-existing coding frame, the following subthemes were formed using an inductive process:

Single-word equivalents derived from the literature included *shame, deadly, grab* and *Koorie*. Codes created inductively included: *risk* and *warning;* language specific equivalents for the microscopic world of disease, particularly language specific terms for *cancer*, *diabetes*, *sexually transmitted infection* and *fungus infection*, as well as language specific terms for the naming of *private body parts*. Codes were also formed inductively for patterned differences including the use of English expressions with a non-standard meaning (see chapter 6).

Phase 6: Once the final themes were established, the write up the findings of Chapter 6, 'Interpreting in Medical contexts for Aboriginal and Torres Strait Islander Patients' commenced. This progressed from a description that illustrated patterns that had emerged in the dataset and then moved onto an interpretation of these patterns in relation to their wider meanings and interpretations by drawing on the extant literature.

4.4 Summary

This chapter has outlined the analytical framework and methods used throughout the development, data collection and interpretation phases of this study. A qualitative approach using a mixed methods approach to the analysis of the data was determined to best address the research questions. Narrative analysis of the stories and

thematic analysis of the non-narrative data underpin the analysis and provide a comprehensive and rich exploration of the opportunities and challenges interpreters and ALOs face, and the strategies they report they use while interpreting for Aboriginal and Torres Strait Islander peoples. The results of the study are presented in Chapter 5, 'Narrative Positioning Analysis' and Chapter 6, 'Interpreting in Medical contexts for Aboriginal and Torres Strait Islander Patients'.

Chapter 5 Narrative Positioning Analysis

5.1 Introduction

Aboriginal communication norms often incorporate the telling of stories as storytelling is a particular way of knowing that stems from a strong oral tradition of imparting knowledge in this way (Batchelor Institute of Indigenous Tertiary Education & Ober, 2017). In this Chapter, I examine the stories offered spontaneously by the interpreters of Aboriginal languages and ALOs to determine how these stories are used to construct a sense of professional self. I present the findings that relate to the first research question pertaining to how interpreters and ALOs talk about how they do their work as they interpret or advocate for their clients or patients. The stories in the context of the interview were emergent in situated talk, about the participants' past professional experiences but more often they were small stories about habitual, future, hypothetical events, vicarious stories whose protagonists are not the actual teller or stories about events that did not happen. These stories are analysed from the analytical lens of narrative positioning analysis to study how the interpreters and ALOs construct a sense of their professional identity (Bamberg & Georgakopoulou, 2008 see sections 2.3-2.5). By employing their three-level approach to narrative analysis I show that the positioning that takes place in level I – at the level of the story, is closely tied to level II positioning – at the level of the interaction. Level III analysis examines how the first two levels come together to help answer the question "Who am I?" and illustrates how the interpreters and ALO position themselves with respect to broader socio-cultural contexts and Discourses in their social and cultural world. These wider Discourses are made relevant through an exploration of Bamberg's (2011) three dilemmatic positions, which the narrators navigate in their active construction of their professional identity (see section 2.3 and 2.5).

In the following section I analyse the five central Discourses that emerge from the narrative positioning analysis. These five central Discourses are reinforced in the non-narrative data analysed in Chapter 6:

Discourses
professionalism and accountability
differing worldviews and knowledge systems
us and them dichotomy
educator and learner
culturally distinct communication patterns

Table 4. Five central Discourses

5.2 Professionalism and accountability

```
"Um …That's a really big fail by um,
the system?"
```

The stories that follow are five out of 25 stories in the data set that touch upon medical institutional practices that fall short of providing appropriate care to Aboriginal patients. The central theme that pervades these stories is that of institutional lack of accountability and this underlies the sometimes negative orientation of the ALOs towards the health practitioners. At the same time, the ALOs' professional identity is foregrounded as integral to the work they do.

5.2.1 Sarah's story

The following story, Extract 1, is a story that comes from an interview with Sarah, an ALO who is an English speaker but who also has a working knowledge of Torres Strait Islander Kriol and Katherine Kriol. The interviewer is probing into how the ALOs do their work. The setting is a metropolitan hospital in the North of Australia, which has a sizeable Aboriginal and Torres Strait Islander population. The story was offered in response to a question asking how ALOs deal with older patients that are not able to read and write. The characters in this story include the narrator Sarah, a 19-month-old infant, the infant's mother, the social worker and 'generic' people that implicitly index the hospital's health practitioners. Sarah narrates her involvement in the care of an Aboriginal infant whose mother suffers from cognitive impairment. These characters and the positions they are said to adopt are invoked to support a reasoned argument that

Sarah develops pertaining to the accountability of the institution in the provision of care to Aboriginal patients. The story is provided in full in Extract 1 below.

Extract 1: The 'failure to thrive' story

1	Sarah	00:08:12	Okay, so we had um a fell—
2			A a a little boy admitted—
3			he's 19 months old,
4			third time for failure to thrive?
5			And his mother um,
6			actually had cognitive impairment?
7	Maria	00:08:19	Mhm.
8	Sarah	00:08:20	So, um,
9			She—
10			Her—
11			So, there was a language barrier,
12			As well as her understanding,
13			and being able to retain that information?
14	Maria	00:08:27	Yes.
15	Sarah	00:08:28	So, we—
16			and just let me know if I'm going off track.
17	Maria	00:08:29	No, you're not.
18	Sarah	00:08:32	@@@@@
19			Okay.
20			So um, ah …
21			Ah .. With her—
22			I was involved briefly in the second admission?
23			And by the third time,
24			I was like,
25			well, we've gotta get this right.
26			This child can't be coming in,
27			for the third time,
28	Maria	00:08:45	[Yeah].
29	Sarah	00:08:45	[with] the same um diagnosis,
30			Um or prognosis.
31			So um … um I—
32			The social worker and I led the—
33			that case.
34			Um, in terms of making sure,
35			that the mother,
36			had a cognitive assessment.
37			'cause there was all this query.
38			Um, mo—
39			mother's understanding,
40			query .. cognitive ability.
41			Um all through the notes.
42	Maria	00:09:08	Mhm.
43	Sarah	00:09:00	And um,
44			All the same information was being delivered.
45			But so when—
46			So anyways,

47			We got that cognitive assessment done.
48			Ah, when the assessment came back,
49			Um, it came up with that um,
50			this mother's unable to retain any information,
51	Maria	00:09:28	And that's why she couldn't [follow instructions].
52	Sarah	00:09:30	[That's right.]
53	Maria	00:09:31	Yeah.
54	Sarah	00:09:32	That's why it was the same admission,
55			.. So three times.
56			You know,
57			And could you imagine,
58			so she went through all of her life,
59			with this unpicked up.
60			[Not picked up].
61	Maria	00:09:34	[That's that's—]
62			Yeah.
63	Sarah	00:09:35	Ah, People were talking about it,
64			but no one was actually,
65			doing anything about it.
66	Maria	00:09:36	Mhm.
67	Sarah	00:09:37	Um …That's a really big fail by um,
68			the system?
69			but anyway,
70			Um ... So they're the usual times,
71			when um—
72	Maria	00:09:45	[When there's such a—]
73			yeah, such an issue there.

(SD16012017)

5.2.1.2 Level I positioning – at the level of the story

The main characters in Sarah's story – the ALO Sarah, and the hospital practitioners – are positioned vis-à-vis each other within the story world. Sarah, the character, is positioned as negatively oriented towards the hospital practitioners. She positions herself as well as the social worker as proactive, knowledgeable and capable while positioning the hospital practitioners as passive and potentially substandard. This positioning is achieved through the actions attributed to the main characters; for instance, by relating the underlying cause of the child's failure to thrive to the hospital practitioners' repeated failure to act upon their previous diagnoses, even though the child's condition had been documented in the case notes. This positioning is presented in Extract 1a, lines 37-41.

Extract 1a

37	Sarah	00:08:55	'cause there was all this query.
38			Um, mo—
39			mother's understanding,
40			query .. cognitive ability.
41			Um all through the notes.

This sense of iteration is reinforced in Extract 1b, as the practitioners had been talking about the case but had not resolved to take any action (lines 63-65).

Extract 1b

63	Sarah	00:09:35	Ah, People were talking about it,
64			but no one was actually,
65			doing anything about it.

In contrast, the character Sarah and by extension the social worker are positioned as proactive. More specifically, In Extract 1c, Sarah presents herself as completely agentive in her initiative and professional conduct and this is indexed through her determination to obtain an accurate diagnosis for why the infant was failing to thrive. (lines 25-27).

Extract 1c

25	Sarah	00:08:41	well, we've gotta get this right.
26			This child can't be coming in,
27			for the third time,

In Extract 1d, the complicating action (lines 47-50) details the action the ALO and social worker took; i.e., going forth with the administration of the mother's cognitive assessment; this is followed by the resolution that revealed that the mum had cognitive difficulties in terms of retaining information.

Extract 1d

47	Sarah	00:09:22	We got that cognitive assessment done.
48			Ah, when the assessment came back,
49			Um, it came up with that um,
50			this mother's unable to retain any information,
51	Maria	00:09:28	And that's why she couldn't [follow instructions].
52	Sarah	00:09:30	[That's right.]
53	Maria	00:09:31	Yeah.

The narrator attributes certain characteristics to parties that she deems are responsible for the child's failure to thrive and these extend to an institutional level as well. The character Sarah implicitly attributes blame to the hospital practitioners by emphasising the hospital practitioners' repeated inaction on three distinct occasions through the repetition of 'third time' or 'three times' (lines 4, 23, 27, 55). She employs what Du Bois (2014) calls parallelism of syntactic structure where there is repetition of similar phrasal structures such as in: 'all this query' (line 37), 'all through the notes' (line 41) and 'all the same information' and these parallel syntactic structures are embedded in evaluative utterances that serve to construct intersubjective alignment with the negative evaluations of hospital practitioners by the ALO. In this manner, parallelism in stance-taking and evaluation expressed through repetition of lexical and syntactic patterns helps build a consistent unified picture of the hospital practitioners as accountable for the child's ill-health. At the same time, the character Sarah, distances herself from previous failed attempts to care for the infant by adopting a qualifier that hedges her response (line 22) and in effect minimises her involvement, as Sarah claims she was 'involved briefly in the second admission'. As is evident in Extract 1e, the failure to provide appropriate diagnosis and subsequent care is lies with the institution who is held accountable for not offering appropriate medical care to this Aboriginal patient.

Extract 1e

67	Sarah	00:09:37	Um …That's a really big fail by um,
68			the system?

I next explore how the story is embedded in the interactive situation and illustrate how the narrator positions herself in the ongoing interaction and in the storyworld.

5.2.1.3 Level II positioning – at the level of the interaction

This story is embedded within talk about low literacy levels among older Aboriginal patients and communication difficulties that subsequently ensue. Sarah is positioned and positions herself as a participant in the interview but also as a professional in her field. Conscious of the situational context, the interview, and Maria's[5] role as the interviewer/researcher, she interrupts the narration (line 16) to gain the interviewer's reassurance that this is the kind of information expected and Maria confirms that this is so in Extract 1f.

Extract 1f

15	Sarah	00:08:28	So, we—
16			and just let me know if I'm going off track.
17	Maria	00:08:29	No, you're not.

Sarah is positioned as an expert by the nature of the research setting and Maria acknowledges Sarah's professional expertise at the onset of the interview. Maria positions herself as a person wanting to learn about how interpreters and ALOs do their work, the challenges they face and strategies they employ to overcome them. In Extract 1g, she reiterates the importance of having ALOs' and interpreters' voices heard as is evident in Extract 1g.

Extract 1g

1	Maria	00:00:52	We want your voices to be heard.

In the ongoing interaction and the story world, Sarah positions herself as responsible for the wellbeing of the Aboriginal mother and her infant and reinforces her

[5] I refer to myself in the 3rd person in the analysis in Chapters 5 and 6

own responsibility by shifting into constructed dialogue. Although Holt (1996) uses the term Direct Reported Speech to refer to instances when "the speaker structures the utterance in such a way as to suggest that he or she is simply reproducing a former locution" (p. 220), as Tannen (2007) argues, instances of reported speech and dialogue, whether they be direct reported speech or indirect reported speech, are not a reiteration of a character's actual utterances but are instances of constructed dialogue. Sarah's shift into constructed dialogue is presented in Extract 1h below.

Extract 1h

23	Sarah	00:08:32	And by the third time,
24			I was like,
25			⌉well, we've gotta get this right.
26			This child can't be coming in,
27			for the third time,
28	Maria	00:08:45	[Yeah].
29	Sarah	00:08:45	[with] the same um diagnosis,
30			Um or prognosis.

This shift is initiated with the quotative verb *like* in 'I was like' (line 24). Changes in prosody also mark this shift into direct reported speech as Sarah adopts a high pitch prior to initiating the turn initial discourse particle *well* and thus anchors the utterance to the original interaction in the story world. Spatial, temporal and personal deixis are all from the point of view of the reported speaker, ALO Sarah. First note that personal pronouns are co-referential with the reporter speaker. She uses 'I' to refer to herself (line 24) and 'we' (line 25) to refer to herself, the social worker and any other hospital practitioner involved in the case at that particular time. Sarah's deictic use of 'this' [diagnosis] (line 25) and 'This child' (line 26) index them as situationally proximate. The temporal references are also co-referential with Sarah, the reported speaker, who reports her own thoughts/speech in the present tense (lines 25-26).

It appears that the constructed dialogue here serves as "a type of demonstration", providing the interviewer with direct access to the interaction under discussion so that she is able to assess it for herself (Clark & Gerrig, 1990, p. 764; Holt, 1996). Furthermore, the constructed dialogue creates suspense as the interviewer, Maria, is left wondering why the child has been admitted into hospital 'a third time for failure to thrive' and this is only resolved at the end of the dialogue when the diagnosis is revealed (line 50-51). Sarah and the interviewer concurrently reach the inevitable conclusion that the mother could not retain information and therefore was unable to follow instructions (lines 50-52). This instance of constructed dialogue therefore sets the scene for the focus of the story that manifests in Sarah's pivotal role in obtaining an accurate diagnosis as is evidenced in lines 47-50 of Extract 1i.

Extract 1i

43	Sarah	00:09:00	And um,
44			All the same information was being delivered.
45			But so when—
47			We got that cognitive assessment done.
46			So anyways,
48			Ah, when the assessment came back,
49			Um, it came up with that um,
50			this mother's unable to retain any information,
51	Maria	00:09:28	And that's why she couldn't [follow instructions].
52	Sarah	00:09:30	[That's right.]

Responsibility and accountability are also indicators of positioning as Sarah makes the case that the institution is accountable for the infant's inability to thrive. Linguistically, in Extract 1j, she builds this idea through the use of a passive construction (lines 43-44), by making use of the generic noun 'people' (line 63) and an indefinite pronoun 'no one' (line 64) where the agent, the hospital practitioners, are implicitly referred to as being responsible for the child's ill-health.

Extract 1j:

43	Sarah	00:09:00	And um,
44	Sarah		All the same information was being delivered.
…			
63	Sarah	00:09:35	Ah, people were talking about it,
64			but no one was actually,
65			doing anything about it.

The interviewer does not intervene much during the interaction other than to acknowledge that she is listening and to index understanding through the use of backchannelling (lines 4, 23, 27 and 55); however, instances of overlapping speech, particularly (lines 50-51) show the interviewer's keen engagement and alignment with the ALO's stance as a proactive professional whose sense of responsibility reflects her duty-of-care towards her Aboriginal patients. I now turn to the possible connections between Sarah's local positioning with the interviewer and the underlying social issues and Discourses that surround this conversation as expressed in other stories and the literature.

5.2.1.4 Level III positioning – addresses the question of "Who am I?"

At this level, I examine how the participant Sarah positions herself with respect to Discourses and ideologies about institutional accountability. These wider Discourses are made relevant in Bamberg's (2011) three dilemmatic spaces, which Sarah navigates in her active construction of her professional identity. In answering the question "who am I?", I focus on how she uses the 'failure to thrive story' "in her interactive engagements to convey a sense of who [she is]" professionally (De Fina & Georgakopoulou, 2012, p. 164). In terms of the first identity dilemma, *constancy and change*, Sarah accounts for how she as a character has emerged over time, as she narrates the progression of the infant's ill-health. It appears that Sarah's frustration at the infant's repeated admission into hospital two previous times, reinforces her sense of responsibility and fuels her resolve to obtain an accurate diagnosis the third time round

(Extract 1, lines 22-25). As for the second identity dilemma, *uniqueness in comparison with others*, as a professional in the health setting, Sarah emerges as same as others by aligning herself positively with other professionals in the hospital such as the social worker (lines 32-33). Yet, at the same time, she emerges as different from the health practitioners through the negative stance taken towards their apparent inaction in the infant's case (Extract 1, lines 63-68). Finally, in the third level dilemmatic space, *the management of agency of the self in the world*, it is the tension evoked during the balancing and processing of her identity as a professional in the health settings that she is able to project her professional identity. In effect, it is through her discursive choices (Extract 1, lines 25, 32-33) that she navigates the agency dilemma and positions herself as an agentive, proactive and responsible ALO.

It becomes clear that Discourses of accountability are explicitly invoked in this interaction as the focal point highlighted is that the institution is accountable for not addressing the mental and health needs of the mother and child. In fact, this Discourse is made relevant through the identification of repeated types of story-lines and patterns that describe the way the participants in other stories view the issue of institutional accountability as we can see in Melanie's and Lenny's stories in Extracts 2-4 below.

5.2.2 Melanie's and Lenny's stories

The theme of institutional accountability in terms of their responsibility to provide appropriate care for Aboriginal patients is also expressed in other stories in the data set. One characteristic example presented below includes inappropriate ways of discussing weight with pregnant 'Aboriginal girls' in maternity wards. I'm using 'Aboriginal girls' in line with the narrator. Extract 2, the 'you're a bit too fat' story is narrated by ALO Melanie, who speaks English, and Aboriginal English. This is a habitual small story narrated in the present tense and is offered in response to a discussion of taboo topics. The setting is a Metropolitan hospital in Victorian and the context in which the story emerges is a discussion on physical appearance. Extract 2 is presented in full below:

Extract 2: The 'you're a bit too fat' story

1	Melanie	0:16:01	… And, generally,
2			the Aboriginal girls coming in,
3			are a bigger girls,
4			than mainstream.
5			And it seems to be an issue,
6			because midwives,
7			are pretty culturally safe,
8			around that aspect,
9			with our girls?
10			And there seems to be a lot of,
11			Um …
12			You know,
13			you're a bit too fat,
14			bit too big, you need to lose weight?
15			You need to do this,
16			and it's ^very offensive.

(NBB01052017)

Melanie highlights the inappropriate language used to discuss weight with pregnant Aboriginal girls, deeming the direct approach adopted by the midwives as '^very offensive' (line 16). Extract 3, the 'titty feeding' story is another habitual story co-constructed by ALOs Melanie and Lenny, who work in the same metropolitan hospital in Victoria. They employ the present tense to explain that Western health providers find culturally specific terms for breast feeding such as 'titty feeding' offensive. Melanie uses constructed dialogue to animate the voices of the nurses. Changes in prosody and voice quality dramatise the excerpt and accentuate the disdain she noted that the particular nurses emanated as they comment on the Aboriginal girls' lexical choices (30-32). Melanie and Lenny in contrast, perceive the use of the term 'titty feeding' as perfectly acceptable as it constitutes a part of the Aboriginal girls' language (line 34). The complete story is provided in full below in Extract 3.

Extract 3: The 'titty feeding' story (NBB01052017b)

1	Melanie	0:39:32	Even internally in the hospital,
2			like there's—
3			Something that that,
4			Aboriginal girls,
5			tend to say a lot.
6			And when we're talking about,
7			breast feeding?
8			Um,
9			They they don't—
10			They they will often,
11			not say breastfeeding,
12			but they will use a term,
13			that mainstream,
14			most probably find,
15			a little bit offensive.
16			And I've had nurses say to me
17			<A> Oh </A>
18	Maria	0:39:53	What is it?
19	Melanie	0:39:55	The tit,
20	Lenny	0:39:56	Titty feeding.
21	Melanie	0:39:57	And I'll say,
22			⌉Oh, baby is on the tit.
23	Maria	0:39:59	[Yeah]
24	Melanie	0:39:59	[And] I don't find it offensive.
25			This is just how,
26			Our .. Aboriginal women,
27			speak to each other,
28			and this is how,
29			they describe it.
30			But I had nurses say to me,
31			⌉Oh, <WHISPER> You know </WHISPER>
32			<WHISPER> it's terrible what she says </WHISPER>
33			And this is just—
34	Lenny	0:40:10	This is just the lingo.

Finally, in Extract 4, the 'peepee and the mutcha' story, ALOs Melanie and Lenny offer a habitual small story in the present tense, where they discuss the negative response Western health practitioners have to the terms Aboriginal English speakers use when making reference to private body parts. These terms include 'peepee' (penis) and 'mutcha' (vagina) which are characterised by mainstream staff as 'crude, slang or crass' (lines 19-29).

Extract 4: The 'peepee and the mutcha' story (NBB01052017c)

1	Melanie	0:43:25	But um,
2			You know,
3			there's some wor—
4			Some common words,
5			that aboriginal people use,
6			in different states,
7			that could be the same.
8			The peepee and the mutcha,
9			and all that,
10			is quite common here.
11			But then,
12			tribes have their own name,
13			for things.
14			So .. It's up to,
15			what people choose,
16			to use.
17			And that's one thing,
18			as Lennie was saying,
19			that sometimes,
20			You know,
21			Western medicine or,
22			Western, you know,
23			health providers don't understand.
24			They—
25			And um they think it's—
26			What's the word.
27	Lennie	0:43:56	Crude.
28	Melanie	0:43:57	It's crude,
29			or it's slang,
30			or crass,
31			and like,
32			in whose eyes.
33	Maria	0:44:02	Mhm.

We begin to see the emergence of themes and patterns in Melanie's and Lenny's stories that invoke similar Discourses surrounding institutional accountability. In the same way that Sarah, in Extract 1, frames the health practitioners' inaction as something the institution is accountable for, Melanie and Lenny, in Extracts 2 – 4, frame the inappropriate comments made towards or about Aboriginal patients as problematic. They present a connection between this problematic treatment of

Aboriginal patients and the health providers' lack of understanding or lack of sensitivity. Sarah, Melanie, and Lenny orient themselves positively towards their Aboriginal patients and it appears that their professional allegiance to their Aboriginal patients overrides their allegiance to the institution. Sarah, Melanie and Lenny position themselves as proactive, or culturally aware and knowledgeable and frame these attributes as a symbol of professional conduct for ALOs, (the in-group); while the medical health institutions and, in particular, some of the mainstream health providers (the out-group) are deemed as potentially insensitive; a symbol of unprofessional conduct. This is a common postulation and points to dominant discourses about institutional accountability for the poorer prognoses for Aboriginal and Torres Strait Islander people (Meiklejohn et al., 2016); feelings of exclusion from the health system (Kowal, 2012) and the prevalence of Anglo-Celtic health modes or worldviews that are alien to Aboriginal communities. As discussed in section 3.5, the Western health model underpins an "assumption of superiority" to Aboriginal traditions of health and care (Collis-McAnespie et al., 1997). On a macro level, the above analysis presents dominant Discourses that expound these institutional issues and legitimise the ALOs' promotion of their professional identity and positioning.

In the following section I discuss differing worldviews and knowledge systems that health practitioners and Aboriginal patients draw on and how medical interpreters and ALOs navigate between these differing orientations to facilitate communication.

5.3 Differing worldviews & knowledge systems

"Well, I'm telling you,
you're asking me,
the same question.
I'm telling you."

The stories presented in this section, reflect the different positions, as reported in the interviews, taken up by medical practitioners and Aboriginal patients as they draw on

their respective worldviews; in the former case, doctors draw on Western medical knowledge systems and prevailing health models based on Anglo-Celtic worldviews. In the latter, Aboriginal patients draw on their own knowledge systems and belief in traditional and holistic medicine.

5.3.1 Sarah's story

The first story to be analysed is set in a metropolitan hospital in the North of Australia. It is offered by ALO Sarah as part of a discussion on how Aboriginal patients use traditional knowledge to understand their illness. In Extract 5, the 'cut foot' story, Sarah, as narrator tells a vicarious[6] story that is set in the emergency department of a metropolitan hospital. An unnamed Aboriginal female patient has come to the hospital to seek treatment for a 'cut foot' that requires stitches (line 29, 31). This story foregrounds the different positions taken up by the medical practitioner and the Aboriginal patient during the history taking stage of a medical consultation where the doctor is probing the patient to identify the cause of the laceration on her foot. Ideas on causation become the central focus of the story as they become the source of miscommunication. The vicarious story is presented in full below in Extract 5.

Extract 5: The 'cut foot' story

1	Sarah	0:30:16	So, um.
2			And and then,
3			even when you're deliv—
4			When you're giving that information,
5			from the beginning,
6			of why,
7			this has happened?
8			That patient then,
9			has to go and process it.
10			Because they've got,
11			that spiritual and traditional belief
12			as well,

[6] A vicarious story is a story whose protagonists are not the actual teller or "the central or affected participant" (Norrick, 2000).

about how did this come on me.
Maria 0:30:21 Yeah.
Sarah 0:30:21 Is this a curse?
Is this um what happened?
So like um,
I'll give you,
just a quick example,
of how that happens.
Maria 0:30:24 Please do.
Please do.
This is really helpful.
Sarah 0:30:26 So um,
down in E D um,
a couple of years ago,
there was this woman,
that came in with this—
with a cut foot.
And um,
she needed stitches,
and the the doctor said,
⌋Oh, how did this happen.
And sh— she goes,
⌋Oh.
Well ..
I was at footy,
and my auntie tol—
My auntie rang me up.
And she wanted me,
to pick her up from footy—
Ah, to come to footy as well.
And I said no.
And he's like,
⌋No no no.
How did your ^foot happen.
How did the cut on your ^foot happen.
Maria 0:30:59 Right.
Sarah 0:31:00 Yeah,
⌋So well ..
I was at footy,
and my auntie asked me,
to come pick her up,
and I said no.
<F ⌋No no no </F>. ..
How did you cut your ^foot.
But that was the whole causation,
of that illness.
She didn't go,

60			and pick up her auntie,
61			therefore she cut her foot.
62	Maria	0:31:14	⌉Oh wow,
63			Yes.
64			I see what you mean.
65	Sarah	0:31:16	So .. um.
66			[There's a lot of stuff on] causation.
67	Maria	0:31:18	[The doctor wanted to know—]
68	Maria	0:31:20	Yeah yeah.
69	Sarah	0:31:25	… So that's why you need to do,
70			your um,
71			health education and teaching,
72			in segments.
73			Because um,
74			Our mob,
75			to be able to process that as well,
76			in their own language,
77			and the way that they view life.
78	Maria	0:31:30	Their worldview,
79			yeah, definitely, definitely.
80			I understand that.
81	Sarah		That's right. Yeah, yeah.
82	Maria	0:31:34	Wow.
83			How did .. the doctor understand,
84			in the end?
85	Sarah	0:31:36	⌉Oh so then, so then—
86			'cause then she started saying,
87			<F> ⌉Well, I'm telling you,
88			you're asking me,
89			the same question.
90			I'm telling you </F>..
91			So he had to sit there,
92			and listen to the whole story.
93			And then he picked up,
94			⌉Ah.
95			This is the—
96			This is um,
97			her ideas on causation.
98	Maria	0:31:44	[Mhm Mhm].
99	Sarah	0:31:44	[And why] it happened.
100			When actually I'm asking about,
101			the medical side.
102	Maria	0:31:49	Mhm Mhm.
103			The medical side.
104			Yeah yeah,
105			[Interesting].
106	Sarah	0:31:54	[Yeah it is].

```
107   Maria  0:31:55  Really interesting.
108   Maria  0:31:56  Really interesting,
                                        (SD16012017)
```

5.3.1.2 Level I positioning - at the level of the story

The main characters in this vicarious story are the female Aboriginal patient who is introduced as 'this woman' (line 27) and a doctor (line 32-33) who inquires how the Aboriginal patient acquired the cut in her foot. From the onset the doctor is preoccupied with finding out the cause of the injury and is positioned as wanting to establish causation in "the context of a systematic description of the [injury] and its etiology" (Kalitzkus & Matthiessen, 2009, p. 84) as evidenced in Extract 5a.

Extract 5a:

```
24  Sarah  0:30:26  So um,
25                  down in E D um,
26                  a couple of years ago,
27                  there was this woman,
28                  that came in with this—
29                  with a cut foot.
30                  And um,
31                  she needed stitches,
32                  and the the doctor said,
33                  ⌉Oh, how did this happen.
```

The doctor's question occasions the production of an embedded story, a story within the original story that is presented in Extract 5b. The narrator, Sarah, offers a story from the perspective of the female Aboriginal patient, who along with her auntie are the main characters. The setting is a football match, and this is where the complicating action unfolds: the protagonist receives a phone call from her auntie. Her auntie requests that she pick her up so that she can also attend the match; however, the protagonist refuses to do so.

Extract 5b:

34	Sarah	0:30:36	And sh— she goes,
35			⌉Oh.
36			Well ..
37			I was at footy,
38			and my auntie tol—
39			My auntie rang me up.
40			And she wanted me,
41			to pick her up from footy—
42			Ah, to come to footy as well.
43			And I said no.

The Aboriginal patient's attempt at explicating what precipitated the injury to her foot is negatively received by the doctor who abruptly interrupts the patient and repeats the original question. In Extract 5c, we can see that his irritation progressively heightens and he employs emphatic stress on the lexemes '^foot' and '^cut' to signal the kind of response he is anticipating from the patient.

Extract 5c:

44	Sarah	0:30:47	And he's like,
45			⌉No no no.
46			How did your ^foot happen.
47			How did the ^cut on your ^foot happen.

The doctor's overall positioning in the story can be characterised as emanating from a medical professional's worldview; it is of a doctor who takes up a seemingly objective, medically-oriented, positivist orientation towards the patient as he seeks to conduct evidence-based medicine in order to integrate "individual clinical experience and the best external evidence" (Sackett et al., 1996, p. 71). The doctor is also positioned as someone who dismisses subjective accounts as superficial and as someone who feels they have the right to inquire about causation so as to make an accurate medical diagnosis. This positioning accounts for his resistance to the patient's explanation (line

55) and his reiteration of the question once again with emphatic stress on '^cut' and '^foot' (line 56) in Extract 5d.

Extract 5d:

```
55                  <F ⌉No no no </F>. ..
56                  How did you ^cut your ^foot.
```

It is not my intention to suggest that this positioning exists outside the story; however, the positioning shifts the doctor makes in the embedded story show him taking up this seemingly objective, positivist position. In contrast, within the story world, the patient refuses this positioning that foregrounds Western medical knowledge systems on causation and takes up a position where traditional beliefs of causation are legitimate explanations of a physical injury. This is her motivation for reiterating her account of why she suffered the injury almost verbatim both times she is asked. The doctor's insistent questioning heightens the patient's frustration and towards the end of the embedded story, the Aboriginal patient's patience is exhausted as she retorts:

Extract 5 e:

```
87                  <F> Well, I'm telling you,
88                  you're asking me,
89                  the same question.
90                  I'm telling you </F>..
```

It is only after the doctor is forced to listen to the whole story that he realises they are invoking different worldviews; that he is drawing on Western biomedical knowledge systems while his patient is invoking traditional belief systems about curses and retribution. This realisation is manifested in Extract 5f lines (91-97).

Extract 5f:

```
91                So .. he had to sit there,
92                and listen to the whole story.
93                And then he picked up,
94                ]Ah.
95                This is the—
96                This is um,
97                her ideas on causation.
```

I next explore how this story is embedded within the broader frame of the talk. Level II positioning analyses the "interactive work that is being accomplished between the participants in the interactive setting and how subject matter and events are constructed linguistically" (Bamberg, 2004, p. 336).

5.3.1.3 Level II positioning – at the level of the interaction

At this level of analysis, in the on-going interaction, the discussion, prior to the narration of the story, has been on how Aboriginal patients use traditional knowledge to understand their illness. The ALO Sarah introduces the importance of notions of causation; for instance, explaining the necessity of identifying 'why this has happened' (line 6-7) and allowing time for Aboriginal patients to process this information. She proceeds to explain that this is because Aboriginal patients tend to situate their illness in terms of their 'spiritual and traditional beliefs' (line 11) and need to know 'how did this come to me' (line 13). In Extract 5g, Sarah invokes discourses of payback and spirituality of the body where an illness may result from a 'curse' placed on the patient by someone seeking retribution.

Extract 5g

```
15  Sarah   0:30:21  Is this a curse?
16                   Is this um what happened?
```

Given the interactional context of the interview setting and having positioned herself as an expert in her field, Sarah takes up the position of narrator and overtly orients the interviewer to an upcoming story by explicitly expressing her intention to provide an example. Maria responds positively to the opportunity to learn more about this topic.

Extract 5h:

17			So like um,
18			I'll give you,
19			just a quick example,
20			of how that happens.
21	Maria	0:30:24	Please do.
22			Please do.
23			This is really helpful.

In Extract 5i, Sarah prefaces her story with the discourse marker ‘So um’ and proceeds by inserting the temporal and spatial coordinates of the event under discussion, namely the setting, the emergency department, and the timeframe, a couple of years ago.

Extract 5i:

24	Sarah	0:30:26	So um,
25			down in E D um,
26			a couple of years ago,

The inclusion of the constructed dialogue in Extract 5j, through Sarah’s animation of the characters in the first person, “makes the story come alive” and involves the audience (Tannen, 2007, p. 105). Indicators of constructed dialogue in this instance are the use of the quotative verb ‘said’ in: ‘and the the doctor said’ (line 32) which prefaces the doctor’s utterance and the turn initial ‘Oh’, voiced in a high pitch, which anchors the utterance to the original interaction in the story world. The same pattern is repeated to introduce the patient’s reply where her utterance is prefaced with the speech verb ‘go’ in ‘And sh— she goes’. This is followed by the turn initial ‘Oh’ voiced in a high pitch followed by the discourse particle ‘Well’ (lines 35-36). This pattern is once again employed to preface the instances of constructed dialogue in line 87.

Extract 5j:

```
32              and the the doctor said,
33              ⌋Oh, how did this happen.
34              And sh— she goes,
35              ⌋Oh.
36              Well ..
37              I was at footy,
38              and my auntie tol—
39              My auntie rang me up.
40              And she wanted me,
41              to pick her up from footy—
42              Ah, to come to footy as well.
43              And I said no.
44              And he's like,
45              ⌋No no no.
46              How did your ^foot happen.
47              How did the cut on your ^foot happen.
…

50              ⌋So well ..
51              I was at footy,
52              and my auntie asked me,
53              to come pick her up,
54              and I said no.
55              <F ⌋No no no </F>. ..
56              How did you cut your ^foot.
…

86              'cause then she started saying,
87              <F> ⌋Well, I'm telling you,
88              you're asking me,
89              the same question.
90              I'm telling you </F>.
```

Although these Extracts in 5j are structured as though they are a reiteration of the actual utterances, which have been referred to as made by the characters on a previous occasion, some two years ago, it is more likely the case these utterances are constructed dialogue. Tannen (2007) contends that "ideas cast as dialogue rather than statements is a discourse strategy for framing information in a way that actively creates involvement" (p. 112). The narrator chooses to report the character's utterances as though almost verbatim in the subsequent exchanges between the patient and doctor, and through this

choice constructs a specific representation of the original exchange as she uses the constructed dialogue to make a point salient in this interaction here and now. In particular, this repetition of constructed dialogue animates the characters' attitudes as the patient's and doctor's frustration and exasperation builds with each telling; the narrator's voice increases in volume (line 55 and 87-90) and by the second telling it appears that they have both reached an impasse (lines 50-56). At this point, Sarah steps out of her role as narrator and positions herself as educator. She argues that this narrated event is not a one-off incident (line 65-66).

Extract 5k:

```
65  Sarah   0:31:16  So .. um.
66                   [There's a lot of stuff on] causation.
```

In Extract 5l, Sarah refers to 'Our mob' to construct a sense of shared identity with Aboriginal people, a community that she belongs to and advocates for. She further reinforces her position as educator with the idea that 'educating and teaching' Aboriginal people requires that it be done 'in segments'(lines 71-72) to enable them to process the information 'in their own language and the way they view life' (lines 73-77).

Extract 5l:

```
69  Sarah   0:31:25  … So that's why you need to do,
70                   your um,
71                   health education and teaching,
72                   in segments.
73                   Because um,
74                   Because um,
75                   Our mob,
76                   to be able to process that as well,
77                   in their own language,
78                   and the way that they view life.
```

Sarah's interactional alignment with the interviewer is achieved through their joint evaluation of the embedded story. Maria's expressions of surprise, in line 62 with 'Oh wow' marks her realisation and construes Sarah's evaluation in lines 57-61 as unexpected.

Extract 5m:

57	Sarah		But that was the whole causation,
58			of that illness.
59			She didn't go,
60			and pick up her auntie,
61			therefore she cut her foot.
62	Maria	0:31:14	⌉Oh wow,
63			Yes. ...
64			I see what you mean.

The story could have finished here with these evaluative phrases that serve to express final evaluations by both participants. However, Maria construed the story as incomplete inquiring 'How did the doctor understand in the end' (lines 83-84). This question prompts a further instance of constructed dialogue where Sarah gives voice to the Aboriginal patient (lines 87- 90). Linguistically this is achieved, in Extract 5n, through the use of the English progressive in 'I'm telling you, you're asking me the same question, I'm telling you' which allows for the expression of emotional connotations such as irritation (De Wit & Brisard, 2014). That this is expressed through parallelism of form and stance serves to construct intersubjective alignment with the negative positioning of the doctor whose insistence in pursuing the same line of questioning is interpreted as culturally inappropriate.

Extract 5n:

85	Sarah	0:31:36	⌉Oh so then, so then—
86			'cause then she started saying,
87			⌉Well, I'm telling you,
88			you're asking me,
89			the same question.
90			I'm telling you.

The story concludes with Sarah orienting us towards the different positions being established through the constructed dialogue by allowing the doctor to voice the different worldviews and knowledge systems each character draws upon to enact their particular stance; that the doctor is invoking Western biomedical knowledge systems while his patient is relying on traditional belief systems about curses and retribution.

Extract 5o:

91			So he had to sit there,
92			and listen to the whole story.
93			And then he picked up,
94			]Ah.
95			This is the—
96			This is um,
97			her ideas on causation.
98	Maria	0:31:44	[Mhm Mhm].
99	Sarah	0:31:44	[And why] it happened.
100			When actually I'm asking about,
101			the medical side.
102	Maria	0:31:49	Mhm Mhm.
103			The medical side.

In Extract 5p, Maria expresses overt agreement towards subsequent evaluations through her two-fold repetition of the adverb ‘definitely’ (line 79) and adjective ‘interesting’ (lines 105, 107, 109). This positive evaluation is made even more explicit with the inclusion of an intensifier in ‘Really interesting’ and the exclamatory ‘Wow’. Therefore, Maria positive aligns with Sarah’s explanation of the source of misunderstanding surrounding notions of causation.

Extract 5p:

105	Maria	0:31:53	[Interesting].
106	Sarah	0:31:54	[Yeah it is].
107	Maria	0:31:55	Really interesting.
108			Really interesting,
109			Wow.

I now turn to level 3 positioning to reflect how Sarah navigates Bamberg's (2011) three dilemmatic spaces to construct a sense of professional self. I then show how Sarah is positioned vis-à-vis cultural Discourses and normative positions that emerge in other stories and the literature.

5.3.1.4 Level III positioning – addressing the question of "Who am I?"

ALO Sarah orients us toward Discourses that highlight clashing worldviews and knowledge systems that exist in the two competing worlds of the medical practitioners and the Aboriginal patients and the miscommunication that may ensue. Thus, in terms of level 3 positioning, and in my attempt to address the question "Who am I?", I illustrate how Sarah invokes Discourses surrounding differing worldviews and knowledge systems as she navigates Bamberg's three dilemmatic spaces. Sarah uses, 'the cut foot' story, to convey a sense of who she is on a professional level. In terms of *constancy and change*, as she is a third person narrator telling a story whose protagonists are not the actual teller, she comes across as a rather stable entity over time. In the ongoing interaction, Sarah differentiates between *sameness and difference*, with respect to self and others. For instance, Sarah's subjective alignment lies with the patient who asserts her positioning that emanates from her Aboriginal identity and traditional belief systems about the causation of illness (Extract 5, lines 37-42). Sarah emerges as different from the doctor as she positions herself as an expert in her field; as an ALO, she is knowledgeable about the differing worldview and knowledge systems that mainstream health staff and Aboriginal patients invoke in patient-doctor consultations (Extract 5, lines 57-61). The third dilemmatic space, *the management of agency of the self in the world,* has Sarah attributing her agency to self as she positions herself as an educator and advocate of Aboriginal patients (Extract 5, lines 69-77) and this positioning is integral to her identity as an ALO. However, this positioning is situated in the wider socio-cultural context in which Western-oriented medical Discourses prevail and thus to some extent govern and determine Sarah's positioning.

We have seen how Sarah navigates the competing worldviews of the doctor and the Aboriginal patient in the ‘cut foot’ story and it is through the telling of this story that Sarah reinforces her shared identity with Aboriginal people by reinforcing her positioning as advocate and educator of Aboriginal knowledge systems. This positioning is taken up in other stories in the dataset.

5.3.2 Sarah’s story

Extract 6, the ‘absconding from ED’ story is also narrated by ALO Sarah, who offers another account of Aboriginal patients experiencing challenges when they act upon their different health beliefs. The main characters are an Aboriginal woman, a traditional healer, and the hospital practitioners. The complete story is present below in Extract 6.

Extract 6: The ‘absconding from ED’ story

1	Sarah	0:19:33	Yeah, so this lady, um.
2			]So .. she was asking for a traditional healer,
3			So,
4			we don't have a list of traditional healers.
5	Maria	0:19:42	Yeah, that's right.
6			That's what you were saying.
7	Sarah	0:19:46	For each area,
8			um so she—
9			According to the notes,
10			absconded for ten hours from E D.
11			Um, and came back,
12			um, with a shaved head.
13			So, they were thinking straight away,
14			]this woman's lost it.
15			She's had a psychotic episode.
16	Sarah	0:19:52	]Oh wow.
17	Sarah	00:19:52	And actually,
18			she had a cleansing ceremony.
19			So,
20			part of the cleansing ceremony was to shave the hair off.
21	Maria	00:19:55	Right.
22	Sarah	0:19:55	Um, yeah.
23			She also had um,
24			like some physical healing done to her.
25			Um. But yeah. The—

26			And so when—
27			When that woman came back,
28			They were like,
29			⌉Oh you know, we—
30			You know,
31			we're gonna do a referral to the psych team.
32			And it's like, ⌉Woah,
33			just hold on a sec,
34			she's just left to have her cleansing ceremony,
35			But there's no—
36			That's the other thing,
37			So no one knows,
38			what a cleansing ceremony is.
39			Or what any type of Aboriginal healing is.
40			So then they have to follow policy.
41			They have to follow—
42			You know,
43			if someone comes back like them,
44			then it's straight way,
45			They're like,
46			⌉Um this person's having a psychotic episode.
47	Maria	0:20:22	Lost it.
48	Sarah	0:20:22	We've got to refer them.
49			So then it just becomes more complicated.
50	Maria	0:20:24	Oh .. the poor woman.
51			Did did they actually refer her or did—
52	Sarah	0:20:26	Yeah, they referred her.
53			But she's, you know,
54			⌉Oh: she had a really long admission.
55			I felt so sorry for her.
56			There's plenty of things,
57			I can think of five different scenarios on that lady.
58	Maria	0:20:31	Wow wow wow.

(SD16012017)

This story exemplifies competing discourses and clashing worldviews, where the Aboriginal patient's plea for a traditional healer (line 2), the hospital's inability to provide one (line 3) and her resolve to consult one (lines 8-12), result in the hospital practitioners' negative positioning of her behaviour as counter normative and requiring psychiatric evaluation (lines 13-14, 31, 46, 48). This is particularly evident in the lexical choices attributed to the health practitioners who document that the woman 'absconded for ten hours from E D' (line 10). The choice of verb 'abscond' is loaded

with negative connotations as it has the meaning of ‘to leave hurriedly and secretly, typically to elude a creditor, escape from custody, or avoid arrest’ (Oxford English Dictionary, 2018a). That the health practitioners interpret the Aboriginal woman’s need to consult a traditional healer in this manner also explains why they diagnose her as having ‘a psychotic episode’ (line 15). Betancourt, Green and Carillo (2003) explain that at times:

> difference may even be pathologised; … For example, a person’s non-adherence to preventative medical practice on the basis of their ‘beliefs, values, preferences and behaviours’ is a common discourse employed when discussing the many root causes of disparities (p. 294).

The narrator’s focus on institutional resistance to holistic medicine and the health practitioner’s ignorance of traditional healing practices such as cleansing ceremonies (lines 37-39) reinforces this negative positioning of the health practitioners and exemplifies the chasm between Anglo-Celtic health modes or worldviews and traditional Aboriginal health beliefs and practice.

5.3.3 Rachel’s story

Extract 7, the ‘talking with ancestors’ story is a hypothetical small story narrated by ALO Rachel, who is an English speaker working in a regional hospital in Victoria. She offers a story narrating hypothetical events where she discusses Aboriginal health beliefs and practices pertaining to mental health. The story is provided in Extract 7.

Extract 7: The ‘talking with ancestors’ story

1	Rachel	33:06.9	So,
2			if I have to bring somebody down.
3			Y' know,
4			if somebody's talking about,
5			talking with their—
6			Ancestors?
7			And they had this—
8			And it was just such a normal thing,
9			Like talking talking,
10			to a Christian person,

11			who talks to God.
12	Maria	33:16.2	Mm. Yeah.
13	Rachel	33:17.4	Or talking to somebody else.
14			Um there's,
15			y' know,
16			that kind of thing.

(RW06122017)

In this instance, unlike the health practitioners in Extracts 5 and 6, Rachel orients positively to Aboriginal patients and normalises traditional health and spiritual beliefs and behaviours such as talking to ancestors by explicitly stating 'it was just such a normal thing' (line 8). This sense of normality is further reinforced by drawing a comparison with Christianity and similar practices that its believers adhere to (lines 9-10).

5.3.4 Trudy's story

In a similar respect, in Extract 8 the 'alternative ways of healing' story, Trudy, an English speaking Aboriginal Service Development Worker[7], based in a metropolitan hospital in Victoria, offers another story that includes the telling of hypothetical events. She details actions that she, other staff and heads of particular units would take in the event that an Aboriginal patient requests traditional treatment. What is of interest in this small story, is the positive positioning of the institution as 'forthcoming' in incorporating alternative ways of healing.

Extract 8: The 'alternative ways of healing' story

Trudy	00:06:58	Ah, Some—
		Yeah.
		Some some—
		Some of the patients I've worked with,
		Ah in terms, like,
		patients that have been in,
		intensive care unit?

[7] The Aboriginal Service Development Worker engages in project work and "works alongside other hospital staff to make certain patients and families receive the care and support that they need" (https://www.thermh.org.au/patients-visitors/services-clinics/aboriginal-health)

So they might have um,
a different health belief in um,
the healing.
And so here at this hospital,
We, I would seek—
You know,
I've sought permission.
Or we would seek permission to ask that,
ah certain,
you know,
that this is a certain type of um,
process or procedure,
that the family are wanting to to use.
Ah you know,
particular creams.

Maria 00:07:38 Mhm. Natural.

Trudy 00:07:39 You know.
Or particular,
Natural remedies.
Um you know,
and it's always about—
My role would be about—
like a family would request,
an alternative way of healing.
And then I would have that conversation,
with the staff.
Um here.
And the head of the particular units.
And say,
'this is what the family have asked.
this is what the patient and the family,
wanting to do,
for the patient.
And um,
can you see,
you know,
how we can get round some of the—

Maria 00:08:09 Yeah.
Get round some of the procedures.
Um to allow this to happen.
And in most cases—
In most cases,
the hospital is very forthcoming,
in understanding that.

Maria 00:08:18 'Oh that's great.

5.3.5 Annie's story

Extract 9, the 'bush medicine' story is offered by interpreter Annie. She interprets for speakers of Walmajarri, Fitzroy Valley Kriol and Kimberley Valley Kriol. This hypothetical story is offered in response to the following question:

Have you helped interpret for Aboriginal patients whose health beliefs are different form Western medical beliefs? In this hypothetical story, the narrator outlines the strategies she uses when interpreting traditional health beliefs that the doctor might not be familiar with or not understand. The story is provided in Extract 9 below.

Extract 9: The 'bush medicine' story

1	Annie	1:03:22	Yeah yeah.
2			Yep yep.
3			So,
4			we usually interpret everything.
5			It's .. part of our job.
6			And so,
7			if their beliefs is different.
8			Like,
9			]Oh we've got,
10			this bush medicine.
11	Maria	1:03:32	Mhm mhm.
12	Annie	1:03:33	and I'll say,
13			exactly what they've said.
14	Maria	1:03:35	Yeah.
15			And if they're
16			not good at explaining,
17			then that's where,
18			my cultural awareness comes in.
19			So it kind of—
20			Yeah.
21			Even though I'm there,
22			as an interpreter,
23			I feel .. like it's my responsibility,
24			in my culture,
25			to explain,
26			in more.
27			Like,
28			if the doctor doesn't understand?
29			So,
30			I'll—
31			I might say,

32			⌋Nah we've got,
33			bush medicine for that.
34	Maria	1:03:57	Mhm.
35			So he might say,
36			⌋Okay.
37			So in—
38			In the um—
39			right time of year?
40			This is—
41			We get this medicine.
42			We do this and this.
43			Yeah.
44			So,
45			I'd have to explain their—
46			their beliefs.
47			Mhm.
48			Like,
49			even if they say,
50			in one short sentence,
51			or one word,
52	Maria	1:04:17	You'll have to [elaborate]
53	Annie	1:04:17	[elaborate].
54	Maria	1:04:14	So the doctor can understand,
55			what kind of bush medicine
56			it is they're using.
57	Annie	1:04:18	[Yeah]
58	Maria	1:04:18	[Mhm] …
59	Annie	1:04:20	So that's where,
60			cultural awareness,
61			comes into interpreting,
62			as well.
63	Maria	1:04:23	Yeah.

(AA18072017)

In the story world, Annie aligns herself positively with any patient who may wish to use traditional healing practices such as bush medicine (lines 10-11). She extends beyond her role as interpreter (lines 12-13) and positions herself as information gatekeeper (lines 37-46) and cultural broker mediating between the patient and the doctor (lines 21-33). These characters and the multiple subject positions they take up are utilised to support Annie's multifaceted role as interpreter; bringing to the fore her identity as information gatekeeper and cultural broker for people she considers Aboriginal.

While ALO Sarah offers accounts of Aboriginal patients experiencing challenges when they act upon their different health beliefs in the 'cut foot' story and the 'absconding from ED' story, Rachel, Trudy and Annie offer stories where the doctors and health practitioners are open to incorporating culturally-sensitive care. Rachel, Trudy and Annie position themselves positively vis-à-vis the patient and the doctor and in doing so are able to achieve the best outcome. Similar findings were presented by Simonds et al., (2011) exploration of patient-doctor interactions in a Native American community. They foregrounded building trust as central in doctor-patient communication. This was influenced by such factors as expectations, history, context, and time. Williams et al., (2008) discuss the importance of effective communication and decision-making as being essential to sustaining overall quality of life. Kushnir et al., (2008) have noted the important link between interpersonal competence and skills of doctors and explain that global trust in the doctor was predicated through the display of interest and collaborative communication styles.

In contrast, Cass et al., (2002) explores the extent of miscommunication between Aboriginal patients and Australian doctors and found that shared understanding between doctors and Aboriginal patients was seldom achieved. This was evidenced firstly, by the patients having fewer opportunities to initiate a topic or be actively involved in decision-making, and secondly, by the doctor's determination to control the conversational direction. This is experienced by Aboriginal patients but also extends to other migrant patients in Australia, who have expressed dissatisfaction with "their passive role during consultations" (Shaw et al., 2015, p. 744). As a result, serious miscommunication regarding diagnosis, treatment and prevention may ensue (Cass et al., 2002).

This section has analysed differing worldviews and knowledge systems and the impact that they may have on patient-doctor communication. In the section that follows,

the stories I analyse address instances when there is little cooperation amongst professionals in the health setting.

5.4 Us and them dichotomy

```
ˡnah I can communicate with them,
Y' know.
Um I just say,
Y' know,
just drag it a bit,
Y' know,
the English words and—
```

The following stories in the data set give prominence to Discourses evoking an 'us and them' dichotomy that is constructed when there is little collaboration between, on the one hand, interpreters and ALOs, and on the other hand, health practitioners and health institutions.

5.4.1 Annie's story

Extract 10, the 'you need a Kriol interpreter' story, was offered in response to a discussion on the importance of using a professional interpreter. Annie, an interpreter of Aboriginal languages in Western Australia, discusses the difficulties associated with finding an interpreter that speaks a particular traditional Aboriginal language such as Kukatja spoken in Balgo Western Australia. In the ongoing interaction Annie explains that interpreters mediate between the doctor and patient over the phone. There is a strong preference however, for interpreting in person even though this is not always possible due to lack of funding or institutional support for trained interpreters. This is the impetus underlying Annie's interactional move in Extract 10, from an argumentative sequence to narrating a story that is set in a public hospital where a doctor deems the use of a professional interpreter as unnecessary.

Extract 10: The ‘you need a Kriol interpreter’ story

1	Annie	10:46.8	Um I did a um—
2			for <##> we went to um.
3			<##> Hospital,
4			To present,
5			and get the word out there,
6			for interpreters.
7	Maria	10:57.9	Mhm.
8	Annie	10:59.1	And there was a doctor there.
9			And he goes,
10			Like,
11			[“dismissive” voice] ⌉nah I can communicate
12			with them.
13			Y' know.
14			Um .. I just say,
15			Y' know,
16			just drag it a bit,
17			Y' know,
18			the English words and—
19			And all that.
20			Y' know.
21			And I said,
22			Like,
23			it's probably,
24			at a completely different meaning.
25			You need a Kriol interpreter.
26			It might sound like.
27			Y' know.
28			Maybe a good strategy,
29			is ask the patient,
30			to repeat back to you,
31			what you've just said to them.
32			He's like— (shrug of the shoulders)
33			Do that,
34			and then see if you—
35			If they've understood you,
36			or not.
37	Maria	11:31.0	And again,
38			there's a danger,
39			that they are just repeating,
40			what they heard.
41	Annie	11:33.9	Mm.
42	Maria	11:34.5	Rather than sl—
43	Annie	11:36.7	Yeah that's it.
44	Maria	11:37.7	Rather than necessarily,
45			understanding again.

(AA18072017)

5.4.1.2 Level I positioning – at the level of the story

Labov (2011) identifies that "participants in many narratives include protagonist, antagonist and third party witnesses" (p. 548). In the 'you need a Kriol interpreter' story Annie is both narrator and protagonist in this story, while the doctor is positioned as antagonist. Annie has visited the hospital on a professional level in order to promote the importance of using trained interpreters as her intention is to 'get the word out there, for interpreters' (line 4-6).

Extract 10a

1	Annie	10:46.8	Um I did a um—
2			for <##> we went to um.
3			<##> Hospital,
4			to present,
5			and get the word out there,
6			for interpreters.

The doctor's positioning vis-à-vis the interpreter is dismissive and negatively oriented towards the interpreter and the Aboriginal patients, thus ameliorating his own capacities of communication. In Extract 10b, this is achieved through his casual rebuff in line 11, and the 'othering' of the Aboriginal patients. It also appears as if the doctor is minimising the work that interpreters do via the lexical choices he makes, 'I just say … just drag it a bit … the English words and all that' (lines 14-19), thus rendering the process of interpreting redundant. This is achieved by underestimating the linguistic barriers that may be present when interpreting for Aboriginal patients.

Extract 10b

11		["dismissive" voice] ⌊nah I can communicate
12		with them.
13		Y' know.
14		Um .. I just say,
15		Y' know,
16		just drag it a bit,
17		Y' know,
18		the English words and—
19		And all that.
20		Y' know.

In Extract 10c, the character Annie, conscious of the doctor's attempt to trivialise the work of the interpreter, draws on her professional positioning to highlight the semantic differences that necessitate the use of a Kriol interpreter (lines 22-23). The doctor's indifference is marked by the lack of a reply.

Extract 10c:

```
21                  And I said,
22                  Like,
23                  it's probably,
24                  at a completely different meaning.
25                  You need a Kriol interpreter.
```

Annie appears to submit under the pressure and rather than continue to contest the doctor's refusal to use an interpreter, she offers a strategy for checking Aboriginal patients' understanding (lines 27-30). This is met with a shrug of the shoulders (line 31).

Extract 10d:

```
26                  It might sound like.
27                  Y' know.
28                  Maybe a good strategy,
29                  is ask the patient,
30                  to repeat back to you,
31                  what you've just said to them.
32                  He's like— (shrug of the shoulders)
```

This story highlights the challenging of Annie's professional identity as she contends with the doctor's denigration of her work and brings to the fore the boundaries that are constructed between the two professionals establishing an 'us and them' dichotomy. How this is achieved linguistically in the ongoing interaction is expounded in level II positioning below.

5.4.1.3 Level II positioning – at the level of the interaction

This story is embedded within talk about the importance of using a professional interpreter particularly when doctors construe the practice as superfluous. Annie's professional identity as interpreter is challenged by the doctor's nonchalant dismissal of what the work of an interpreter entails. In line with McNeill (1992), this dismissive behaviour and attitude is paralinguistically embodied in a shrug of the shoulders. Annie attributes this gesture to the doctor to mark his failure to respond constructively. This embodied narrative event is crucial in constructing and reproducing the perception of a routinised construction of doctors' repeated resistance to the use of interpreters. In this manner, Annie is progressively constructing an 'us and them' dichotomy. This positioning is further reinforced through the use of constructed dialogue. There is only one instance where there is a shift in voice quality in the story and this is in lines 11-20. Here the doctor is animated in a dismissive voice and the quality of that voice creates the persona that Annie is constructing for him; that of an uncooperative and perhaps ill-informed medical professional. Through the animation of the dialogue with a highly marked voice quality, Annie constructs a tension between what appear to be lifelike characters and as a result the audience becomes involved by actively aligning with the 'us and them' positioning. This is evidenced by Maria's contribution to the ongoing interaction once Annie has stepped out of the story world. Maria questions the use of repetition as a knowledge checking strategy and draws on an earlier discussion on gratuitous concurrence, what Eades (2016) refers to as "the act of saying yes to a question, regardless of whether the speaker agrees with the proposition being questioned, or even understands it" (p. 476; see section 3.5). Annie uses the term when discussing the pitfalls of addressing yes/no questions to Aboriginal patients. Maria's interjection here highlights the inherent dangers of relying on repetition of an utterance as there is no guarantee of understanding.

This discussion on gratuitous concurrence occasions the production of a story, Extract 11, the ‘you definitely need an interpreter’ story, that contains hypothetical events that are employed as a strategy for evaluation of the original story presented above in Extract 10. Annie questions her handling of the doctor’s positioning of herself, the interpreter, as redundant and offers the hypothetical story to evaluate what did not happen in the story world. The complete story is presented in Extract 11 below.

Extract 11: The ‘you definitely need an interpreter’ story

46			Y' know,
47			what I should have said,
48			to the doctor.
49			That maybe—
50			that if they can put it,
51			in their own words.
52			Um,
53			what you've just said to them,
54			then—
55			Yeah.
56			You'll you'll find that,
57			you definitely need,
58			an interpreter.
59	Maria	12:11.7	Yeah,
60			that’s absolutely right.

(AA18072017)

Linguistically, Anne’s use of the discourse marker ‘you know’ (line 46) indicates the connection between the irrealis in Extract 11 and the story world in Extract 10, thus relating informational units in the discourse to each other (Schiffrin, 1987). Annie is setting up the irrealis to directly evaluate her actions in the story world; and it appears as if these are deemed as inadequate given that Annie’s use of deontic modality in ‘what I should have said to the doctor’ (line 47-48) expresses an unfulfilled obligation or an action that was neglected (Palmer, 2001; Van Der Auwera & Plungian, 1998). She proceeds to use ‘if’ to introduce the conditions under which the subsequent hypothetical event takes place (lines 49-58). Namely, hypothetically requesting that Aboriginal patients rephrase a doctor’s utterances. However, she concludes that the

Aboriginal patient would not be able to do so. In effect, Annie is returning to her initial premise and positioning; that it is imperative that doctors use professional interpreters and the emphatic stress on the adverb 'definitely' reinforces this positioning (lines (57-58).

Maria's overt agreement in 'Yeah, that's absolutely right' (lines 59-60) shows complete alignment with Annie's move to reject the strategies that she had proposed to the doctor. It appears that Annie is reporting that she is indirectly placating the resistant doctor via the provision of strategies the doctor could employ while consulting with Aboriginal patients. In hindsight, these strategies are considered ineffectual and Annie reclaims her initial positioning asserting her identity as a professional interpreter.

I now turn to level 3 positioning to reflect how Annie navigates Bamberg's (2011) three dilemmatic spaces to construct a professional identity and I then illustrate how similar patterns emerge in other stories and across the literature.

5.4.1.4 Level III positioning – addressing the question of "Who am I?"

Annie's stories portray the challenges inherent in interpreter mediated interactions when doctors display resistance towards incorporating professional interpreters during their communicative encounters with Aboriginal patients. This may strain relations between these two professional groups and widen the gulf between them, thereby constructing a Discourse surrounding an *us and them dichotomy*. Looking back to Annie's story, the 'you need a Kriol interpreter' story in Extract 10, her professional identity is challenged by erroneous assumptions that undermine the work of interpreters. As Level 3 positioning sets out to answer the question who am I? "above and beyond the current storytelling situation" (De Fina & Georgakopoulou, 2012, p. 181), we can see how Annie navigates her identity through Bamberg's (2011) three dilemmatic spaces. With respect to the first dilemmatic space, *constancy and change*, Annie shows how her professional identity evolves over time. On the onset, she foregrounds her professional

positioning as a Kriol interpreter through her resolve to promote the work of accredited interpreters in health institutional settings. However, when her professional identity is undermined by the doctor's trivialising the work the interpreters do, she succumbs to pressure and placates the doctor by orienting to the doctor's perspective. Upon reflection, in the subsequent small story, Annie questions her response to the doctor's dismissive positioning and reclaims her identity as a professional Kriol interpreter. In terms of the second dilemmatic space, the navigation of *sameness and difference with respect to self and others*, Annie emerges as same as other accredited interpreters through the recognition of their utility and indispensability in doctor-patient interactions with Aboriginal patients whose first language is not English. She emerges as different from the mainstream doctor via her negative positioning and animated portrayal of the doctor's resistance to incorporate interpreters in their communicative encounters with Aboriginal patients. Finally, in the third dilemmatic space, *the management of agency of the self in the world*, it seems that power differentials exist between the doctor and interpreter, as the doctor exerts his power by drawing on the status proffered to him by the institution that legitimises or acquiesces to the use of unofficial interpreting. However, Annie is able to exert her influence on the social structures that challenge the utility of the interpreter and exhibits the agency to make decisions and express them in behaviour as she condemns the doctor and reclaims her identity as a professional in her field.

The following stories highlight that interpreters Gary and Francesca and ALO Sarah, often face institutional resistance as they undertake to advocate or interpret for Aboriginal patients.

5.4.2 Gary's story

Extract 12, the 'unofficial Kriol interpreting' story was offered in response to a discussion on the misconception about Aboriginal people's fluency in English. Gary, a Kriol interpreter, narrates a story about Justin, who is an Aboriginal patient, and a head

doctor, who asks Justin to give consent about his impending transfer to a metropolitan hospital. However, the patient has received no information concerning what has precipitated such a move. Gary, who is visiting Justin at the time, is called to act as an interpreter on an informal basis, something which defies hospital policy. In the full version of the story, Gary has narrated how he came to visit his Aboriginal friend who is also a Kriol speaker in hospital. The following sequence follows the head doctor's entry into the ward.

Extract 12: The 'unofficial Kriol interpreting' story

1	Gary	00:40:51	Anyway,
2			I think the doctor then,
3			came over.
4			So,
5			I sort of had this vague— …
6	Maria	00:40:56	[Idea?]
7	Gary	00:40:56	[Ah vague] idea,
8			of what was happening,
9			and the doctor came over,
10			and he said,
11			]Oh—
12			And he said to Justin,
13			]Oh If I said—
14			If I said to you,
15			that I wanna send you to Darwin,
16			what would you say.
17			And so,
18			me and Justin,
19			had already spoken about,
20			what was happening to him.
21			And I mean,
22			he hadn't mentioned anything,
23			about Darwin.
24			And when Justin—
25			When the doctor said this,
26			Justin kind of looked at me,
27			and I sort of looked at him.
28			And I said to Justin,
29			]did they say anything about,
30			going to Darwin?
31			And he's like,
32			]No.
33	Maria	00:41:21	Aha.
34	Gary	00:41:22	And I said to the doctor,

35			this is this head doctor,
36			that I know.
37			And I said,
38			]Maybe if you tell him,
39			What .. it's ^for,
40			like Darwin’s three hours away.
41	Maria	00:41:30	Yes.
42	Gary	00:41:31	And it’s like—
43			And it’s like—
44			So then,
45			it's even further,
46			from this remote community,
47			as well.
48			And I said,
49			]Oh well,
50			maybe if you tell him,
51			what it's about,
52			the,
53			He—
54			he can make a decision,
55			about if he would go,
56			or not.
57			And the doctor was like,
58			]Oh No.
59			well, I was just asking,
60			because some people,
61			just say they don’t wanna go,
62			to Darwin.
63			And I was like,
64			]yeah?
65			So yes.
66			But he needs to know,
67			what it’s for,
68			and he can make a decision.
69			I'm like,
70			and so,
71			this like straight away,
72			I had my backup,
73			because I'm like,
74			you kind of asking someone,
75			if—
76			To me,
77			it sounds like,
78			you’re asking for consent for something,
79			without ^any information about,
80			what it's for?
81	Maria	00:42:02	Wow, yeah.
82	Gary	00:42:03	So,
83			I was just like,
84			what is going on in here?

85			And Justin—
86			And Justin said,
87			]No,
88			they haven't mentioned anything about,
89			like going to Darwin.
90			So,
91			he didn't know,
92			what was going on either.
93			And I was like ..
94			You need to tell him,
95			what it's for.
96			He's like,
97			]Okay,
98			we'll look.
99			I'll come back and—
100			He said,
101			I'll come back and explain,
102			a little bit more.
103			And Gary,
104			if you can interpret,
105			then that will be great.
106			So,
107			he went off.
108			And I was getting real—
109			That kind of really,
110			knocked me for six that.
111			And I was getting really cranky,
112			that he'd done that.
113			And then I was like,
114			and then I also annoyed.
115			because I was kind of asked,
116			to interpret,
117			just informally.
118			You know,
119			whereas normally,
120			it should be booked.
121	Maria	0:42:42	That's right.
122	Gary	0:42:42	And it should be a paid job,
123			and it should be done professionally.
124			But I was like—
125			So,
126			then I was caught in a situation where,
127			I wanted the communication,
128			to be done ^well.
129			So,
130			I wanted to do it,
131			but I knew that it was wrong.
132			It shouldn't be done informally,
133			like that.
134	Maria	0:42:59	Right, right.

135	Maria	0:42:59	So,
136			like I did it.
137			So eventually, he came back,
138			and we sat down,
139			and we had a chat.
140			And I pretty much interpreted,
141			and talked about it.
142			and it all got straightened out.
143			Like,
144			He was just ..
145			talking about how—
146			that the medicines,
147			that he was getting,
148			weren't helping as much as,
149			they would.
150			So,
151			he wanted to go to Darwin,
152			for tests and stuff.
153			And kind of it all.
154			He got the communication sorted,
155			but that—
166			That initial bit,
167			was really—
168			Really got my back up,
169			and it was shocking.

(GG12062017)

Gary's story mirrors Annie's story in Extract 10, not in terms of challenging the utility of his interpreting for Aboriginal patients, but in terms of undermining his status as a professional interpreter. There is an implicit understanding that an interpreter should be commissioned using formal procedures and not sanctioned in an ad hoc manner. There is also the added issue of offering one's services free of charge. When Gary is called to interpret informally, he becomes thoroughly perturbed, and this is expressed through his choice of specific linguistic forms such as the idiomatic cricketing phrase, 'knocked me for six', and inclusion of evaluative intensifiers and adjectives in 'really cranky' and, 'annoyed' (lines 110-111, 114).

Extract 12a

108	Gary	And I was getting real—
109		That kind of really,
110		knocked me for six that.
111		And I was getting really cranky,

112		that he'd done that.
113		And then I was like,
114		and then I also annoyed.
115		because I was kind of asked,
116		to interpret,
117		just informally.
118		You know,
119		whereas normally,
120		it should be booked.

The tension created by this unlicensed request, constructs the 'us and them dichotomy' as Gary aligns with the patient and dis-aligns with the doctor. Gary's alignment with the patient is evidenced as he questions the doctor's handling of the patient's imminent transfer to a metropolitan hospital without having informed the patient about what has necessitated such a move (lines 48-56).

Extract 12b:

48	Gary	And I said,
49		⌋Oh well,
50		maybe if you tell him,
51		what it's about,
52		the,
53		He—
54		he can make a decision,
55		about if he would go,
56		or not.

The doctor's dismissal of the interpreter's concern and his underplaying the patient's right to information about his condition, finds expression in constructed dialogue in Extract 12c (lines 57-68).

Extract 12c:

57	Gary	And the doctor was like,
58		⌋Oh No.
59		well, I was just asking,
60		because some people,
61		just say they don't wanna go,
62		to Darwin.

63 And I was like,
64]yeah?
65 So yes.
66 But he needs to know,
67 what it's for,
68 and he can make a decision.

The doctor is positioned as minimising his initial request for a transfer through the mitigating phrase 'I was just asking' (lines 59). The doctor's use of the generic 'some people' may potentially point to the doctor's engaging in 'othering' of Aboriginal patients in general. This is something that Gary picks up on and immediately contests with 'yeah?', which is uttered as an appeal. Gary then proceeds to specify the doctor's utterance by referring to Justin using a third person pronoun, stating that 'he needs to know, what it's for, and he can make a decision'. This orientation positively aligns Gary with the patient and negatively positions him with the doctor, reinforcing the 'us and them' dichotomy.

5.4.3 Sarah's story

The following small story the 'I'm a big referee' was offered in response to a discussion about the importance of allowing time for patients to process information. ALO Sarah, narrates instances when she has had to actively intervene when health practitioners do not practice culturally sensitive care. The main characters are ALO Sarah, staff members and a female Aboriginal patient. Extract 13 is provided below.

Extract 13: The 'I'm a big referee' story

1 Sarah 00:44:37 So if um—
2 and this is what I try to tell the staff,
3 just take your time,
4 when you're asking a question.
5 Um,
6 Especially if you want a good answer.
7 It sometimes—
8 'Cause we we had one patient that,
9 That is um,
10 not so long ago.
11 Like,

12		You can say something to her—
13		You can see her thinking about it,
14		but because we're so time-orientated,
15		the staff would go,
16		Well do you wanna do that,
17		or not.
18		And it's like hey:—
19		And so later on,
20		So I—
21		I try not to,
22		Ah,
23		I feel like,
24		I'm a big referee sometimes.[LAUGH]
25		So …
26		I get wild inside.
27		But I'm like,
28		I can't do this,
29		in front of the patient.
30		You feel like,
31		mum and dad arguing,
32		in front the kids.
33		You know?
34	Maria	[LAUGH]
35	Sarah	I'm not gonna escalate this,
36		right now.
37		But I'll remember it.
38		We're gonna talk,
39		when we get around the corner. [LAUGH]
40		Um so,
41		I was like,
42		⌉Look,
43		I understand,
44		that you were late,
45		for your break.
46		But,
47		that's not that patient's fault.
48		Okay,
49		when you were waiting,
50		for an answer,
51		don't have your arms folded,
52		don't be jittery,
53		just look and wait.
54		So yeah, um …
55		A lot of body language.
56		But yeah,
57		Like um …
58		Silence is you know,

questions—
allowing questions to be answered,
time for questions to be answered
um is very, very ..
important.
Very important with our mob.
'Cause they need to process it,
and then answer.
And our mob take our time.

(SD16012017)

In this story, ALO Sarah, is placed in opposition to other staff members as she negotiates how best to approach Aboriginal patients with respect to asking questions and allowing time for the patient to respond. The character Sarah aligns with the female Aboriginal patient as she advocates on her behalf by objecting to the staff's pressurising the patient for an answer that potentially functions to intimidate the patient: (Extract 13a, lines 8- 18).

Extract 13a

'Cause we we had one patient that,
That is um,
not so long ago.
Like,
You can say something to her—
You can see her thinking about it,
but because we're so time-orientated,
the staff would go,
Well do you wanna do that,
or not.
And it's like hey:—

Linguistically, in Extract 13b, Sarah draws on two telling analogies to describe her collaboration with staff members: - that of 'a big referee' (line 21) and of a 'mum and dad arguing in front of the kids" (lines 22-34).

Extract 13b

22		Ah,
23		I feel like,
24		I’m a big referee sometimes.[LAUGH]
25		So …
26		I get wild inside.
27		But I'm like,
28		I can't do this,
29		in front of the patient.
30		You feel like,
31		mum and dad arguing,
32		in front the kids.
33		You know?
34	Maria	[LAUGH]

The first analogy conjures an image of Sarah presiding over the staff and Aboriginal patients in the same way that a referee enforces rules and issues penalties. While the second, evokes images of inappropriate parental behaviour. She invokes these analogies when she refrains from admonishing the staff members in front of the patient (28-32). By drawing on these analogies Sarah constructs a negative alignment with the staff who fail to practice culturally sensitive care.

In Extract 13c, the story proceeds with a series of reproaches targeted towards the staff members.

Extract 13c

40		Um so,
41		I was like,
42		⌉Look,
43		I understand,
44		that you were late,
45		for your break.
46		But,
47		that's not that patient’s fault.
48		Okay,
49		when you were waiting,
50		for an answer,
51		don't have your arms folded,
52		don't be jittery,
53		just look and wait.

These are directives (lines 51-53) that are issued so as to correct the culturally insensitive care that was practised with the Aboriginal patient. In Extract 13c, the story brings to the fore how relations with staff members may become strained when culturally safe practices are ignored. This has the potential to perpetuate the 'us and them' dichotomy particularly when an ALO has to resort to overtly condemning the mainstream staff members' inappropriate behaviour.

5.4.4 Francesca's story

The following story, 'we'll ring you when we need you' story bears resemblance to Annie's stories (Extracts 10 and 11). The common theme pervading these stories is institutional resistance to using professional interpreters. In this story an 'us and them' dichotomy is constructed as interpreters are pitched in direct opposition to ALOs. In the ongoing interaction Francesca, an interpreter of Aboriginal languages including Kriol and Walmajarri has noted that differences exist between even geographically proximate language groups and that geographical proximity does not equate to mutual intelligibility. Rather than using interpreters as a first resort, they are commissioned as a final resort when the ALO's attempts to communicate with an Aboriginal patient have broken down. Francesca is the narrator and protagonist of this story. She recounts the events that precipitated the commissioning of an interpreter following a female patient's hospitalisation. The antagonists are the hospital staff who initially deem the use of an interpreter as unnecessary. The story that ensues commences at line 9:

Extract 14: The ‘we’ll ring you when we need you’ story

1	Francesca	0:23:05	There are people,
2			that don’t realise that,
3			the simplest things,
4			could be even just,
5			speaking to somebody,
6			who has the same um ..
7			language group,
8			or background.
9			I remember one time,
10			they got in their,
11			ALOs?
12			Now,
13			their ALOs are Broome background.
14			So,
15			their language,
16			And their—
17			Just even how they speak,
18			are totally different,
19			to how we are,
20			Fitzroy,
21	Maria	0:23:30	Oh really.
22	Francesca	0:23:31	So,
23			they were speaking ..
24			Western Kimberley Kriol.
25	Maria	00:23:31	[Aha.]
26	Francesca	00:23:31	[To s]omebody who had,
27			more of a language background,
28			than to have—
29			You know, more than—
30			So,
31			she had Kukatja,
32			which is a very heavy,
33			and strong language.
34			And she didn't say anything.
35			So,
36			they had to ring us up,
37			and we were already ringing,
38			and saying,
39			you've got a patient there,
40			We we would like to do,
41			interpreting there.
42			They said,
43			]no it's okay,
44			we've got our ALOs,
45			our ALOs will do interpreting and—
46			And it was like,
47			]Nah that's not gonna work.
48			Nah nah,

49			and they just said,
50			]Oh well,
51			we'll ring you,
52			if we need you.
53	Maria	0:24:07	[And they did.]
54	Francesca	0:24:07	[Sure enough,]
55			they had to ring us,
56			because she wasn't answering,
57			to the ALOs,
58			because ..
59			I think even with their Kriol,
60			Kimberley Western Kriol,
61			was still,
62			too confronting for her.

(FF19072017)

Such institutional resistance to the use of interpreters creates tension and is not conducive to the provision of culturally safe care to Aboriginal patients. Doane and Varcoe (2005) assert that attending to cultural differences "cannot be overlooked, discounted, erased, or trivialized – they must be taken seriously" (p. 304). However, when conceptualisation of culture is narrow in scope there is a tendency to construe culture as static or fixed and as a consequence particular behaviours, values and beliefs are inherent to particular groups (Doane & Varcoe, 2005; Kirkham et al., 2002). This attribution of certain cultural traits to different ethno-cultural groups singles out those traits that are perceived as different from the assumed dominant norm. Culturalist discourses help shape mainstream and Aboriginal assumed identities by constructing a binary between Other cultures and Western cultures (Narayan, 2000). Ahmad (1993) explicates that by 'defining the Other (usually as inferior) one implicitly defines oneself against that definition (usually as normal or superior).' With reference to culturalist discourse about Aboriginal people, McConaghy (2000) contends:

> ... frequently these images and stereotypes limit and contain Indigenous people and prevent them from attaining material and symbolic gains. In a real sense, these images objectify and de-humanise Indigenous people … It is this notion of culture which allows Indigenous people to be othered in colonialism (p.83).

Health practitioners may draw upon "discourses that construct people in ways that reflect popularized negative stereotypes" (Browne et al., 2011, p. 161). As we have seen, such othering of Aboriginal patients finds expression in several small stories through the use of generic references to Aboriginal patients as in Extract 12 where doctors may refer to them generically as 'some people' and hence make gross generalisations about Aboriginal patients. Therefore, as Downing and Kowal (2011) note "by creating a false dichotomy of cultures – 'us' and 'them' – there is a risk of generating and perpetuating power imbalances in health service provision in which certain cultural beliefs of mores are privileged over others" (p. 8).

In the context of providing healthcare to Aboriginal patients, attentiveness to issues of cultural sensitivity is a major priority (Downing et al., 2011; Freeman et al., 2014; Henderson et al., 2011). Cultural sensitivity is typically based on notions of 'liberal tolerance' (Doane & Varcoe, 2005, p. 160). However, as McConaghy (2000) argues this term is loaded with negative connotations: "The tolerance and intolerance binary masks the more significant underlying binary of the tolerating majority and the tolerated minority, a power-laden division which lies at the heart of Australian [and we would add Canadian] multiculturalism" (emphasis in the original, p. 41). Central to the notion of liberal tolerance is the creation of an ambivalence toward the Other (Henry & Tator, 2010). This is often externalised as either an expression of admiration or disdain for different cultural differences (Furniss, 2000). In the narrative data set, culturally distinct ways of healing have been branded non-normative as evidenced in Extract 6 by the non-Indigenous health practitioners' resolve to have the Aboriginal patient undergo psychological assessment after their having sought a traditional healer. Similarly, the use of culturally specific terminology for private body parts in Extract 4 is considered 'crude, slang or crass', and in Extract 3 the term 'titty feeding' is treated with disdain.

Dwyer, Kelly, Willis, Mackean, Battersby, Pekarsky, and Glover (2011) identify lack of coordination and continuity of care as particularly problematic and contend that

they contribute to problems faced by Aboriginal patients when transferring between hospitals. Two rural staff in this study commented on these problems by stating:

> You can see how nervous they are; they don't know where they're going, they don't know what's at the other end and they don't know who's going to be standing there for them (RA2) (p. 10)

Dwyer et al., (2011) found that staff often lacked knowledge of other health providers and operated in isolation or as "'two worlds' that don't work together" (p. 2). Therefore, problems arise for patients being transferred from hospitals in terms of coordination of their transfer and continuity of their care because "unreliable assumptions are made about the roles of other care providers" (p. 2). As Gary illustrated in the 'unofficial Kriol interpreting' story in Extract 12, such hospital transfers may be exacerbated when there is insufficient information provided to a patient and communication difficulties are not resolved through the use of a trained interpreter.

This section has shown that medical interpreters and ALOs sometimes have their professional identity questioned, undermined or dismissed. Instead of commissioning medical interpreters as a first resort, they may be commissioned only when the communicative encounter breaks down following the "preferential use of unofficial interpreters (family members) for convenience" (Ralph et al., 2017, p. 9). Such resistance towards a joint cooperation between health practitioners and professional interpreters may construct Discourses related to an 'us and them dichotomy' which positions health practitioners in opposition to interpreters or ALOs. This positioning in effect impacts the duty-of-care of Aboriginal patients. As Ralph et al. (2017) assert "inadequate uptake of interpreters is emerging as a leading knowledge practice gap nationally and internationally" (p. 10).

The finding from this analysis feed into the following section, which discusses ways in which medical interpreters overcome some of the difficulties they encounter by positioning themselves as educators and facilitators or learners.

5.5 Educator and learner

He rang me up,
and he said,
]Melanie I've got this patient,
she keeps saying,
she wants the DJillawa[8].
What is she talking about.

5.5.1 Melanie and Lenny's story

The following stories instantiate Discourses that help construct the multiple positions that ALOS and interpreters invoke as they undertake to train staff members or educate Aboriginal patients. Extract 15, the 'Don't make assumptions' story gives prominence to educating staff members on strategies they can use in instances when there is breakdown in communication when staff members do not understand what the patient is saying. This Extract was offered as part of a discussion on educating and empowering treating teams. ALO Melanie, who works in a metropolitan hospital in Victoria, is responsible for the provision of training to intern students and as part of this training she explicates how she accentuates the importance of not making assumptions. She reiterates the necessity of making enquiries in an attempt to educate the interns by instructing them to 'ask, send an email, ask us' (lines 7-9). This discussion prompts Melanie's interactional move from this argumentative sequence to the offering a story. The main characters in the 'Don't make assumptions story' are ALO Melanie, who is both narrator and protagonist, a male nurse, and a female Aboriginal patient. The student interns are indirectly referred to in the story world, as they are the original audience for whom the story was intended. The setting is the emergency department of a metropolitan hospital and this is where the story unfolds. The story is presented in full below in Extract 15.

[8] *DJillawa - toilet

Extract 15: The ‘don’t make assumptions’ story

1	Melanie	1:13:00	So,
2			I'd rather people a:sk,
3			than make assumptions.
4			So,
5			that's what I told the,
6			Intern students on Friday.
7			Ask,
8			send an email,
9			ask us.
10			Don't make assumptions,
11			about things.
12			Ask.
13			And if somebody's—
14			I was telling the example,
15			of a male nurse in the ED.
16			He rang me up,
17			and he said,
18			⌉Melanie I've got this patient,
19			she keeps saying,
20			she wants the DJillawa*.
21			What is she talking about.
22			Okay,
23			she's been asking me,
24			for about fifteen,
25			twenty minutes.
26			⌉‘Cause she wants to go,
27			to the toilet.
28			And he goes,
29			⌉Oh my god,
30			she's probably busting.
31			I said,
32			^Yes [LAUGH],
33			she probably is.
34			And he got off the phone.
35	Lenny	1:13:27	[LAUGH]
36	Maria	1:13:27	[LAUGH]
37	Melanie	1:13:28	And he rang me back.
38			And I said to him.
39			If somebody talks—
40			Says a word,
41			an Aboriginal word,
42			that you don't understand.
43			Ask them.
44			It's okay,
45			to ask them.
46			Say,
47			I’m really sorry Aunt.
48			Or,

49			I'm really sorry Mrs <##>.
50			But I'm not sure what word,
51			you're asking me in English.
52			Or y' know.
53			A simple—
54			Or,
55			I could be—
56			Y' know,
57			I don't know the language.
58			Can you explain to me.
59			And they'll probably tell you,
60			they need to go,
61			to the toilet.
62			Or they need to go,
63			and have a wee [LAUGH]
64	Maria	1:13:52	[Yeah yeah.]
65	Melanie	1:13:52	[or whatever.]
66			So um—
67			Yeah.
68	Maria	1:13:54	[The poor woman.]
69	Melanie	1:13:54	[She was busting]
70			He goes,
71			]She keeps asking,
72			And I said,
73			Well,
74			]What are you doing.
75			And I just laughed.
76			She needs to go,
77			To the toilet
78			And he goes,
79			Oh my God—
80			Yeah.
81	Maria	1:14:05	[LAUGH}
82	Lenny	1:14:05	I know,
83			I know.
84	Melanie	1:14:06	She was nearly beside—
85			She went crook,
86			went I went and seen her.
87			She was going,
88			]The stupid thing,
89			I just wanted,
90			To have a wee.
91	Lenny	1:14:13	[LAUGH]
92	Maria	1:14:13	[LAUGH]
93	Melanie	1:14:14	Mind you,
94			She was full of the goods.
95			She'd had about,
96			a slab of Jim Beam.
97			Or something.
98	Maria	1:14:14	Oh right.

99	Melanie	1:14:15	And,
100			she was a character.
101			She loved him though.
102			So I said to him ..
103			⌉It's okay to ask the person,
104			I'm really sorry,
105			but I don't understand,
106			what that word is.
107			How else are you gonna learn?
108	Lenny	1:14:25	Or I say sometimes,
109			can you say it,
110			a different way.
111	Melanie	1:14:30	[Yeah] yeah.
112	Maria	1:14:30	[Yeah.]

*DJillawa – toilet (NBB01052017)

5.5.1.2 Level I positioning – at the level of the story

Melanie the narrator, positions herself as educator and the nurse as learner and this positioning is constructed through the actions attributed to the nurse. He invokes the position of a learner and consults Melanie when he is confounded by the Aboriginal patient's persistent request to use the 'dJillawa' (lines 16-20). Melanie interprets the meaning of the lexeme for the nurse with 'cause she wants to go to the toilet' (lines 26-27). This revelation stuns the nurse as he comes to realise the urgency of the situation with 'oh my God, she's probably busting' (lines 29-30). Melanie agrees, and this prompts him to abruptly end the conversation with Melanie so as to consult with his patient immediately to ensure that her needs are met.

Extract 15a:

16	Melanie	He rang me up,
17		and he said,
18		⌉Melanie I've got this patient,
19		she keeps saying,
20		she wants the DJillawa*.
21		What is she talking about.
22		Okay,
23		she's been asking me,
24		for about fifteen,
25		twenty minutes.
26		'Cause she wants to go,
27		to the toilet.

28			And he goes,
29			]Oh my god,
30			she's probably busting.
31			I said,
32			^Yes[LAUGH],
33			she probably is.
34			And he got off the phone.
35	Lenny	1:13:27	[LAUGH]
36	Maria	1:13:27	[LAUGH]

As represented by Melanie, the nurse feels compelled to ring her back potentially to acknowledge her assistance, or to thank her and this reflects on his professionalism as well as his re-invoking his positioning as a learner. The nurse's positioning as learner makes available a position as educator for Melanie. As such, Melanie construes this as an opportunity to extend her expertise in treating Aboriginal patients and positions herself as uniquely qualified to do so. She is positively oriented towards the nurse and offers a series of strategies to help resolve instances when treating teams are unable to comprehend Aboriginal words or phrases.

Melanie, the narrator, assigns certain attributes to Melanie, the character. She comes across as agentive in her resolve to educate the nurse and does this directly and in a non-intrusive and non-patronising manner. In a hypothetical statement (lines 39-43), Melanie suggests that the male nurse should not hesitate to ask when he does not understand. The directives in this exchange are instructive and designed to facilitate communication (lines 37-63) with Aboriginal patients.

Extract 15b:

37	Melanie	1:13:28	And he rang me back.
38			And I said to him.
39			If somebody talks—
40			Says a word,
41			an Aboriginal word,
42			that you don't understand.
43			Ask them.
44			It's okay,

45			to ask them.
46			Say,
47			I’m really sorry Aunt.
48			Or,
49			I’m really sorry Mrs <##>.
50			But I’m not sure what word,
51			you’re asking me in English.
52			Or y’ know.
53			A simple—
54			Or,
55			I could be—
56			Y’ know,
57			I don’t know the language.
58			Can you explain to me.
59			And they’ll probably tell you,
60			they need to go,
61			to the toilet.
62			Or they need to go,
63			and have a wee [LAUGH],
64	Maria	1:13:52	[Yeah yeah.]
65	Melanie	1:13:52	[or whatever.]

Melanie steps outside the story world and offers a shortened version of the same story (lines 66-79) and this reinforces the urgency that the patient must have felt at not being able to relieve herself. In line 84, Melanie resumes the story at the point in time when she visits the Aboriginal patient in order to shed light on the Aboriginal patient’s evaluation of the nurse. The actions and words attributed to the Aboriginal patient accentuate the exasperation that she felt at not having been understood. For instance, upon the ALO visiting her, ‘she was nearly beside— [herself], she went crook’ (lines 84-85) and the choice of the negative modifier ‘stupid’, in ‘the stupid thing’ (line 88) renders the nurse as ignorant. Even though the Aboriginal patient is presented as being negatively oriented towards the nurse through her lexical choices, the narrator Melanie mitigates the force of the Aboriginal patient’s response through the vivid portrayal of the Aboriginal patient as being intoxicated at the time the incident takes place (lines 95-96). Despite this portrayal, Melanie remains positively aligned to the patient, describing her as ‘a character’ (line 100) who held no hard feelings towards the nurse. She concludes with an evaluation: “she loved him though” (line 101).

Extract 15c:

84	Melanie	1:14:06	She was nearly beside—
85			She went crook,
86			went I went and seen her.
87			She was going,
88			⌉The stupid thing,
89			I just wanted,
90			To have a wee.
91	Lenny	1:14:13	[LAUGH]
92	Maria	1:14:13	[LAUGH]
93	Melanie	1:14:14	Mind you,
94			She was full of the goods.
95			She'd had about,
96			a slab of Jim Beam.
97			Or something.
98	Maria	1:14:14	Oh right.
99	Melanie	1:14:15	And,
100			she was a character.
101			She loved him though.

The next section explores how Melanie, the narrator constructs this positioning linguistically within the ongoing interaction and the story world.

5.5.1.3 Level II positioning – at the level of the interaction

At this level of positioning analysis, in the interactional context, before offering the 'don't make assumptions' story, Melanie initiates a discussion on educating treating teams on how to engage with Aboriginal people. In Extract 15d, she explains how different disciplines within the hospital setting work together, whether that be on a formal basis or an informal basis such as when conversing in the corridor.

Extract 15d:

1	Melanie	01:12:22	Yeah well,
2			met one of your girls,
3			the other day,
4			and yadda yadda yadda.
5			Tell a story.
6			And you don't realise,
7			But at the time,
8			You don't realise,

```
9                       but you're educating about
10                      How to work with,
11                      Aboriginal people.
```

In Extract 15e, which follows on from the discussion on educating treating teams in Extract 15d, Melanie prefaces her story by reinforcing the importance of asking rather than making assumptions (lines 1-3) and situates the story in the context of training intern students. What follows is a series of directives offered as two consecutive three-part structures (lines, 7-9 and lines 10-13). The parallel structures in lines 7-9 allow both speaker and hearer to orient to the three-part structure and establish the class of actions that are being invoked (Jefferson, 1990, Lerner, 1994). The list provides a sense of the kinds of things that the interns can do when faced with breakdown in communication. The second list (lines 10-13) has two parallel structures, but the third part undergoes "de-listing" through a change in the imperative structure of the first two parts. Jefferson (1990) asserts that a three-part list can "orient [speakers and hearers] to such matters as a 'weak', 'absent', or 'missing' third part" (p. 63). In this case the weak third part is initiated with the hypothetical truncated fragment 'and if somebody's—' which as Jefferson (1991) claims may be "used to accomplish particular interactional work, such as topic-shifting …" (p. 63); in this instance it signals the telling of the story that promptly commences in Extract 15e. lines 14-15.

Extract 15e:

```
1    Melanie   1:13:00  So,
2                       I'd rather people a:sk,
3                       than make assumptions.
4                       So,
5                       that's what I told the,
6                       intern students on Friday.
7                       Ask,
8                       send an email,
9                       ask us.
10                      Don't make assumptions,
11                      about things.
12                      Ask.
```

13 And if somebody's—
14 I was telling the example,
15 of a male nurse in the ED.

In Extract 15f, we can see that from the onset, Melanie uses constructed dialogue to dramatise the phone interaction she had with the nurse. This shift into constructed dialogue is marked by changes in prosody; particularly, Melanie's high-pitched voice in line 18 and lines 29 where she animates the nurse's voice and in line 26 where she animates her own voice. This stretch of constructed dialogue lays out the positioning Melanie the narrator attributes to the main characters; that of educator for Melanie the character and that of a learner for the nurse. The nurse reinforces this positioning through the sense of bewilderment he experiences at not being able to understand the patient's request to use the 'DJillawa' (lines 28-25).

Extract 15f:

18 ⌉Melanie I've got this patient,
19 she keeps saying,
20 she wants the DJillawa*.
21 What is she talking about.
22 Okay,
23 she's been asking me,
24 for about fifteen,
25 twenty minutes.
26 ⌉'Cause she wants to go,
27 to the toilet.
28 And he goes,
29 ⌉Oh my god,
30 she's probably busting.
31 I said,
32 ^Yes [LAUGH],
33 she probably is.
34 And he got off the phone.

The sense of bafflement is reinforced through the nurse's lexical and syntactic choices in line 19, 'she keeps saying'; here the English aspectual construction keep + V-ing functions like "a kind of progressive marker" (Biber & Quirk, 1999, p. 746). In this

case, the action of ‘saying’ in ‘keep saying’ seems to be iterative, repeated over and over again (Quirk, Greenbaum, Leech, & Svartvik, 1985). This has the effect of heightening the mutual sense of helplessness the nurse and the Aboriginal patient are experiencing; on the one hand, the patient’s repeated requests are not met, and on the other hand, the nurse comes to a growing realisation that he is ill-equipped to help his patient. The action in ‘she’s been asking me’ extends over time through the use of the perfect progressive and the durative adverbial phrase, ‘for about fifteen, twenty minutes’ (lines 24-25). This syntactic choice helps to construct the continuous event as bound to the present in the story world, creating a sense of urgency. This sense of urgency is once again heightened with the exclamatory clause ‘ˈOh my god,’ (line 29) that marks the nurse’s moment of revelation. The story is momentarily interrupted, as the second participant Lenny and the interviewer, Maria, laugh concurrently indicating their involvement in Melanie’s story. Laughter can be employed to mark validation or agreement of another’s speaker’s previous turn (Ragan, 1990). Here, it also signals solidarity with her positioning as educator and facilitator.

Upon return to the story world, the nurse rings Melanie back and this initiates a series of directives. As discussed in level I positioning analysis, Melanie adopts the position of educator and the nurse that of a learner and this mutual acknowledgement of one another’s positioning allows Melanie to issue directives without feeling the need to always mitigate the strength or force of the directive by employing subtler lexico-grammatical means. Brown and Levinson (1987) and Myer (1989) argue that directives are often perceived to be marked and constructed in interaction, and the choices speakers make are dependent on an appraisal of social relationships along the continuum of social distance and relative power. For example, the directives Melanie issues range from imperatives as in ‘Ask them’ (line 43) ‘Say’ (line 46), and directives using mitigators such as ‘It’s okay’ in ‘It’s okay to ask them’ (lines 44-45) and ‘It’s okay to ask the person’ (line 103). In this way, in line with Reinhardt (2010) she

"distances [herself] from the source of the obligation while indirectly building solidarity and involvement, as well as projecting a measure of subjectivity onto the directed-listener" (p. 99). The next section looks at how Melanie makes use of the 'Don't make assumptions' story to convey a sense of who she is. It also examines the potential link between Melanie's local positioning in the story world with the underlying social issues and dominant Discourses as they find expression in additional small stories and the existing literature.

5.5.1.4 Level III positioning – addressing the question of "Who am I?"

By analysing the 'Don't make assumptions' story through the lens of level III positioning, we have seen that Melanie's professional self is closely linked to her positioning as educator and facilitator as she navigates her communication with a staff member in order to reiterate the importance of reaching out for assistance when communication barriers between themselves and Aboriginal patients emerge. In response to the question "Who am I?" we can see how Melanie navigates her identity through Bamberg's (2011) three dilemmatic spaces. The first, *constancy and change*, sees Melanie portraying a coherent self as she reinforces her role as educator and facilitator throughout the story. This is achieved through the use of directives, which appear in the preface of the story (lines 7-12) and are then repeated within the story world to the nurse (39-63 and 103-106). The second space, that of *uniqueness in comparison with others,* has Melanie align professionally with the male nurse who is also a fellow staff member. In this sense, the interactional context in which the directives are offered is amongst 'equals' and this potentially explains Melanie's laughter (line 32, 63 and 75) which functions to mitigate the force of the directive (Holmes, 2000). This use of humour serves to maintain collegiality and attends to the nurse's negative face. Melanie also emerges as distinct from the nurse given her role as an ALO, which is closely associated with the third dilemmatic space. In terms of the third dilemmatic space, *the management of agency of the self in the world,* we can see

that Melanie's agency rests with herself as she uses her extensive expertise and level of communicative competence with respect to communicating with Aboriginal patients to claim the positioning as educator. This positioning allows her to issue what can be construed as direct imperatives to the nurse, which in other contexts may have been perceived as face-threatening acts. However, given the social structures that are in place in institutional settings that acknowledge the role of the ALO as cultural broker and advocate of Aboriginal patients, Melanie's agency also rests, as Bamberg (2011) maintains, within contextual and social forces. This is evidenced by the fact that the nurse acknowledges the ALO's status and the validity of her advice and these directives are positively received.

As I have illustrated, the positions of educator, facilitator and learner emerge in Melanie' story and these are further explored in additional stories narrated by other interpreters and ALOs.

5.5.2 Rachel's story

Extract 16, the 'Give her time to answer' story is offered by Rachel, an ALO, who invokes this story to highlight the kinds of strategies that mainstream staff members are encouraged to implement when faced with communication difficulties. The setting is a hospital in regional Victoria and the main characters are ALO Rachel, who is narrator and protagonist, the mainstream health practitioners, and a female Aboriginal patient who speaks English as her fifth language (line 3). This patient has been admitted into hospital after suffering multiple strokes (line 5). The most recent stroke has left her suffering from a speech impediment, which has impacted her ability to speak English (lines 6-12). Rachel details how she educates staff around their communicative encounters with this patient.

Extract 16: The 'give her time to answer' story

1	Rachel	19:30.9	So one person whose,
2			Whose Eng—
3			English is her fifth language?
4			Um,
5			she's had strokes.
6			The first thing that went,
7			was English language component.
8			So she understands it.
9			You couldn't speak it.
10			So when she gets stressed,
11			and really unwell,
12			she can't speak it.
13			So.
14			And then she gets frustrated,
15			which actually makes it worse.
16			It's kind of like,
17			a catch twenty-two for her.
18			So what I do is—
19			I'll say,
20			to them,
21			Y' know,
22			⌉If she's had enough of me,
23			and she doesn't want,
24			anything to .. do with me.
25			Okay so,
26			⌉I can't come down there,
27			right now.
28			However,
29			this is what you need to do.
30			Um.
31			Talk a bit ^slower.
32			But don't be—
33			don't be …
34			^offensive with it.
35			Like,
36			there's no need to be ^patronising.
37	Maria	20:08.8	Yeah.
38	Rachel	20:09.5	She's a very very smart,
39			intelligent woman.
40	Rachel	20:11.7	So you migh—
41			I'll say,
42			Um.
43			Her,
44			Y' know—
45			just er provide
46			p—
47			Y' know,
48			piece of paper

49			for her to draw,
50			if need be.
51	Maria	20:20.0	Yeah.
52	Rachel	20:20.4	Um provide um.
53			Y' know.
54			Talk a little bit ^slower.
55			^Don't just rattle the stuff at her,
56			and give her ^time to ..
57			^answer.
58			So that's probably,
59			one of the ^big:est things.
60			Probably one of the biggest things,
61			is giving her ^time to ..
62			^answer.
63	Maria	20:31.8	Yeah.
64	Rachel	20:32.4	Ask her a question,
65			and say,
66			It's okay,
67			you can take your time.
68			And give her time.
69			Don't just sit there,
70			and go in there,
71			for ten minutes.
72			And think you're going to have,
73			^all the answers,
74			and walk out.
75			She wo—
76			She's not going to give you that,
77			in ten minutes.
78	Maria	20:41.6	Mm Mhm Mhm.
79	Rachel	20:42.1	She might not be able to say,
80			^hello to you,
81			in ten minutes.
82			So just,
83			yeah,
84			just do do that.
85	Maria	20:44.8	It's amazing yeah.

(RW06122017)

This story draws parallels with the ‘Don’t make assumptions story’ (Extract, 15) in that both Melanie and Rachel issue directives to health practitioners when educating and training them on culturally appropriate ways of communicating with Aboriginal patients. Like Melanie, Rachel employs imperatives when discussing ways to talk with the Aboriginal patient in order to underscore the importance of ‘giving her time to answer’. The directives Melanie uses are syntactically positive as in ‘Ask them’ and

softened imperatives such as ‘It’s okay to ask them’ (Extract 15, lines 43-45) (Bryant, 1944, p. 178). On the other hand, Rachel employs a series of parallel structures including positive and negative imperatives as can be seen in the Extracts presented in 16a.

Extract 16a:

```
31                  Talk a bit ^slower.
32                  But don't be—
33                  don't be …
34                  ^offensive with it.
…
54                  Talk a little bit ^slower.
55                  ^Don't just rattle the stuff at her,
56                  and give her ^time to  ..
57                  ^answer.
…
66                  It's okay,
67                  you can take your time.
68                  And give her time.
69                  ^Don't just sit there,
70                  and go in there,
71                  for ten minutes.
72                  And think you're going to have,
73                  ^all the answers,
74                  and walk out.
```

As Kent and Kendrick (2016) explain imperatives not only instruct the recipient to “perform the directed actions, enforcing the relevance of [their] production, but they also “tacitly treat the absence of the action as a noticeable failure for which the recipient is being held accountable” (p. 279). Therefore, the alternation of positive and negative imperatives as well as the use of prosodic stress in lines (31, 34, 55, 57, and 69), locate the health practitioners’ current actions with respect to their communication practices with the Aboriginal patient in the past as inappropriate and not currently relevant. The educator versus learner positioning also constitutes the social context in which these kinds of “tacit accountability directives” are able to be effectively given and received, as they fall into the arena of “socializing novices into socially normative behaviors”

(Kent & Kendrick, 2016, p. 284); in this case, the mainstream health practitioners may implicitly be deemed as novices in relation to their communicative competence when treating Aboriginal patients.

5.5.3 Lenny's story

In the next Extract, the 'acutely ill' story, Lenny is an ALO, who is an Aboriginal English and English speaker. She is currently working in a metropolitan hospital in Victoria, although she previously has worked in remote communities where English is typically the second language of almost all her clients. In this Extract, she narrates a story about educating treating teams on culturally appropriate ways of conversing about taboo topics such as death. The main characters are ALO Lenny, and the treating team in the sub-acute ward of the hospital. The complete story is presented in Extract 17 below.

Extract 17: The 'acutely ill' story

1	Lenny	0:12:32	Um.
2			Yeah actually,
3			a patient that I've been,
4			dealing with,
5			for a long time?
6			Um,
7			Recently was,
8			Acutely acutely ill.
9			Um,
10			But he was in a sub-acute,
11			ward.
12			And they actually asked me,
13			to come over,
14			and consult with,
15			the treating team,
16			on how .. they should approach.
17			Um,
18			Because it looked like,
19			he was gonna pass away.
20	Maria	0:12:59	Mhm.
21	Lenny	0:12:59	How should they approach that?
22			What the needs of of—
23			the patient and the family,

24			would be,
25			at that time?
26			And,
27			generally like,
28			ways to speak.
29			Um,
30			especially …
31			in the Northern territory,
32			and in Western Australia,
33			it's after,
34			someone has passed away?
35			It's it’s taboo,
36			to say their name out loud.
37			You probably,
38			might have heard that,
39			a lot.
40			But yeah,
41			Um.
42			So,
43			and that was something
44			that they were not aware of,
45			on the ward here.
46			Um.
47			And you know,
48			just talking to them about,
49			you know,
50			the actions that,
51			the family might wanna take,
52			with regards to a smoking ceremony.
53	Maria	0:13:40	Yeah yeah.

(NBB01052017)

Similar patterns emerge, as the ‘acutely ill story’ mirrors the ‘don’t make assumptions story’. The treating team are positioned as learners and seek counsel on ways to broach the subject of death with the patient and the family, from Lenny, who is oriented as an educator. In the story world, Lenny offers specific advice on ways of referring to a deceased Aboriginal person; for instance, she advises the treating team that ‘it’s it’s taboo, to say their name out loud’ (lines 35-36). Two focal points of interest in this story that reinforce the respective positions of learner and educator are firstly, the treating team’s lack of awareness of taboos related to death and secondly, their

willingness to learn about culturally appropriate ways of talking about deceased persons.

5.5.4 Alicia's story

In another Extract, the 'we don't make decisions in one day' story Alicia, an interpreter of Aboriginal languages including Gooniyandi, Walmajarri and Kriol, offers a hypothetical small story about having to educate doctors on the necessity of allowing Aboriginal patients and their families time to absorb information. In this story the main characters are Alicia and a hypothetical doctor. In the hypothetical story world, Alicia's role as interpreter enables her to approach the doctor in a forthright manner when communication differences impede a patient's treatment. The complete story is presented below in Extract 18.

Extract 18 'We don't make decisions in one day' story

1	Alicia	0:36:23	Well,
2			you've got to explain,
3			to the doctor,
4			and say,
5			]look,
6			it's it's not a one,
7			straight off thing,
8			for one day,
9			things happen,
10			it takes a lot of time.
11	Maria	0:36:47	Mm-hm.
12	Alicia	_00:36:47	Yeah, took four days for—
13			for families to get together,
14			to discuss,
15			the importance of,
16			their family member's ..
17			health condition.
18			and it doesn't—
19			We we don't make decisions,
20			in one day.
21	Maria	0:36:49	Yes, yeah.
22			That's important.
23	Alicia	0:36:49	Making them understand,
24			that this is how …
25			we communicate.
26			This is how we work.

27	Maria	0:36:54	Yeah.
28			Yeah yeah.
29			So—
30	Alicia	0:36:58	We don't rush rush.
31	Maria	0:36:59	That's right, that's right.
32			And I think,
33			that's the problem with doctors.
34			They expect answers,
35			straight away.

(AL19072017)

As educator, Alicia invokes constructed dialogue to animate her own voice explaining to the doctor the significance of allowing time for Aboriginal patients and their families to make decisions (lines 5-10).

Extract 18a:

5		]look,
6		it’s it's not a one,
7		straight off thing,
8		for one day,
9		things happen,
10		it takes a lot of time.

This notion is reiterated through the adoption of adverbial phrases such as ‘takes a lot of time’ (line 10), ‘took for days’ (line 12), and the repetition for emphasis of lexical choices such as ‘we don’t rush rush’ (line 30).

In the same way that ALO Sarah, in the ‘Cut foot story’ refers to ‘our mob’ to construct a sense of shared identity with Aboriginal people, Alicia uses the 1st person plural inclusive pronoun ‘we’ in ‘We we don’t make decisions, in one day.’ (lines 19-20), ‘this is how … we communicate’ (lines 24-25), ‘This is how we work’ (lines 26) and ‘We don’t rush rush’ (Line 30) to construct a shared way of talking for Aboriginal people and to underscore the manner in which interpreters of Aboriginal languages do their work.

5.5.5 Jill's story

In the subsequent Extract, the 'I am not sick one' story, Jill, an interpreter of Aboriginal languages including Gooniyandi, Walmajarri and Kriol, offers a story about educating Aboriginal women on the necessity to attend regular gynaecological check-ups. The main characters are interpreter Jill, a doctor, Jill's mother and other women from their community who are referred to by Aboriginal kinship terms such 'mum' and 'aunt'. Jill has been commissioned to inform women in the local community about an ensuing doctor's appointment where they would undergo a preventative screening test for cervical cancer. The complete story is presented in full below.

Extract 19: The 'I'm not sick one' story

1	Jill	0:11:31	Well,
2			there's some taboo about,
3			Um, you know,
4			how when,
5			they're women check-up.
6			You know,
7			There's—
8			This is a good example,
9			as well.
10			See?
11			You know how,
12			when they have um,
13			pap smears?
14	Maria	0:11:49	[Yes.]
15	Jill	0:11:49	[The] doctors,
16			at one point,
17			a couple years ago.
18			I worked with this doctor,
19			and we had to go,
20			around communities,
21			and you know,
22			there was a list of women's names,
23			that wanted check-up.
24			So,
25			I went to my mother's community,
26			And um,
27			her name was on the list.
28			And there was ..
29			other ladies,
30			that are from our language group,
31			on the list,
32			as well.

33			And all I—
34			my job was,
35			to just tell them,
36			your name came up.
37			This check-up has to be done,
38			at the clinic.
39			Ah,
40			Doctor so and so,
41			gonna check you all,
42			and they looked at me.
43			And you know,
44			I said,
45			It’s that woman check-up.
46			You know,
47			when you have babies,
48			your private parts.
49	Maria	00:12:31	[Mhm]
50	Jill	00:12:31	[I had] to say it in a way
51			that I wasn't making,
52			^fun of them.
53	Maria	0:12:34	[Yeah]
54	Jill	0:12:34	[And you] know,
55			I said um,
56			We use the word name.
57			like wadi wadi.
58			if I'm talking to my mothers,
59			or aunts,
60			I’ll have to use,
61			the word wadi wadi.
62			Wadi wadi parts.
63			Or to—
64			You know,
65			because that's like ah,
66			personal—
67			body body parts.
68	Maria	0:12:48	Yes.
69	Jill	0:12:49	Private parts. [LAUGH]
70			And anyway,
71			they understood that part,
72			‘cause I didn't have to,
73			use the word cervical cancer.
74	Maria	0:13:10	[Yeah.]
75	Jill	0:13:10	[I don’t] use um,
76			whatever word the doctors use.
77			And then,
78			They looked at me.
79			Because they were older,
80			than me.
81			They said,
82			no.

83	Maria	0:13:14	Oh Wow.
84	Jill	0:13:15	What was that doctor,
85			gonna look at me?
86			I am not sick one,
87			'Cause they—
88			'Cause they thought,
89			There was no need,
90			for them,
91			to have ^any check-ups,
92			in their private parts.
93			you know the—
94			You know for cancer,
95			in the uterus,
96			or whatever whatever—
97			they call it?
98	Maria	0:13:37	Yep yep yep.
99	Jill	0:13:38	And um,
100			And I—
101			And I explained to them,
102			in language,
103			and I said to them,
104			You gotta go for—
105			You know,
106			In case something might—
107			They might find something—
108			In simple way,
109			I interpret it to them.
110	Maria	0:13:42	Yes.
111	Jill	0:13:42	And some said yes.
112			Some said no.
113			And late on, when—
114			When the ones,
115			who didn't go,
116			to get checked.
117			You know,
118			they realized,
119			they got very sick.
120			I didn't have to force them.
121			I just basically,
122			interpreted for them.
123			That this is gonna happen today,
124			and if they come up,
125			but because they were my mums,
126			I couldn't really .. force them.
127			Some were my aunt,
128			you know?
129	Maria	0:14:19	Yeah.
130	Jill	0:14:19	So, I said to the— [LAUGH]
131			I said to them.
132			Let's go up.

133			And see the specialist.
134			If you don't want to,
135			well then,
136			it's up to you.
137	Maria	0:14:24	That's right.
138			I mean,
139			you can't force anybody.
140	Jill	0:14:27	Yeah, you can't force anybody.
141	Maria	0:14:29	That's right.

(JJ19072017)

Jill employs constructed dialogue (lines 39-48) and animates her voice as she broaches the topic of the gynaecological check-up with the Aboriginal women in her community. As Clark and Gerrif (1990) and Holt (1996) assert, constructed dialogue serves as a type of demonstration, providing the interviewer with direct access to the interaction under discussion. In this case, as evidenced in Extract 18a, it enables the interviewer to experience the difficulties that Shahid, Finn and Thompson (2009) report as being involved in broaching taboo topics such as one's private body parts with Aboriginal people.

Extract 18a:

39	Jill		Ah,
40			Doctor so and so,
41			gonna check you all,
42			and they looked at me.
43			And you know,
44			I said,
45			It's that woman check-up.
46			You know,
47			when you have babies,
48			your private parts.
49	Maria	00:12:31	[Mhm]

Jill positions herself as educator and facilitator as she attempts to frame cultural difference in ways to which Aboriginal people can relate. She is cautious not to dumb down the information or undermine the Aboriginal women's intellectual standards as she steps momentarily out of the story world and explains to Maria 'I had to say it in a way, that it wasn't making fun of them' (lines 50-52).

Extract 18b:

50	Jill	00:12:31	[I had] to say it in a way
51			that I wasn't making,
52			^fun of them.
53	Maria	0:12:34	[Yeah]

As an integral part of framing cultural difference, Jill draws on their shared cultural heritage and upholds perceptions of cultural appropriateness by choosing to use the term ‘wadi wadi’ for making reference to private body parts (lines 56-62). Linked to this, is Jill’s decision to consciously avoid using the taboo term ‘cancer’ as she refrains from using ‘whatever word the doctors use’ (line 76).

Despite Jill’s tentative approach to the subject of preventative screening for cervical cancer, there are other factors at play that are potential barriers to seeking treatment or medical care. As discussed in Chapter 3, section 3.5, the provision of information to Aboriginal and Torres Strait Islander patients entails taking into consideration the patients’ cultural beliefs and practices that pertain to relationships that guide communication. This involves having an understanding of network relationships in a particular community and knowing to whom it is appropriate to dispense information (McGrath et al., 2005). These restrictions, which are based on customary law, substantiate Jill’s explanation that the Aboriginal women’s initial refusal to seek treatment was potentially because of their age difference and classificatory relationship, which implicitly points to their being in a wrong kinship relationship. This may explain the Aboriginal women’s initial refusal to take up the request to undergo the proposed check-up and Jill’s inability to make them comply with the doctor’s request as is shown in Extracts 18c, lines 77-82 and again later in Extract 18d, lines 125-128.

Extract 18c:

75	Jill	0:13:10	[I don’t] use um,
76			whatever word the doctors use.
77	Jill		And then,
78			they looked at me.
79			Because they were older,

80			than me.
81			They said,
82			no.

Extract 18d:

125			but because they were my mums,
126			I couldn't really .. force them.
127			Some were my aunt,
128			you know?

In Extract 18e, Jill shifts into constructed dialogue and animates one of the Aboriginal woman's voices with:

Extract 18b:

84	Jill	0:13:15	What was that doctor,
85			gonna look at me?
86			I am not sick one,

This small snippet of constructed dialogue is particularly revealing. Rather than seeing this check-up as a preventative measure, it seems that the Aboriginal women are constructing a causal relationship between visiting a doctor and being diagnosed as 'sick'. As Taylor, Smith, Dimer, Wilson, Thomas and Thompson (2010) assert, this correlation may be a result of the association of continuous media coverage of the poor Aboriginal and Torres Strait Islander health statistics with this segment of the population's reluctance to seek diagnosis and medical treatment for chronic illness and disease. This may also mean that in some cases, Aboriginal and Torres Strait Islander social identity is closely intertwined with a narrative of deficit and disadvantage that forefronts the prevalence of disparity and illness (Fogarty & Lowitja Institute, 2018).

As a part of educating the Aboriginal women, Jill speaks in more practical terms and interprets for them 'in language … in simple way I interpret it to them' (line 102, lines 108-109). Jill explains the preventative nature of the screening test with 'in case something might—, they might find something' (lines 106-107). Her conscious omission of the word 'cancer' and her decision to use circumlocution illustrates the

importance of the avoidance of taboo topics. This is done in order to maintain cultural sensitivity and adhere to Aboriginal customary law. Finally, Jill acknowledges the Aboriginal women's agency and autonomy in their decision to engage with health services or not. She concedes 'but because they were my mums, I couldn't really .. force them. Some were my aunt, you know?' (lines 125-129).

What we have seen in level iii positioning is repeated storylines that show the positions of educator and learner being taken up by ALO Melanie, and other ALOs and interpreters as they narrate their own experiences of educating staff and Aboriginal patients. For Rachel, Lenny and Alicia, their stories are a point of departure from which they project their professional identities as educators; For instance, Rachel educates staff on ways to enhance communicative and cultural competence when conversing with Aboriginal patients. Lenny centres her story on educating treating staff on culturally acceptable ways of discussing taboo topics such as death; Alicia educates doctors on the necessity of allowing Aboriginal patients and their family members time to absorb and process information and finally, Jill's role as educator of Aboriginal patients is instantiated in her education of Aboriginal women on the necessity of preventive screening tests for cervical cancer.

Discourses pertaining to the necessity of educating mainstream staff and patients also emerge in the literature. In the Australian context, governmental bodies as well as policy-makers have focused on providing training for non-Indigenous mainstream health workers. Most recently, the *Cultural Respect Framework 2016–2016* was developed "to support the corporate health governance, organisational management and delivery of the Australian health system to further embed safe, accessible and culturally responsive services" (Australian Health Ministers' Advisory Council's National & Aboriginal and Torres Strait Islander Health Standing Committee, 2016, p. 4). The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Health Plan) and the *Implementation Plan for the National Aboriginal and Torres Strait Islander*

Health Plan 2013-2023 have been developed in collaboration with the National Health Leadership Forum and envisage to improve the wellbeing and health of this segment of the population. The Health Plan vision is as follows:

> The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031
> (Department of Health, 2015; Department of Health and Ageing, 2013, p. 1).

These efforts have been effected in order to reconcile the cultural differences between Aboriginal and Torres Strait Islander peoples and health service providers as part of the Australian government's initiative to Close the Gap (Holland, 2018). Thomson (2005) makes reference to a "cultural chasm" that is a barrier to positive health outcomes for Aboriginal and Torres Strait Islander peoples (p. 1). Non-Indigenous health workers also acknowledge the prevalence of this gap as evidenced by a survey conducted by Lowell (2001) who found that "82% [of those] who have contact with Aboriginal clients reported some difficulty in their interactions" (p. 34). Barriers such as racist or ethnocentric approaches to the provision of health have also been cited by Janzen et al., (2018) for First Nations people in rural Saskatchewan, Wilson (2008) for Māori people in Aotearoa New Zealand, and Brach and Fraser (2000) for minority Americans such as American Indians, Native Alaskans and African Americans.

As mentioned in section 3.6, approaches that are commonly adopted as part of Indigenous cultural training in Australia include: "cultural awareness, cultural competence, cultural respect, cultural security and cultural safety" (Downing & Kowal, 2011, p. 7). These programs serve two different purposes; for example, cultural awareness training programs tend to place emphasis on "individual behaviour change" while in a cultural security model the onus for the provision of culturally secure health

care is on "the system as a whole" (Downing & Kowal, 2011, p. 7). Downing and Kowal (2011) and Thomson (2005) explain the ways in which these approaches vary with:

> While a cultural safety training program usually emphasises processes of culture and identity formation in order to understand how the effects of colonialism manifest in the health system, cultural awareness training typically aims to enhance participants' knowledge of 'cultural, social and historical factors applying to Indigenous peoples' (Downing & Kowal, 2011, p. 7; Thomson, 2005, p. 3).

Downing, Kowal and Paradies' (2011) review of such approaches to Indigenous cultural training for health workers found that these programs generally have had limited impact in changing the health professionals' attitudes and behaviours. What is disconcerting is that there is little evidence as to whether this cultural training translates to "changes in health and wellbeing that follow from improved knowledge, attitudes and/or skills" (Downing et al., 2011, p. 254).

The interpreters' and ALOs' efforts to educate mainstream health practitioners, treating teams as well as Aboriginal patients falls under cultural awareness training. It appears that education takes place on an as needed basis with the intention to effectuate individual change. When it is undertaken on a more formal basis as a part of cultural awareness training, ALO Sarah acknowledges there are limitations to the kind of training on offer as training does not take place 'according to the cultural continuum' nor is it embedded in extant policy.

The following section addresses some of the communication differences medical interpreters and ALOS face and the approaches they adopt to help the facilitation of communicative encounters between health practitioners and Aboriginal patients.

5.6 Culturally Distinct Communication patterns

```
I'm obviously in my uniform,
and they'll look at me.
And I'll just go,
⌉No no no no,
let's start from the beginning.
I'm not asking you to tell me,
what ^I wanna hear.
We're trying to find out,
what's going on.
So we can send you home,
better.
```

The narrative positioning analysis thus far has established the multiple shifting positions the interpreters and ALOs adopt as they construct their professional identity around Discourses pertaining to ‘professionalism and accountability’, ‘differing worldviews and knowledge systems’, an ‘us and them dichotomy’ and ‘educator and learner’ positioning. By unpacking these Discourses, we have seen how the interpreters and ALOs contend with institutional resistance to the use of holistic medicine, or the use of professional interpreters; how interpreters and ALOs frame cultural difference as they navigate competing Discourses that stem form differing worldviews; and how working relations may become strained when the health practitioner’s positioning does not align with the interpreter’s, ALO’s or patient’s positioning. The stories in the following section, illustrate the positioning of the interpreters and ALOs as they construct Discourses surrounding the complexity of communicating in healthcare settings where they contend with different communication patterns that stem from culturally distinct ways of talking or behaving. The central theme that connects these stories is the positioning of the medical interpreters, ALOs and Aboriginal Service Development Worker, as they advocate for Aboriginal patterns of communication.

Extract 20, the ‘sitting, listening and talking’ story, is a habitual story that takes place in a metropolitan hospital in Victoria. The main characters are generic patients,

medical and nursing staff and Trudy, the English-speaking Aboriginal Service Development Worker who is both narrator and protagonist. Trudy's narration centres around communication practices pertaining to doctors' bedside consultations. The complete story is presented below.

5.6.1 Trudy's story

Extract 20: The sitting, listening and talking story

1	Trudy	00:19:30	I think sometimes sometimes,
2			doctors consultation bedside,
3			with ah patients,
4			can be short sharp.
5			You know,
6			little opportunity for,
7			ah one on one explanation.
8			Um. You know.
9			Because and and so I think
10			sometimes that
11			is not a practice that is um,
12			culturally respectful,
13			in our culture.
14			Because the thing is that,
15			when you have a conversation with,
16			um our people
17			there's a process of
18			like ..
19			Sitting listening talking.
20			And I think sometimes
21			the medical and nursing staff,
22			they don't understand that concept,
23			of um how how--
24			you know,
25			how you communicate together.
26			And you know,
27			I think that makes it difficult,
28			because quite often,
29			doctors will be in,
30			to talk to patients—
31			to my patients,
32			and then I'll go,
33			later in the afternoon,
34			and I'll say,
35			⌉Oh, what did the doctor say today.
36			And they will say,
37			⌉Ah I don't know,

I don't know,
but yet they've had,
a conversation bedside.
So then it means that,
I have to go and read the notes,
and then I have to poss—
Sometimes even call,
the the consultant,
or talk to the nurse.
And then I have to then,
go back.
And and and--
because I have the time,
to sit and respectfully—
it’s it's respectful
to sit with my own people,
and listen,
and I help to,
understand.
So then I sit and,
help them to understand.
what it is that—
what's the procedure,
that's going to happen.
What um,
you know,
are you worried,
do you have any,
you know,
concerns,
and you know
that’s that's
when you get to really know,
what's going on.
I think sometimes
doctors and nurses,
or people don’t allow—
the process doesn't allow them
to open up to that level.

Maria 00:21:20 Yeah,
I understand that.
So,
Instead of the three steps,
that you mentioned.
They just go to the,
talk section.

5.6.1.2 Level I positioning - at the level of the story

In Extract 20a, prior to embarking on her habitual story, Trudy, the Aboriginal Service Development Worker, situates the story in the context of bedside consultations with Aboriginal patients, which she characterises as being 'short' and 'sharp' (line 4). She highlights the adverse impact that such brief and potentially abrupt consultations can have on Aboriginal patients by noting that there is 'little opportunity for, ah one-on-one explanation" (lines 6-7). She then broaches the subject of culturally acceptable communication and listening behaviours to contrast existing practices that are deemed not to be 'culturally respectful' (line 12). Trudy aligns with her Aboriginal patients and identifies the intricacies of conversing with them. She explains that 'when you have a conversation with, um our people, there's a process of like .. sitting listening talking' (line 15-19). Trudy proceeds to distance herself from medical and nursing staff who she tentatively describes as not understanding this concept of 'how you communicate together' (line 21-25).

Extract 20a:

1	Trudy	00:19:30	I think sometimes sometimes,
2			doctors consultation bedside,
3			with ah patients,
4			can be short sharp.
5			You know,
6			little opportunity for,
7			ah one on one explanation.
8			Um. You know.
9			Because and and so I think
10			sometimes that
11			is not a practice that is um,
12			culturally respectful,
13			in our culture.
14			Because the thing is that,
15			when you have a conversation with,
16			um our people
17			there's a process of
18			like ..
19			Sitting listening talking.

And I think sometimes
the medical and nursing staff,
they don't understand that concept,
of um how how--
you know,
how you communicate together.

The habitual story ensues in line 26, and Trudy proceeds to elaborate on the difficulties that arise in light of the medical and nursing staff not understanding the concept of culturally respectful ways of communicating. Doctors are positioned as typically partaking in bedside conversations with patients; which the latter do not understand (lines 26-40). The patients are depicted as having little-to-no agency because despite their having had a consultation with the doctor, they have little to no comprehension of the subject matter pertaining to their medical condition, as evidenced in Extract 20b.

Extract 20b:

And you know,
I think that makes it difficult,
because quite often,
doctors will be in,
to talk to patients—
to my patients,
and then I'll go,
later in the afternoon,
and I'll say,
⌊Oh, what did the doctor say today.
And they will say,
⌊Ah I don't know,
I don't know,
but yet they've had,
a conversation bedside.

Trudy the character is positioned as an advocate for her Aboriginal patients. This positioning is constructed through the series of actions Trudy the character performs as evidenced in Extract 20c.

Extract 20c:

So then it means that,
I have to go and read the notes,
and then I have to poss—
Sometimes even call,
the the consultant,
or talk to the nurse.
And then I have to then,
go back.
And and and—
because I have the time,
to sit and respectfully—
it's it's respectful
to sit with my own people,
and listen,
and I help to,
understand.

…

I think sometimes
doctors and nurses,
or people don't allow—
the process doesn't allow them
to open up to that level.

Trudy the character feels obliged to 'go and read the notes', 'even call the the consultant, or talk to the nurse' and then 'go back' to the patient (41-48). Trudy's positive orientation towards and alignment with the Aboriginal patients is indexed through her lexical choices; for instance, 'my own people', the repetition of 'respectful' and 'respectfully' and 'help [them] to understand' to highlight the importance of embracing culturally appropriate communication and listening behaviours and providing what Lorié et al., (2017) refer to as "culturally competent empathetic care" when interacting with Aboriginal patients (p. 412). Trudy concludes that doctors and nurses or generic people are guided by processes that do not 'allow them to open up to that level' (lines 72-76).

I next explore how this habitual story is situated within the wider context of the ongoing talk. This entails focusing on how the interactive work develops between the participants in the interview setting and an analysis of how the subject matter and narrated events are constructed linguistically.

5.6.1.3 Level II positioning – at the level of the interaction

As mentioned in level 1 positioning, this habitual story is embedded within talk about the importance of employing culturally acceptable communication and listening behaviours while conducting bedside consultations with Aboriginal patients. The nature of the research setting allows Trudy to extend her expertise as an Aboriginal Service Development Worker. Trudy's professional identity as well as her identity as Aboriginal by descent, reinforce her positioning as an advocate for her people. In line with, Lin, Green, and Bessarab (2016), she uses her combined status to reorient existing communication practices to a more patient and person-centred framework. Trudy draws on her knowledge of 'how you communicate together' (line 25) by 'sitting, listening, talking' (line 19). Such culturally acceptable styles of communication are in effect "a conversational, relaxed, open-ended style of communication" (Lin et al., 2016, p. 378). Trudy underpins the importance of this way of communicating health information by shifting into constructed dialogue (lines 34-40).

Extract 20d

```
34                  and I'll say,
35                  ⌋Oh, what did the doctor say today.
36                  And they will say,
37                  <STRAINED VOICE QUALITY> ⌋I don't know,
38                  I don't know <STRAINED VOICE QUALITY>,
39                  but yet they've had,
40                  a conversation bedside.
```

Trudy as narrator, adopts a high pitch prior to initiating the turn initial ‘Oh’, which, as Heritage (1984) argues, indexes that the speaker has undergone “some kind of change in his or her locally current state of knowledge, information, orientation or awareness” (p. 299). In this instance, Trudy orients us to the imminent animation of her own voice as an Aboriginal Service Development Worker and then subsequently the voice of her patients. Trudy imputes an affective quality – a strained voice quality – on the voices of her patients and in doing so she provides the means by which she signals her affective stance – or “at least as it is perceived, evaluated, and reported in the reporting context” by the narrator (Hodges, 2015, p. 51). In this case, her affective stance indexes her consternation that the patient has had no understanding of their doctor’s prognosis of their condition even though ‘they had a conversation bedside’ (line 40).

Trudy as narrator then proceeds to outline the actions she takes as a morally responsible professional. This is in line with Van der Auwera and Plungian (1998) who assert that employing deontic modality indexes the actions of a morally responsible agent. This is evidenced within the following bolded parallel structures.

Extract 20e

42	**I have to go** and read the notes,
43	and then **I have to poss—**
44	Sometimes even **call,**
45	the the consultant,
46	or **talk** to the nurse.
47	And then **I have to** then,
48	**go back.**

The repetition of the parallel structure ‘I have to …’ accounts for Trudy’s self-imposed obligation to carry out the series of activities, which enable her to become informed about her patients’ prognosis. This series of events aid her in achieving the best outcome for her patients as evidenced in Extract 20f; the result of which is reinforced in

the repetition of the phrases ‘and I help to understand’ and ‘help them to understand .. what’s the procedure, that’s going to happen’ (lines 55-56, 58, 60-61).

Extract 20F:

```
49                  And and and--
50                  because I have the time,
51                  to sit and respectfully—
52                  it’s it's respectful
53                  to sit with my own people,
54                  and listen,
55                  and I help to,
56                  understand.
57                  So then I sit and,
58                  help them to understand.
59                  what it is that—
60                  what's the procedure,
61                  that's going to happen.
```

Thus in effect, Trudy is also positioned as an informational gatekeeper as she extends the medical information to her patients in a more coherent manner.

I now turn to level 3 positioning to show how Trudy navigates her identity though Bamberg’s (2011) three dilemmatic spaces in the ‘sitting, listening and talking story’ and the ‘I can’t read story’. I also illustrate the potential connections between Trudy’s local positioning in this story with other cultural Discourses and positioning that emerge as patterns in other stories and existing literature.

5.6.1.4 Level III positioning – addressing the question of “Who am I?”

In terms of level III positioning, prevalent Discourses emerge surrounding the complexity of communicating in healthcare settings, where ALO Trudy deals with different communication patterns that stem from culturally distinct ways of talking. Given the typically clinical nature of the conversations that unfold in the healthcare setting, health practitioners often adopt biomedical styles of communication rather than patient-centred communication patterns. Doctor-centred communication styles often

lead to unsatisfactory consultations between patients and doctors and typically result in non-compliance with proposed treatment. In contrast, the adoption of patient-centred communication patterns offer patients the space and time to convey relevant information to the doctor and to voice their concerns (Charlton et al., 2008; Slade et al., 2016). Trudy adopts the dual positions of patient advocate (Drennan & Swartz, 2002) and informational gatekeeper (Davidson, 2000, 2001) as she tries to bridge the communication differences that exist between health practitioners and Aboriginal patients. Trudy draws on the 'sitting, listening and talking story' and the 'I can't read story' to construct a Discourse pertaining to culturally distinct ways of talking to illustrate her positioning as advocate for her Aboriginal patients who have difficulties communicating. First of all, in terms of *constancy and change,* Trudy emerges as a relative stable entity over time as she consistently identifies with Aboriginal patients by indexing their collective Aboriginal identity. This is achieved through the use of indexical markers such as the first person singular and plural possessive pronouns 'my' and 'our' in such instances as 'in our culture' (line 13), 'our people' (line 16), 'my patients' (line 31) and 'my own people' (line 53). This conscious identification with her people instils in Trudy a duty-of-care to ensure that her patients reach an understanding of their illness and related treatment. The second dilemmatic space, that of *uniqueness in comparison with others,* has Trudy aligning positively with her Aboriginal patients as she reinforces her role as advocate while she accounts for objectifying styles of communication that occur during bedside consultations and impede communication. At the same time, she tentatively distances herself from professional staff by indirectly rendering them accountable for failing to communicate effectively with the Aboriginal patients. This is initially achieved through her lexical reference to the responsible agents as being 'doctors and nurses' or generic 'people'. However, she then initiates a self-repair and identifies the 'process' as not 'allow[ing] them to open up to that level'. In this manner, Trudy as narrator, mitigates the force of her assertion, and thus

addresses the face needs of the professional staff, while at the same time acknowledging the problem of inappropriate communication styles and listening behaviours. The third dilemmatic space, *the management of agency of the self in the world*, sees Trudy attributing her agency to self as her expertise as an Aboriginal Service Development Worker and her self-disclosed Aboriginal identity equip her to advocate for the Aboriginal patients in her care. However, given the institutional power differentials that exist in the hospital setting, Trudy's agency also rests within contextual and institutional forces that may partly determine her positioning, particularly in light of the her earlier self-repair that identifies the 'process' and not the hospital staff as responsible agents.

The following stories highlight the barriers to communication that interpreters and ALOs often face as they interpret or advocate for Aboriginal patients and the strategies they report they use to resolve them.

5.6.2 Trudy's stories

Extract 21, the 'I can't read' story, is a habitual story, also offered by Trudy, the Aboriginal Service Development Worker, as another account where communication difficulties need to be addressed in culturally sensitive ways. The main characters are Trudy, who is narrator and protagonist, generic patients, doctors and nurses. The context in which this habitual story emerges is a metropolitan hospital in Victoria where Trudy discusses barriers to communication such as illiteracy and the impact this may have on the communication encounter as well as on the patients themselves. The complete story is presented below.

Extract 21: 'I can't read' story

1	Trudy	0:03:04	Um you obviously—
2			um, you know,
3			um, you know
4			you obviously have—
5			I think it's more about,
6			having the communication—

7			the verbal communication,
8			rather than the written.
9			Um. The visu—
10			Sometimes it can be visual,
11			um things as well.
12			Writing it down.
13			Um. You know,
14			in most cases,
15			I will say to them,
16			]If I write information down,
17			will you be um able to—
18			will you be okay to—
19			to read that,
20			And because they're usually,
21			a patient that,
22			Um I've worked with,
23			and because they're Aboriginal
24			and I am,
25			they're comfortable in saying
26			I can't read
27	Maria	0:03:48	Yeah that's lovely.
28	Trudy	0:03:50	Okay in in in my case,
29			But I could—
30			It would—
31			It might be—
32			It might not be so forthcoming
33			when it's a a doctor,
34			or a nurse to
35			provide that information,
36			because they're too,
37			they're too shy,
38			to let them know
39			that they can't read or write.

(TT04022017)

This habitual small story bears comparison with the 'sitting, listening and talking story' in that Trudy draws on her identity as Aboriginal by descent as well as her professional expertise as an Aboriginal Service Development Worker to advocate for Aboriginal patients that have difficulties communicating when literacy, particularly 'written' communication is lacking. As Browne, et al., (2011) suggest, being presented with written information is often construed as foreign to some Aboriginal patients that have

been brought up in a largely oral tradition. In the story world, Trudy shifts into constructed dialogue where she animates a hypothetical scenario between herself and an Aboriginal patient. Trudy states that she would tentatively enquire about the patient's ability to read written material (lines 16-19) and this is because she would ask the question in a culturally prescribed and respectful manner. Trudy emphasises that the relationships cultivated with Aboriginal patients in the past are paramount in establishing trust and rapport with the patient as is their shared identity as Aboriginal people (lines 20-24). Finally, in line 26, Trudy animates the voice of the patient who is perceived as feeling 'comfortable in saying I can't read'.

Extract 21a:

```
15              I will say to them,
16              ⌉If I write information down,
17              will you be um able to—
18              will you be okay to—
19              to read that,
20              And because they're usually,
21              a patient that,
22              Um I've worked with,
23              and because they're Aboriginal
24              and I am,
25              they're comfortable in saying
26              I can't read.
```

This constructed hypothetical dialogue is juxtaposed with a further hypothetical dialogue where the patient 'might not be so forthcoming' (line 32) when presented with written information. This may be because as Trudgen (2000) and Cass et al., (2002) have found, practitioner-centred communication style may be interpreted as impolite and confrontational by Aboriginal people. This may also explain patients' reluctance to admit they are illiterate as in 'they're too shy to let them know that I can't read or write' (lines 37-39).

Extract 21b:

28	Trudy	0:03:50	Okay in in in my case,
29			but I could—
30			It would—
31			It might be—
32			It might not be so forthcoming
33			when it's a a doctor,
34			or a nurse to
35			provide that information,
36			because they're too,
37			they're too shy,
38			to let them know
39			that they can't read or write.

5.6.3 Sarah's story

The theme of communication differences that create difficulties in communication is further explored in the following habitual small story, 'it's not part of the storyline' (Extract 22), which emerges in the context of a discussion on syntactic patterns, particularly, certain question-types that Aboriginal patients may find more difficult to answer. The main characters are Sarah the narrator, generic doctors and generic Aboriginal patients. Sarah constructs a habitual story to explain that Western ways of asking questions in order to determine a prognosis or diagnosis through a structured series of questions, may be incongruent with Aboriginal people's knowledge systems and life experiences. The complete story is presented below.

Extract 22: 'It's not part of the storyline' story

1	Sarah	00:22:49	So um,
2			with the um ..
3			Like the Arnhem people,
4			people of Arnhem Land.
5			Um They—
6			If they get a diagnosis,
7			a new diagnosis,
8			it's not part of,
9			the story line.
10			So it's not part of,
11			the song line,

		or story line.
		So they need to know,
		when that illness,
		comes into that.
		And at what point?
		And they need to know,
		from the beginning.
		So a lot of the times,
		they won't accept,
		when they think,
		the doctor's lying.
Maria	00:23:23	[When?]
Sarah	00:23:23	[When] they s—
		Yeah.
		When ah—
		About the—
		Um, just say they got—
		Sorry.
		I'm not explaining this,
		very well.
		Um just say,
		they get a diagnosis of,
		diabetes again.
		Um,
		so they wanna know,
		when in that song line,
		did this-
Maria	00:23:25	Did the diabetes appear,
		Yeah yeah yeah yeah.
Sarah	00:23:26	Did this diabetes come.
		But,
		the doctor's not understanding,
		that part.
		All the doctor wants to know is,
		when did you start getting sick?
		When did you get this?
		When did you get that?
		Why are you here?
Maria	00:23:33	Yes.
Sarah	00:23:34	They don't really unders—
		And like,
		Aboriginal people need to know,
		from the start.
		And they need to know,
		who to blame.
		That's just part of culture.
		You know,

59			So, it could be someone's—
60			Someone’s put it on them,
61			in the community.
62			or you know, so—
63	Maria	00:23:41	Like a payback,
64			vengeance,
65			kind of thing,
66			yes.
67	Sarah	00:23:41	Yeah, yeah.
68			Um .. but yeah,
69			questions like—
70			Yeah, I understand,
71			what you're saying,
72			questions like that.
73			Um yeah,
74			a lot of the times,
75			Aboriginal people struggle with,
76			answering those things.
77			Yeah when and how.
78	Maria	00:23:46	How when what,
79			how long.
80	Sarah	00:23:57	‘Cause sometimes,
81			they're processing too.
82			Thinking when and how,
83			this happened,
84			and they don’t know themselves.
85	Maria	00:24:00	Yeah yeah.
86	Sarah	00:24:02	Yeah yeah.

(SD16012017)

In this Extract, we observe a shift in roles, as Sarah shifts from an argumentative sequence into narrative mode in order to explain that when doctors ask Aboriginal people of Arnhem land about the onset of a particular symptom or symptoms, the Aboriginal patients do not interpret this as a question that is designed to elicit vital biomedical information during the history taking stage of the consultation. For instance, this is evidenced in lines 45-49.

Extract 22a

```
45                    All the doctor wants to know is,
46                    when did you start getting sick.
47                    When did you get this.
48                    When did you get that.
49                    Why are you here.
```

Sarah notes that when Aboriginal Arnhem Land patients are given a new diagnosis, it is not received in a manner that is compatible with Western medical expectations; instead, the diagnosis is perceived as 'not [being] part of the storyline. It's not part of the song line' (lines 6-9). Therefore, Sarah advises that a viable response to 'when' for 'people of Arnhem Land' (line 4) would be one that determines when the illness becomes part of their storyline or song line.

Extract 22b

```
3                     Like the Arnhem people,
4                     people of Arnhem Land.
5                     Um They—
6                     If they get a diagnosis,
7                     a new diagnosis,
8                     it's not part of,
9                     the storyline.
10                    So it's not part of,
11                    the song line,
12                    or story line.
13                    So they need to know,
14                    when that illness,
15                    comes into that.
16                    And at what point?
17                    And they need to know,
18                    from the beginning.
```

Sarah's interpretation illustrates that she draws on her understanding of Aboriginal knowledge systems to outline the underlying impetus for such a response to a doctor's question about when a symptom occurred. She attributes the dispreferred response to the Aboriginal patients' invoking traditional belief systems about retribution; for example, 'they need to know who to blame. That's just part of culture' (lines 55-57).

This contrasts with the doctor's overall positioning in the story that 'they don't' really unders[tand]' (line 51) in Extract 22c. Such a position can be characterised as emanating from a medical professional's worldview, which finds such ideas on causation and retribution as rudimentary.

Extract 22c

51	Sarah	00:23:34	They don't really unders—
52			And like,
53			Aboriginal people need to know,
54			from the start.
55			And they need to know,
56			who to blame.
57			That's just part of culture.
58			You know,
59			So, it could be someone's—
60			Someone's put it on them,
61			in the community.
62			or you know, so—

As an ALO, Sarah is also positioned as being discerning of other potential explanations for why 'Aboriginal people struggle with answering those things. Yeah .. when and how' (lines 75-77). For example, she notes that 'they're processing too. Thinking when and how this happened, and they don't know themselves' (lines 81-84).

Extract 22d

73			Um yeah,
74			a lot of the times,
75			Aboriginal people struggle with,
76			answering those things.
77			Yeah .. when and how.
78	Maria	00:23:46	How when what,
79			how long.
80	Sarah	00:23:57	'Cause sometimes,
81			they're processing too.
82			Thinking when and how,
83			this happened,
84			and they don't know themselves.
85	Maria	00:24:00	Yeah yeah.
86	Sarah	00:24:02	Yeah yeah.

5.6.4 Katrina's story

Extract 23, the 'I am not asking you to tell me what I wanna hear' story is a hypothetical story that is also offered in the context of a discussion on syntactic question patterns. ALO Katrina discusses the efficacy of tag questions (lines 1-3). The main characters are generic Aboriginal patients and Katrina who is narrator and protagonist. Katrina is an ALO in a Metropolitan hospital in Victoria and speaks English and Aboriginal English. The complete story is presented in Extract 23 below.

Extract 23: 'I am not asking you to tell me what I wanna hear' story

1	Maria	00:24:52	How about questions like,
2			your left knee hurts,
3			doesn't it?
4	Katrina	00:24:56	Yeah.
5	Maria	00:24:57	Those confirmation—
6	Katrina	00:25:01	Yeah. No.
7			Not effective,
8			'cause they're gonna go,
9			yeah,
10			straight away.
11			They'll see the uniform.
12			And even with me too.
13			Even—
14			I'm obviously in my uniform,
15			and they'll look at me.
16			And I'll just go,
17			⌉No: no no no.
18			Let's start from the beginning.
19			I'm not asking you to tell me,
20			what ^I wanna hear.
21			We're trying to find out,
22			what's going on,
23			so we can send you home better.
24	Maria	00:25:22	Beautiful beautiful.

(NBB01052017)

Katrina is positioned as a facilitator in this communication encounter as she pre-empts Aboriginal patients' responses to questions containing question tags. Being conversant in Aboriginal English, Katrina is knowledgeable about syntactic question patterns that could pose comprehension difficulties. She anticipates that a question such as 'you're left knee hurts, doesn't it?'(lines 1-3) would produce an affirmative response from

Aboriginal patients who would answer ‘yeah, straight away’ (lines 9-10). Here, once again the incidence of gratuitous concurrence is prevalent (Eades, 1992, 2010, 2016 see section 3.5).

```
17                          ]No: no no no.
18                          Let's start from the beginning.
19                          I'm not asking you to tell me,
20                          what ^I wanna hear.
```

Katina is positioned as being discerning of Aboriginal patients’ tendency to offer responses that they feel the staff want to hear and thus shifts into constructed dialogue to animate her own voice making this observation in lines 17-20.

5.6.5 Sarah’s stories

Unlike the previous stories in this Chapter that explore the communication challenges facing medical interpreters and ALOs in hospital settings, the following story, the ‘teaching iPad’ small, presents strategies employed by ALOS to facilitate communication for Aboriginal patients. The main characters are ALO Sarah, who is both narrator and protagonist and Sarah’s manager. The context in which the story is offered is a discussion on the use of visual material as aids to verbal communication. This story occasions the emergence of a subsequent embedded story, ‘there’s nothing that’s Indigenous specific’ (Extract 25). The main characters are ALO Sarah and a female Aboriginal patient with cognitive impairment. Sarah shares the stories so as to highlight the necessity of supplementing verbal interaction with visual aids. The complete Extracts 23 and 24 are presented below.

Extract 24 ‘the teaching iPad’ story

```
1   Sarah  0:28:49  So um just recently,
2                  Um ..
3                  My my manager,
4                  has just um,
5                  got approval for me,
6                  to get a teaching iPad.
7                  So I show a lot of visual stuff,
```

8			as as we're going through,
9			yeah.
10	Maria	0:29:16	Mhm Mhm.

(SD16012017

In the first story, 'the teaching iPad' story, Sarah is positively oriented towards her manager who has recently granted her approval to obtain a teaching iPad (lines 4-7). This teaching iPad is perceived as an effective communication tool as Sarah consistently utilises visual material as she converses with Aboriginal patients (line 8). This story is the impetus for the 'there's nothing Indigenous specific' story presented in Extract 25.

Extract 25 'There's nothing that's Indigenous specific' story

11	Sarah	0:29:16	So,
12			the same mother,
13			that had the cognitive impairment,
14			she couldn't even say,
15			something simple like,
16			I wanna go downstairs.
17	Maria	0:29:18	[Yeah, wow.]
18	Sarah	0:29:18	[So she nee]ded cue cards.
19	Maria	0:29:18	Oh cue cards,
20			Picture cards showing—
21	Sarah	0:29:18	But there's nothing that's,
22			Indigenous specific.
23			Um,
24			Or—
25			I even looked at,
26			some of the cue cards,
27			and some of them were like,
28			I was like,
29			⌉What?
30			That's ^really asking me,
31			to go to the toilet?
32	Maria	0:29:54	[LAUGH] And you couldn't understand,
33			what it was.
34	Sarah	0:29:55	Yeah,
35			I couldn't understand it myself.
36			So—
37	Maria	0:29:55	So you're gonna design them,
38			are you?
39	Sarah	0:29:55	Hopefully yeah.

40			So things like um.
41			You know,
42			the C T G?
43			For monitoring baby inside.
44			So just something that has,
45			what it's called,
46			and what it does.
47	Maria	0:29:55	That's excellent.
48			That's excellent.
49			Yeah that's great,
50			yeah.
51	Sarah	0:43:01	Yeah.

(SD16012017)

In Extract 25, Sarah identifies the compelling need to create Indigenous specific material when one of her patients with cognitive impairment found mainstream cue cards designed to assist verbal comprehension as inadequate (lines 18-22). Sarah is positioned as resourceful because upon failing to understand what the mainstream cue cards were depicting (lines 25-35) she seeks to design her own cue cards that illustrate for instance what cardiotocography (CTG) is and what it does (lines 41-46).

Overall ALOs Trudy, Sarah and Katrina assert that effective communication entails constructing meaning in such a way as to reach agreement between the health practitioner and the Aboriginal patient. In line with Shahid et al., (2013), and as we have seen in section 5.2 *Differing worldviews and knowledge*, health practitioners and Aboriginal patients draw on their own "individual, physical, social and cultural orientations, prior knowledge, experiences, verbal and non-verbal communication styles (p. 2). As discussed in section 3.5, language is typically perceived as an impediment to communication particularly in instances when Aboriginal patients converse in Aboriginal English which differs from Standard Australian English in systematic ways (Eades, 2015). Popular assumptions about how language works tend to draw on culturally-based assumptions and as Eades (2015) notes these assumptions are not mutually shared across all sociocultural groups. For instance, in terms of obtaining information, Western-oriented communication styles make use of question-answer

formats common to interview formats as they are perceived as an efficient way of obtaining information; This expectation is central to communication in the legal process and to other mainstream institutional contexts, including communication in a medical context. However, many Aboriginal people have been socialised to employ more indirect means of communication such as "talking around a topic, hinting and waiting until the other person is ready to share information" (Eades, 2015, p. 46). What is more, direct questioning is often construed as confronting and impolite (Cass et al., 2002; Trudgen, 2000). Another common source of misunderstanding is interactional patterns such as gratuitous concurrence, where an Aboriginal patient finds it easier to respond with 'yes' than to admit to not comprehending the question or to a limited English proficiency. In such contexts 'yes' does not always mean 'yes' but instead serve as a means of appeasing the interlocutor and terminating the conversation without causing offence (Mitchell & Hussey, 2006; Westwood et al., 2008). Eades (2015) asserts that the prevalence of gratuitous concurrence is not limited to Aboriginal speakers who do not speak Standard Australian English well, but extends to Aboriginal people whose first language may be English. "There are cultural reasons at the heart of the widespread Aboriginal use of gratuitous concurrence, including a preference for withholding from contradiction during an interaction, and dealing with areas of disagreement over time, and where possible with some indirectness" (p. 47). Furthermore, silence is often perceived to indicate ignorance or reticence as in Western Anglo societies we are socialised to avoid long pauses or silences; however, as Carbaugh (1990) asserts silence is closely linked to cultural identities in Indigenous communities and is an indication of mutual respect (see section 3.5).

This Chapter has identified a range of Discourses the interpreters and ALOs construct to highlight the positions that they adopt as they navigate the challenges they encounter as they fulfil their respective roles. These positionings represent the interpreters' self-perceived roles and as such they constitute their perceived experiences

of interpreting in medical settings. This is one of the limitations of employing interview data; it becomes evident that at times the participants tend to report what they deem is ethically appropriate and as such might shape their responses to ensure that the researcher collects good examples. For instance, Jill in Extract 19 remarks 'this is a good example as well' (lines 8-9).

Although these Discourses have been analysed as distinct Discourses in this Chapter, in Chapter 7, the Discussion, I show that these Discourses overlap and interact with one another. The positioning analysis conducted in this Chapter also complements the following section that discusses interpreting in medical contexts, particularly, the difficulties that arise when English medical terminology and concepts have little or no equivalent in Aboriginal languages or vice versa.

Chapter 6 Interpreting in Medical settings

This chapter is motivated by the results of Chapter 5, narrative positioning analysis, that highlighted Discourses surrounding *culturally distinct communication patterns* that stem from differing *worldviews and knowledge systems*. The multiple shifting positions the interpreters and ALOs adopt as they claim the positions of educator, facilitator, informational gatekeeper or advocate of Aboriginal patients brings to the fore communication differences and challenges. Here I present the findings from a thematic analysis of the non-narrative data. These findings relate to the second research question (see section 4.1) that explores the strategies and actions interpreters of Aboriginal languages and ALOs report they use to resolve potential communication differences that may confound the interpreting process. In section 6.1, I first conduct an analysis of macro issues addressing the interpreters' and ALOS' reported experience of interacting with Aboriginal and Torres Strait Islander patients in order to gain an understanding of how they perceive the institutional issues that confound communication in an interpreter-mediated encounter. In section 6.2, I then undertake an analysis of micro

issues, examining communication differences and difficulties that emerge during interpreter-mediated encounters as perceived by medical interpreters and ALOs. These communication differences and difficulties stem from language-specific differences between Aboriginal languages and Standard Australian English (SAE) such as interpreting of single-word equivalents and false friends. Other challenges to interpreting that are discussed include medical terminology, taboo topics, differences in syntactic question structure and the effect of paralinguistic features in interpreter mediated interactions.

Section 6.1 discusses institutional issues that the participants present as impediments to interpreting in a medical setting and to communication between health practitioners and Aboriginal and Torres Strait Islander patients. The following recurring themes have been identified: service availability, low levels of utilisation of trained interpreters and time constraints. These themes are discussed below.

6.1 Analysis of macro issues: structural and institutional barriers

The structural and institutional barriers discussed in this section highlight some of the challenges that interpreters of Aboriginal languages face as they interpret for Aboriginal patients. These include the availability of interpreters in remote, regional and metropolitan areas, the low utilisation of accredited interpreters and the time constraints placed on interpreters during interpreter-mediated interactions. The following institutions are discussed in the following sections: Top End Health Services, which include Royal Darwin Hospital and other Northern Territory hospitals and clinics (Ralph et al., 2017); Aboriginal Interpreting WA (AIWA), located in Broome, which provides accredited interpreters in over 40 Western Australian Aboriginal languages (aiwaac.org.au, 2018); and Aboriginal Interpreter Services (AIS), located in Darwin and Alice Springs, that covers the major languages of the Northern Territory and an additional 100 languages and dialects (AIS, 2018).

6.1.1 Service availability

The service availability of interpreters of Aboriginal languages in Australia is variable and this is partially dependent on the availability of interpreting services in metropolitan, regional or remote areas. “Dedicated Indigenous language interpreter services” are currently only available in the Northern Territory and Western Australia. This is in stark contrast with the national Commonwealth funded Translating and Interpreter Service (TIS) that caters for migrant communities across Australia in more than 160 different languages (Commonwealth Ombudsman (Australia), 2016, p. 1).

In remote regions, there is a high concentration of Aboriginal and Torres Strait Islander people; for instance, according to the 2016 Census data, in the Northern Territory Aboriginal and Torres Strait Islander people comprise 25.5% of the population and 10% speak an Indigenous language at home (ABS, 2018). Even though some of these people may have some conversational English skills, an interpreter is nonetheless necessary to facilitate “complex medical communication, decision-making and for helping to mitigate alienating medical environments” (Ralph et al., 2017, p. 2).

In Top End Health Services, hospital policy stipulates against the use of family members as interpreters and advocates the utilisation of accredited interpreters (Ralph et al., 2017). Despite this, the dearth of accredited interpreters particularly for minority languages emerges as a prevalent Discourse in stories offered by the participants. Discourses pertaining to *institutional accountability* are a recurrent theme in the interview data set. For example, Sarah, an ALO in the Northern Territory is an English speaker who also has a working knowledge of Torres Strait Islander Kriol and Katherine Kriol. She explains in Extract 1 that the health institution regularly draws on the Aboriginal Interpreter Service yet there are occasions when non-completion of requests occurs for minority languages.

Extract 1

1	Sarah	00:04:06	Most interpreter services are avail—
2			Available twenty-four hours.
3			But there's an odd occasion,
4			where you can't get a language.
			(SD16012017)

Similarly, Annie an interpreter of Aboriginal languages in Western Australia who interprets for speakers of Walmajarri, Fitzroy Valley Kriol and Kimberley Valley Kriol, broaches the issue of lack of institutional funding for trained interpreters in Extract 2 below.

Extract 2:

1	Annie	09:17.1	And y' know. But um—
2			The hospital always like,
3			we don't have the funding or—
4			Y' know,
5			it's not in our budget,
6			to travel interpreters and—
			(AA18072017)

Ralph et al., (2017) explain that in the Northern Territory the main hospitals do not employ on-site interpreters and rely on a booking system that provides on-demand interpreters via the Aboriginal Interpreter Service. This has created barriers to access as the interpreter services are not "co-located geographically, with resultant lack of visibility and timeliness" (p. 9). The Commonwealth Ombudsman (2016) identified that there are "unique challenges" in the domain of Indigenous language interpreting and individuals and governmental agencies often are unable to access accredited interpreters even in instances when the need for an interpreter has been identified (p. 1). The interpreters and ALOs in this study identified cultural considerations that impact who may act as an interpreter. ALO Sarah, discusses the prevalence of avoidance and poison relationships that preclude interpreters from taking on interpreting assignments in Extract 3 below.

Extract 3:

1	Sarah	00:04:20	So .. um,
2			in Aboriginal groups,
3			we've got our um—
4			We've got our skin groups,
5			and your poison relatives.
6			So if you've—
7			If we've got an interpreter pool,
8			that's part of the poison relative,
9			to that patient,
10			they can't always do the job.

(SD16012017)

This is in line with Butcher (2008) who explains that in Northern Australia there are certain types of avoidance relationship and this type of relationship "typically forbids direct communication or even physical proximity between kinship relatives". [T]his is expressed linguistically in Australian Aboriginal English with "the prefix poison [that] is used to denote such relationships" (p. 637, emphasis in the original). Therefore, avoidance or poison relationships may be an impediment to direct interpreting. However, in Extract 4, Sarah goes on to discuss ways that such cultural kinship considerations may be accommodated by inquiring whether 'the interpreter is comfortable' doing the assignment in the event that a conflict relationship has been identified (lines 8-10). Another strategy put forward includes interpreting for a patient over the phone so 'you're not actually looking at each other', and in this way direct contact with the patient who is in the wrong kinship relationship is avoided (lines 15-16).

Extract 4:

1	Sarah	00:05:44	So, um.
2			So yeah,
3			if the interpreter has um ..
4			a conflict relationship,
5			or poison relationship,
6			with that particular patient.
7			We can do—

We can ask whether,
the interpreter is comfortable,
for doing interpreting,
over the phone.
So you're not actually talking,
or look—
Well you're talking,
but you're not actually looking,
at each other.

(SD16012017)

Aboriginal Interpreting WA (AIWA) and the Aboriginal Interpreter Service (AIS) try to minimise problems associated with avoidance relationships, gender and other kinship constraints through pre-assignment briefing sessions offered to interpreters prior to their allocation to a particular client. The pre-assignment briefing allows the interpreter to determine whether they are in the right kinship relationship to be able to carry out the assignment. It also enables the interpreter to clarify subject matter, and to negotiate meaning, particularly when English terms and concepts do not have an equivalent in the Aboriginal language (AIWA, 2018). This is in line with purpose-driven approaches to interpreting such as Skopos theory (Reiss & Vermeer, 1984/2014). As we have seen in section 3.1, in accordance with Skopos theory, the guiding principle in any translation is to ensure that the target text fulfils its designated purpose as set out in the commission or pre-assignment briefing. As Munday (2016) asserts, if the target text fulfils the purpose set out by the commission, it is "functionally and communicatively adequate" (p.84). In consonance with this guiding principle, is one of the stipulations in the *Protocol on Indigenous Interpreters for Commonwealth Government Agencies* (2017), which states that it is essential to allocate time between appointments so that briefing can "explain the context of the interaction to the interpreter, which allows them to ask questions and understand the nature of the interaction" (p.6).

6.1.2 Low levels of utilisation of accredited interpreters

Partially related to service availability is the low uptake of interpreters in healthcare settings. Ralph et al., (2017) found that there has been a downward trend in the number

of completed assignments by interpreters for Top End Health Services clients. The most common reasons cited for non-completion were “no interpreter available” or “interpreter did not show” (p.3). In some cases, there is reluctance from health practitioners within health institutions to call upon interpreters; instead, there is preferential use for unofficial interpreters such as relatives or family members as they are more readily available. This theme finds expression in Discourses pertaining to *institutional accountability* (section 5.2) and an *us and them dichotomy* (section 5.4) that are established in the narrative data. The theme also recurs in the non-narrative data set and is attested by several interpreters who work in the Northern Territory. Kriol interpreter Gary expresses his frustration at the preferential use of unofficial interpreters in Extract 5.

Extract 5:

1	Gary	0:33:59	My biggest difficulty,
2			with health interpreting in XX
3			is the actual—
4			How the hospital treats it.
5			That there's really not,
6			a big uptake.
7			That the hospital isn't—
8			Doesn't use interpreters well.
9			Doesn't think they need,
10			interpreters very much.
11			That they rely on family.
12			They think,
13			their own family's sufficient.
14			That they don't clearly understand,
15			the role of interpreters.
16			And they haven't had,
17			a good experience,
18			with good interpreters.

(GG12062017)

Gary touches upon several barriers to the use of interpreters; namely, that ‘the hospital doesn’t use interpreters well’, ‘they don’t think they need interpreters very much’ and that ‘they rely on family’ (lines 8-11). Gary attributes the low uptake of accredited

interpreters to firstly, the health practitioners or health institution not having a clear understanding of the role of interpreters and secondly, their not having 'had a good experience with good interpreters' (lines 15-18). Another interpreter, Annie, explains why Aboriginal Interpreting WA (AIWA) does not recommend the use of family members or friends as interpreters. In Extract 6 below, she underscores the importance of impartiality (line 4) and explains that placing the onus on the family member or friend to interpret can be emotionally taxing.

Extract 6:

1	Annie	05:13.7	Well I think,
2			family members and friends,
3			Um ..
4			Can't be impartial.
5			That's my opinion.
6			Um .. because their emotions,
7			and everything is all—
8			Y' know?
9	Maria	05:20.5	Yeah.
10	Annie	05:21.8	It's too much I think,
11			to ask a family or a friend
12			to act as an interpreter.

(AA18072017)

In Extract 7, Francesca, an interpreter of Aboriginal languages including Kriol and Walmajarri, also identifies the inherent dangers of using unofficial interpreters by pointing out that friends and family are not bound by the AUSIT code of ethics.

Extract 7:

1	Francesca	00:07:19	Yeah there's been—
2			I think that's where,
3			the mistake is.
4			That they don't realise,
5			that friends and family,
6			don't use the ethics.
7			Whereas interpreters,
8			are bound by ethics.
9			Which is,
10			confidentiality .. impartiality
11			accuracy.

(FF19072017)

Similarly, in Extract 8, Alison, an interpreter of Gooniyandi, Kriol, and Walmajarri brings up two additional issues that should preclude family members from interpreting; firstly, that there may be a conflict of interest (line 5), and secondly, they do not have the necessary training to understand medical terminology (lines 7-12).

Extract 8

1	Alicia	0:06:17	Because family—
2			Is confidential when you're interpreting
3			for family members.
4			It could be ..
5			a conflict of interest.
6			The family,
7			who hasn't been,
8			through training,
9			they have to have,
10			a really good understanding,
11			of medical terms,
12			that's used.

(AL19072017)

In Extract 9, Indigo, an interpreter of Walmajarri and Kriol, discloses that doctors tend to call upon family to act as interpreters. She acquiesces to their use only in instances when the family member understands the subject matter and is able to relay this information to the patient.

Extract 9:

1	Maria	0:02:16	Who do doctors usually call,
2			to act as an interpreter.
3	Indigo	0:02:20	Family—
4	Maria	0:02:22	Families,
5			Yeah.
6			How do you feel ..
7			about that.
8	Indigo	0:02:25	Well,
9			As long as the family member knows,
10			what the doctor ..
11			is talking about.
12			Because I think,
13			it’s the most important thing.
14			As long as the person knows,
15			what the doctor,
16			is talking about,
17			to relay information,

```
18                      back to the patient,
19                      and vice versa.
                                                    (II19072017)
```

In contrast, in metropolitan and regional areas in Australia the relatively small number of Aboriginal and Torres Strait Islander people speaking an Indigenous language is often cited as a reason why there is no need to commission an interpreter in hospitals. In the 2016 Census, in metropolitan areas such as Victoria, 0.8% of the state's population identified as being of Aboriginal or Torres Strait Islander descent, and of these 0.3% identified as speaking an Indigenous language at home (ABS, 2018b).

In Extract 10, ALO Rachel, who is an English speaker working in a regional hospital in Victoria claims that 'the majority of the people, that access this service have— um .. have good grasp of, the English language' (lines 2-5) and this seems to be the rationale for the use of family members as interpreters. She also explains that the Aboriginal languages that 'are utilised in Australia, are utilised by family groups' (lines 17-21) and this again appears to justify the use of family members.

Extract 10:

```
1   Rachel   16:22.3     We probably never—
2                       The majority of the people,
3                       that access this service have—
4                       Um .. have good grasp of,
5                       the English language
6                       And it's just around—
7                       It's usually around literacy.
8                       There has been a couple of people,
9                       that've come through,
10                      and they've had,
11                      very limited English.
12                      And …
13                      I think it would be a case of,
14                      is there a family member.
15                      It's just finding out
16                      who that family member is.
17                      And …
18                      like I was saying to you before,
19                      the the Aboriginal
20                      languages,
```

that ^are utilised,
in Australia,
are utilised by family groups.
So,
the the interpreter,
will be a family member.

(RW06122017)

In Extract 11, Trudy, an English-speaking Aboriginal Service Development Worker, based in a metropolitan hospital in Victoria explains that doctors may call on a friend or family, but the majority of the times 'it's the Aboriginal Service Development Worker or the Aboriginal Liaison Officer at the hospital' (lines 2-10) who interpret for Aboriginal patients. Trudy outlines the dual role that Aboriginal Service Development Workers and ALOs serve; to help the patient 'understand medical procedures, medical terminology' and to assist in educating medical nursing staff 'to provide plain English information so that it's understood easy' (lines 17-25).

Extract 11:

1	Trudy	00:01:05	So they um—
2			It may be a friend,
3			or a family of a patient.
4			And um in—
5			You know,
6			most of the cases also,
7			it's the Aboriginal,
8			Service Development Worker,
9			or the Aboriginal Liaison Officer
10			at the hospitals.
11			Ah …
12			because of the work,
13			that they have in,
14			um .. helping the patient.
15			And um ..
16			understand medical procedures,
17			medical terminology.
18			Um …
19			it's also our role to,
20			to help the um ..
21			medical nursing staff,
22			to provide,
23			um ..
24			plain English information,
25			so that it's understood easy.

(TT04022017a)

Melanie, an ALO in a metropolitan hospital in Victoria, who speaks English and Aboriginal English, also specifies that ‘very rarely do we have to engage with interpreters here in Victoria’ (lines 3-6). In Extract 12, however, Melanie narrates an instance when the need for an interpreter was identified, which necessitated commissioning ‘an Aboriginal Liaison Office from another state, say .. The Northern Territory’ (lines 12-13) or ‘using an interpreter, or using somebody, who understood language up there, who wasn't ^related” (lines 40-43). She does however, concede that the use of a family member is ‘not foolproof enough’ (lines 50-53).

Extract 12:

1	Melanie	0:07:58	If you're talking about
2			aboriginal .. community language,
3			very rarely,
4			do we have to engage,
5			with interpreters
6			here in Victoria.
7			Occasionally,
8			I've had two um patients,
9			that we've had to,
10			ring back their home.
11			And get um,
12			an Aboriginal Liaison Officer
13			From another state,
14			Say ..
15			The Northern Territory.
16			And um …
17			have the ALO interpret,
18			on a tele-conference.
19			To speak—
20			So there’s a doc—
21			The training team,
22			the patient,
23			myself,
24			and the ALO,
25			In wherever that patient,
26			comes from.
27			And they’ve had to do a little bit—
28			So that they could explore,
29			That the patient understood,
30			Why they’re in here.
31			And what was going on for them.
32			It—
33			The person did understand,

some English.
But to get across the um—
I guess—
The the extent of
the chronic illness,
they needed it,
to be very clear.
So the best way was around,
Um using an interpreter,
or using somebody,
who understood language up there,
who wasn't ^related.
So not um—
The interpreters,
it needs to be—
Often, people say,
]Oh my son can interpret,
for us.
You know.
but it's not foolproof enough.

(NBB01052017)

Interpreter Annie clarifies why family members and ALOs are not well-equipped to undertake the task of interpreting for Aboriginal patients. In Extract 13, she identifies limited English proficiency as impeding the accurate transmission of information to a patient by a family member; for instance, ‘they might just say yes no. They might need an interpreter themselves’ (lines 1-3). She explains that having basic English skills does not afford the family member the confidence to say ‘can you break that down’ (lines 18-20). She concludes that this is a skill that interpreters are trained to exercise (lines 22-23).

Extract 13:

1	Maria	06:06.0	Have you had instances where like,
2			there's not enough language there.
3			Between the family member,
4			and the doctor,
5			and what's interpreted.
6	Annie	06:16.0	Oh yeah yeah definitely.
7			Yeah yeah.
8			Yep. For sure.
9			Like they don't um—
10			Yeah they might just say,
11			yes no.

12			They might need,
13			an interpreter themselves.
14	Maria	06:28.6	[Mhm.]
15	Annie	06:29.6	[But] because they've got,
16			that basic English.
17			Ah they--
18			I don't think they'd feel,
19			confident enough to say,
20			can you break that down and--
21	Annie		Y' know,
22			whereas we are trained,
23			to do that.
24	Maria	06:40.4	That's right.
25			That's right.

(AA18072017)

In Extract 14, interpreter Annie proceeds to explain why the use of ALOs as interpreters is not always conducive to interpreting for Aboriginal patients. She highlights that being of Aboriginal descent does not automatically equate to being proficient in an Aboriginal language (lines 1-8). Annie acknowledges the value that most ALOs bring to the health sector, particularly their cultural competence as she states: 'they've got the cultural background' (line 15); however, she also identifies a segment of ALOs who have 'grown up in the city' (line 20), thus implicitly suggesting that they may not have the cultural and/or linguistic skillset to accommodate the communicative needs of Aboriginal patients. She concludes by reiterating the necessity of employing interpreters in lines 24-25.

Extract 14:

1	Annie	07:16.3	Sometimes they don't
2			have the language skills.
3			Y' know,
4			just because they're Aboriginal
5			doesn't mean that they speak ...
6	Maria	07:18.6	Mhm.
7			Mhm.
8	Annie	07:22.0	the language.
9	Maria	07:22.9	True.
10	Annie	07:23.5	It's good that,
11			they've got,
12			Aboriginal Liaison Officers.

13			'Cause then they—
14			Y' know.
15			They've got the cultural background,
16			most of them.
17			But some of them,
18	Maria	07:28.3	Mhm.
19	Annie	07:29.5	Y' know,
20			grown up in the city.
21	Maria	07:34.1	Mhm.
22	Annie	07:35.8	And so—
23			Yeah it's a bit tricky.
24			Like ^definitely,
25			get an interpreter.

(AA18072017)

In Extract 15, Melanie, Katrina and Lenny, who speak English and Aboriginal English, are ALOs working in a metropolitan hospital in Victoria. They discuss the preference for cultural interpreting in the hospital. Melanie draws on national accreditation guidelines for interpreters that stipulate that an interpreter must be unrelated to a patient (lines (1-4). She outlines reasons why this is important: she questions the accuracy of the information relayed to a patient and the difficulty of ascertaining whether this information is precise or not (lines 5-11). Katrina also brings up the issue of family members diluting information and she draws comparisons with interpreting for other community languages showing that similar issues prevail (lines 12-24).

Extract 15:

1	Lenny	00:09:10	Under the national accreditation
2			of interpreters,
3			it has to be an unrelated,
4			um person.
5			Because they could interpret
6			in a very different way,
7			to what's been said,
8			by the treating team.
9			And we have,
10			no way of knowing,

11			did they translate—
12	Katrina	00:09:28	Or they might want,
13			to dilute it
14	Lenny	00:09:30	or dilute it or--
15	Katrina	00:09:31	Well,
16			they're the same issues,
17			that um …
18			that interpreters have here,
19			like um,
20			Chinese interpreters or Italian.
21			The reasons that they will not let,
22			family members,
23			interpreters,
24			the same.

(NBB01052017)

In Extract 16, ALO Melanie also brings to the discussion her personal experience of working with young people in the maternity unit.

Extract 16:

1	Melanie	00:09:41	Um.
2			I know myself,
3			because I work with,
4			young people,
5			being in the maternity area.
6			I don't—
7			I don't use interpreters,
8			never needed to,
9			but I consider it,
10			my role more of,
11			a cultural interpreter.
12			So often,
13			there will be a situation,
14			where the midwives,
15			or the doctors,
16			don't understand,
17			that culturally,
18			what they're saying,
19			to someone,
20			or how they're,
21			treating someone,
22			is offensive to them,
23			or something.
24			So I have to interpret,
25			why they're feeling,
26			that way,
27			and a better way,

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28                          for them to approach,
29                          our clients.
                                                    (NBB01052017)
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She states that she does not use interpreters as the need has never arisen (lines 1-8). However, she continues to clarify that rather than interpreting linguistically for her patients she takes on the role of cultural interpreter (lines 9-11). She offers indicative examples of when she would enact this role as cultural interpreter. Firstly, she intervenes when health practitioners are unaware that their communication or behaviour is not culturally sensitive (lines 13-23). Secondly, Melanie explicates that her role entails explaining to staff why the patients are feeling this way and she then proceeds to educate them on 'a better way to approach our clients' (lines 24-29).

When comparing the roles that accredited interpreters and ad hoc interpreters (family members or friends) report fulfilling and the resultant clinical outcomes, Karliner et al., (2007) found that:

> professional interpreters are associated with an overall improvement of care for LEP patients. They appear to decrease communication errors, increase patient comprehension, equalize health care utilization, improve clinical outcomes, and increase satisfaction with communication and clinical services for limited English proficient patients (p. 748).

The systematic review by Brisset, et al., (2013) revealed that although many of the relational issues that Karliner et al., (2007) identified are valid, there are also other studies that temper these findings. Firstly, communication errors may not necessarily be negative especially when alternative renditions are made "to express empathy, find equivalent meanings, and coordinate speech" (Brisset et al., 2013, p. 138). Secondly, use of professional and ad hoc interpreters and associated levels of satisfaction are "not as linear" as Karliner's (2007) review suggests, as patient satisfaction "is a function of emotional distance and involvement" (p. 138). Finally, even though working with ad hoc interpreters may create issues such as "the loss of patient agenda", ad hoc

interpreters are also “appreciated by patients and can be seen as allies in the healthcare process by practitioners” (p. 138). Brisset, et al., (2013) conclude that the benefits of using informal interpreting should be acknowledged since health institutions and health practitioners utilise ad hoc interpreters. However, AIWA (2018) and AIS (2018) strongly discourage the use of untrained bilingual family members or friends by outlining the serious consequences that may ensue:

- breach of privacy and confidentiality
- lack of impartiality
- filtering of information to protect their relative or friends
- inability to cope with subject matter or specialised terminology

6.1.3 Time constraints as barriers to interpreting and establishing rapport

Another key theme emerging in the dataset is the importance of allowing adequate time for interpreting and time for relationship building amongst health practitioners and patients and non-Aboriginal staff and Aboriginal staff. As we have seen, this theme manifests in Discourses surrounding *differing worldviews and knowledge systems*, in the ‘cut foot story’ (section 5.3.1) and ‘I’m a big referee story’ (section 5.4.3) where the ALO Sarah discusses the importance of allowing Aboriginal patients time to process information. It also emerges in Discourses related to *educator and learner* positionings, where ALO Rachel highlights the necessity to allow patients time to answer questions directed at them in the ‘give her time to answer story’ (section 5.5.2). Alicia, an interpreter of Aboriginal languages including Gooniyandi, Walmajarri and Kriol, also educates doctors on allowing patients to absorb information in the ‘we don’t make decisions in one day’ story (section 5.5.4). Similarly, in Extract 17, Kriol interpreter Gary, expresses concern over the time pressures that are placed on interpreters when they are called to interpret for Aboriginal patients.

Extract 17:

1	Gary	00:15:48	If it's an interpreting situation,
2			it's kind of—
3			Most of the time,
4			You're pressed for time.
5			You can't go into,
6			A half hour expert,
7			sort of verification,
8			and explanation.
9			To make sure,
10			the patient or the client,
11			knows exactly what,
12			diabetes is.
13			Or what cancer is.
14			So,
15			you just sort of—
16			If it's it's a term that,
17			they are comfortable using.
18			Most times,
19			I would just go with it.
20			Ah ...
21			You don't have time,
22			to verify,
23			that their understanding,
24			is the same as yours.
25			Sometimes I might paraphrase,
26			and just add in,
27			a bit of explanation.
28			Especially if um,
29			it might be,
30			a certain type of cancer.
31			And you might just,
32			wanna add in,
33			a bit of extra info.
34			Um .. but you can't—
35			you don't really have time,
36			to go into too much—
37	Maria	00:16:45	Too much detail.
38			Yeah.
39	Gary	00:16:46	Verification.
40			Yeah.

(GG12062017)

In lines 3-8, Gary explains that there is insufficient time to provide an expert explanation or to verify information. He addresses the subjects of diabetes and cancer and suggests that if the patient is comfortable using the term [cancer], the interpreter

'just go[es] with it' (line 16-18). Gary offers examples of strategies he employs, including paraphrase and explication, particularly, in instances where the doctor is discussing a 'certain type of cancer' (lines 25-30). Finally, Gary's three-fold repetition of 'you don't have time' underscores the time constraints interpreters face as they are unable to provide verification of information to ensure that 'their [patients'] understanding is the same as yours' (lines 4; 21; 35).

With respect to building relationships and rapport with Aboriginal patients, ALO Trudy, delineates the importance of having culturally safe conversations with Aboriginal patients. In Extract 18, she notes that this requires investing time and effort into building up a relationship over 'a length of time' (line 8).

Extract 18

1	Trudy	00:18:38	And you know,
2			I find that,
3			I have those conversations,
4			with patients,
5			who who ..
6			have been patients,
7			here of mine for,
8			for a length of time.
9			And I've built up,
10			a bit of a,
11			Relationship with them.
12			And that they're not someone,
13			who is new to the um …
14			public health system.
15			They have been.
16			using it,
17			for years,
18			and years and years.
19			And they have a number of um,
20			diagnosis going on,
21			as well.

(TT04022017)

In Extract 19, Trudy goes on to discuss culturally safe practices that facilitate engaging with the patient.

Extract 19:

1	Trudy	00:21:20	and and and …
2			because I have the time,
3			to sit and respectfully—
4			it’s it's respectful,
5			to sit with my own people,
6			and listen,
7			and I help to understand.
8			So then,
9			I sit and help them,
10			to understand.
11			What it is that—
12			What's the procedure,
13			that's going to happen.
14			What um,
15			you know,
16			are you worried.
17			Do you have any,
18			you know,
19			concerns.
20			And you know,
21			that’s that's,
22			when you get to really know,
23			what's going on.
24			I think sometimes,
25			doctors and nurses,
26			or people don’t allow—
27			the process,
28			doesn't allow them,
29			to open up to,
30			that level.

(TT04022017)

For instance, she forefronts her allocating ‘the time to sit and respectfully … listen … and help them to understand’ (lines 1-7). Trudy’s empathetic conversations with her patients enable them to be more receptive to opening up and expressing their concerns. This is when, as Trudy points out, ‘you get to really know what’s going on’ (lines 20-23). As discussed in section 5.5, in the ‘sitting, listening and talking story’, Trudy attributes communication deficiencies with Aboriginal patients to institutional processes that ‘don’t allow them [health practitioners] to open up to, that level’ (lines 25-30).

This section has established that structural and institutional barriers such as time constraints tend to be systemic in health institutions and adversely impact the

interpreter-mediated encounter. Sturman, et al., (2018) assert that having to abide by the expectations and requirements relating to time allocation for interpreter-mediated sessions in health institutions, often results in interpreter-mediated consultations being rushed and this results in reducing their effectiveness. In addition, there is consensus amongst the interpreters and ALOs about the need for allocation of sufficient time for Aboriginal patients to absorb and process information. Thus, the current service delivery model with the existing time constraints is not always conducive to trust and rapport building with Aboriginal patients. This is confirmed by Mercer et al., (2014) who reiterate "the importance of adequate time for relationship building amongst non-Aboriginal staff and Aboriginal staff and clients" (p. 330).

The following section discusses challenges that arise when interpreting between Aboriginal languages and SAE and the strategies that the interpreters and ALOs use to facilitate communication.

6.2 Analysis of micro issues: communication differences & communication strategies

In Chapter 5, I illustrated how interpreters and ALOs construct Discourses surrounding *culturally distinct communication patterns* (section 7.2.4) and illustrate the complexities of communicating in healthcare settings. The interpreters and ALOs explain how they navigate different communication norms as they converse with Western medical practitioners and Aboriginal patients. These different communication patterns stem from Discourses related to *differing worldviews and knowledge systems* (section 5.3) that dictate culturally specific ways of talking. As discussed in section 3.5, language-specific differences between Aboriginal languages, including Aboriginal English and Standard Australian English (SAE) may lead to difficulties in interpretation of meaning. Vass et al., (2011) assert that English words or concepts that English speakers may consider to be simple or straightforward, in fact, "carry significant conceptual information" for which there may not be an equivalent in the English language or vice versa (p. 34). section 6.2 discusses communication differences and difficulties that stem

from language-specific differences between Aboriginal languages and Standard Australian English (SAE) such as interpreting of single-word equivalents and false friends. Additional challenges to interpreting that are discussed by the interpreters and ALOs include: interpreting medical terminology, taboo topics, differences in syntactic question structure and the effect of paralinguistic features in interpreter mediated interactions.

6.2.1 Single-word equivalents in English

The interpreters in this study have highlighted that interpreting goes beyond simply translating words from one language to the other. To illustrate this, they offer some indicative examples of interpreting difficulties that arise with the words *shame, risk, deadly, grab* and *Koorie.* Firstly, in Extract 1, interpreter Annie discuses single-word equivalents in English in particular the word *shame*, which has a different sense in Kriol.

Extract 1:

1	Annie	00:30:15	So,
2			shame to us is like,
3			]Hey stop getting shame.
4			Like,
5			don't be shy.
6			Just go and get a feed.
7			Help yourself,
8			or whatever.
9			So,
10			shy has a more positive meaning,
11			than shame—
12			Than shame in English.

(AA18072017)

Annie explains that *shame* translates more closely to ‘shy’ in Kriol (line 5). The strategy Annie uses to explain the Koori term is what Vinay and Darbelnet (1995) refer to as “adaptation”, where she attributes the sense of ‘shyness’ to the word *shame* and highlights that it is associated with more positive connotations than the SAE word s*hame*. This interpretation is supported by Moore (2014) who argues that although the

word *apure,* from Arrente, a language spoken Central Australia, is often translated as "shame" or "shamed" in SAE, the Eastern and Central Arrente to English Dictionary (Henderson & Dobson, 1994) provides additional senses of the word.

The dictionary entry includes cultural and contextual information surrounding *apure* which suggests that apart from "shyness, embarrassment, shame, [and] not knowing how to behave … having a degree of *apure* is a positive and healthy attitude and that the lack of *apure* is a social problem" (Moore, 2014; Morgan et al., 1997). Annie acknowledges the disparity in meaning in Extract 2.

Extract 2:

Annie	00:31:15	That's another English word, that's got, A completely different meaning.

(AA18072017)

Other scholars have acknowledged that the Aboriginal English word *shame* is a complex concept that is difficult to translate into SAE (Harkins, 1990; Morgan et al., 1997; Spencer & Schlemmer, 1997). Harkins (1990) explains that the concept of *shame* "describes situations in which a person has been singled out for any purpose, scolding or praise or simply attention, in which the person loses the security and anonymity provided by the group" (p. 10). The different senses that *shame* acquires in the different Aboriginal communities then necessitates understanding the speaker's intention and context when interpreting so as to be able to discern what meaning is used in a given context.

Another English expression that does not have an exact analogue in Aboriginal languages is the word *risk*. In Extract 3, ALO Sarah, remarks that 'there is no actual word for risk' (lines 14-15) and describing what risk involves 'is really hard' (line 20).

Extract 3:

1	Maria	00:32:15	Are there any words,
2			or ideas,
3			in traditional Aboriginal languages,
4			that you found difficult to explain,
5			or translate in English.

6	Sarah	00:32:19	Yeah, risk.
7	Maria	00:32:20	Risk. [Risk]?
8	Sarah	00:32:20	[Yeah].
9			You um—
10			One in ten people,
11			will have this,
12			your risk is—
13			So …
14			There's no actual word,
15			for risk.
16	Maria	00:32:24	Oh wow.
17	Sarah	00:32:24	There's no Aboriginal word,
18			for risk.
19			Ah so ...
20			Describing that is really hard,
21			Yeah,
22			and that's how we talk,
23			every day.
24			isn't it?
25			Among professionals—
26	Maria	00:32:28	Of course,
27			yeah.

(SD16012017)

In her first attempt to provide an equivalent, the interpreting strategy Annie offers is substitution. She provides the word *warning* which has an underlying connotation of a sense of readiness as illustrated below in Extract 4, lines 2-4, 10-11.

Extract 4:

1	Annie	1:09:19	We don't really use risk.
2			We'd more or less use,
3			another word for it.
4			Like a warning kind of thing.
5			A warning is another,
6			Kriol concept.
7	Maria	1:09:28	Is there a specific word,
8			you'd use?
9	Annie	1:09:43	Yes …
10			Be ready.
11			Like a warning.
12			You've got to start,
13			eating healthier,
14			otherwise …
15			you might get diabetes.
16			It's like a warning.

17			Be ready.
18			That's the risk.
19			Start eating healthy.
20			Look after yourself …
21			This and that.
22			That's a warning,
23			to be ready.
24			That's how we interpret risk.

(AA18072017)

In Extract 5, Annie points out that even the word *warning* has a different sense in SAE and clarifies that the Kriol word for *risk* has the sense of 'to be ready' or 'prepare yourself' (lines 8-9).

Extract 5:

1	Maria	01:10 21	So,
2			risk is interpreted,
3			in terms of a warning?
4	Annie	1:10:23	A warning means,
5			something completely different,
6			in [SAE] English,
7			That's our Kriol concept,
8			to be ready.
9			Prepare yourself.
10			That's where English speakers,
11			get it wrong.
12			That Kriol concept,
13			it's completely different,
14			to how we speak in general.
15			We might have a warning,
16			or be ready.
17			But it's not,
18			what it actually means,
19			In [SAE] English.
20	Maria	1:12:07	Yeah.
21			Because warning,
22			automatically flashes danger,
23			Whereas in this case,
24			it's not.
25			It's prepare yourself,
26			take the necessary steps,
27			to avoid something.
28	Annie	1:12:19	Exactly.

(AA18072017)

Additionally, Kriol interpreter Gary considers Aboriginal patients' understanding of the notion of *risk* as presented in Western medicine to be undermined by the patients' mistrust and wariness of the Western health system as a whole (lines 15-19; 21-23; 40-42).

Extract 6:

1	Gary	00:27:07	I think only maybe,
2			Yeah.
3			But maybe only,
4			because of the factor of,
5			how much you trust in,
6			Western medicine.
7			So,
8			as most Westerners,
9			we just have,
10			one hundred percent trust,
11			in what doctors tell us.
12			And what the risks are,
13			and that.
14			But if—
15			If your trust is partial,
16			or you're not very trusting,
17			of the underlying health system,
18			where that advice,
19			is coming from.
20			Then you might be—
21			The doctor might be,
22			talking to you,
23			about risks.
24			Um …
25			But you just—
26			But they just,
27			might not be as relevant—
28			Might not be as relevant,
29			to you.
30			Because if your trust,
31			is undermined any way,
32			in the whole system,
33			that you're finding yourself in.
34			Um .. then yeah,
35			the risks might not be,
36			well,
37			the risks that,
38			you're being told about,

you mightn't take—
You wouldn't take it seriously,
because you don't have,
as much trust in the system.

(GG12062017)

The difficulties that interpreter Annie experiences in locating a SAE equivalent may be attributed to the absence of a one-on-one equivalent in Walmajarri and Kriol. Lupton and Tulloch (2003) assert that the Western concept of *risk* is associated with negative ascriptions denoting "danger, hazard or threat" (p. 320). However, the word *risk* does not appear to exist in Aboriginal languages such as Kriol (Tulloch & Lupton, 2003, p. 320). Vass et al., (2011) found that for Yolŋu, the Aboriginal people of north-east Arnhem land, *risk* as an abstract notion seems to be absent in Yolŋu worldview. They observed that "[t]here appears to be no conceptual frameworks for understanding degree of risk, nor how multiple risk factors may interact with each other or vary in impact relative to time and exposure" (p. 36). In Yolŋu Matha, each situation is perceived to have "its own warning signs, actions to take and outcomes" (p. 36). This seems to also be true in Kriol where *risk* is interpreted as a sense of preparedness or readiness in a given context. Such an interpretation of the word *risk* may potentially have more macro consequences. This is because the Western conceptualisation of *risk* that underlies preventive health measures such as "screening, certain chronic disease medications and behavioural strategies" may have implications on Aboriginal patients' understanding of "mainstream health promotion messages or the relevance of health care to their immediate lives" (Vass et al., 2011, p. 36).

Annie's attempt at conveying the Kriol meaning of *risk* through the provision of the English equivalent *warning* or the phrase *preparedness or readiness* highlights her approach to interpreting. The interpreting strategies she employs fall in line with target-oriented and functionalist approaches to interpreting; in particular, the Interpretive Theory of translation that places emphasis on sense making. Although the theory calls for "total accuracy", this is achieved via the interpretation of meaning and not through

the transcoding of words (Seleskovitch, 1994, p. 102). As Seleskovitch (1994) explains the target message "must be geared to the recipient" (p. 9) and what becomes apparent is that Annie makes use of the target audience's background knowledge. In line with Pöchhacker (2016) Annie explains, paraphrases and simplifies "in order to achieve the communicative effect desired by the speaker" (p. 60). This culminates in the construction of a shared understanding of the word *risk* as 'prepare yourself, take the necessary steps, to avoid something' at the end of the Extract (Extract 5: lines 25-27).

The participants offered a few other examples of words that could be considered false friends. False friends typically have a common origin, sound the same but have different meanings. They may be understood in ways that may cause offence or breakdown in communication. These include the words *deadly* and *grab*. In Extract 7, Melanie the ALO, provides an interpretation of the word *deadly* as used in Aboriginal English.

Extract 7:

1	Melanie	0:04:47	So deadly,
2			to aboriginal people is a word,
3			this is great,
4			this is fantastic.
5			That's really good.
6			But into the eyes of,
7			non-aboriginal people,
8			that would be seen as,
9			poor taste and derogatory.

(NBB01052017)

The strategy she uses is explanation; *deadly* has the senses of 'great', 'fantastic' and 'really good' (lines 3-5). However, she also considers the potential contexts of use and concludes that in a non-Aboriginal setting, it 'would be seen as poor taste and derogatory' (lines 7-9).

In Extract 8, the word *grab* is offered by Kriol interpreter Gary to discuss the prevalence of false friends, which could contribute to communication difficulties.

Extract 8:

1	Gary	00:04:20	Young kids giving evidence,

2			that police,
3			grabbed them.
4	Maria	00:24:25	Yeah.
5	Gary	00:24:26	Which I think,
6			to a Standard Australian,
7			English speaker,
8			It's kind of forceful.
9			And I guess,
10			verging on violent.
11	Maria	00:04:30	Yes yes.
12	Gary	00:04:31	But for Aboriginal English,
13			it's not at all.
14			It's more just like,
15			a getting verb.
16			It doesn't really have,
17			that strength of connotation,
18			of maybe,
19			against someone's will.

(GG12062017)

He draws on the following example: 'Young kids giving evidence that police grabbed them' and illustrates that in Aboriginal English the verb does not carry the same 'violent' 'forceful' connotations that are attached to the verb in SAE (lines 1-3; 8-10). The use of the verb *grab* does not typically manifest in medical exchanges in the health settings; however, in the context of courtroom talk, Eades (2012) discusses the implications of assuming a literal interpretation of the word *grab* explaining that it contributes to "facilitating problematic interactions in court". She goes on to outline the adverse outcomes such literal interpretations may have "on the interpretation and understanding of what witnesses say" (p. 472).

In Extract 9, ALO Melanie makes the distinction that *Koori*[9] is a 'slang' term used for identifying Aboriginal people in Victoria and parts of New South Wales. She clarifies

[9] "'Koorie' derives from the word for 'people' in the indigenous languages of the coastal groups of central and northern New South Wales. It is the current group self-description of many people of indigenous descent living in Victoria and south-central New South Wales. Reverend L.E. Threlkeld first recorded the word as 'Ko-re' in his *An Australian grammar* (1834), after language research which was based on the Awabakal people of the Newcastle region. The word drifted south around 1900 as Aboriginal people travelled more widely in their now colonial world or were shifted about by white authorities. However, it remained a semi-secret self-identification in Victoria until its first public use for an 'Aborigines only' association, the Koori Club formed in Fitzroy in 1969. Despite lacking universal acceptance among Australians, including those of Aboriginal descent, Koorie is now used widely by individuals and associations in Melbourne. Its use reflects the resurgence of indigenous identities and cultures among those previously and erroneously claimed to have lost their culture. 'Koorie' exists alongside other indigenous words that define specific indigenous groups such as the Wurundjeri, while

that there are other terms used for Aboriginal people across the different states in Australia; for instance, ‘Murries’ and ‘Noongars’. She concludes that the co-existence of other Aboriginal words that define specific Aboriginal groups needs to be explained so as to ensure understanding.

Extract 9:

1	Melanie	00:05:00	Well,
2			even the word Koori,
3			is is a south-eastern term,
4			for Aboriginal people,
5			that live in Victoria.
6			And parts of New South Wales.
7			So the word Koori?
8			is like,
9			a slang name,
10			for Aboriginal people,
11			in the south-eastern.
12			And there’s Murries,
13			for Queensland.
14			Um,
15			this is all words,
16			for Aboriginal people.
17			But in different states,
18			of Australia.
19			There's Noongars ...
20			Um.
21			So that ..
22			people wouldn’t understand
23			So ...
24			You need to,
25			explain that.

(NBB01052017)

This section has shown that patterned differences including the use of English expressions with a non-standard meaning may be potentially harmful for Aboriginal people of non-English speaking background. Conversely, an Aboriginal or Torres Strait Islander person speaking English may use false friends that have the potential of being misconstrued by speakers of Standard Australian English. The next section explores English medical terminology and concepts that may not align with Aboriginal knowledge

the older terms 'Aborigine(s)/al(s)' still function as convenient pan-Australian names” (Broome, 2008) http://www.emelbourne.net.au/about.html

systems and illustrates the strategies that interpreters and ALOs use when interpreting these health concepts for Aboriginal people.

6.2.2 Interpreting medical terminology

In this section, I draw on the findings from Chapter 5, the narrative positioning analysis, which brings to the fore Discourses related to different communication patterns that are motivated by the health practitioners' and Aboriginal patients' orienting to *differing worldviews and knowledge systems*. When interpreting medical terminology, the interpreters navigate between Western medical knowledge systems and Aboriginal ways of knowing to convey meaning. This is particularly true for key foundational health concepts that have no precise equivalents in Kriol or other traditional Aboriginal languages. Some of the biomedical health concepts discussed by the interpreters include the microscopic world of disease, for example: cancer, fungus infection and diabetes.

In terms of cancer, interpreter Annie suggests that an equivalent term for cancer in Walmajarri, a Pama–Nyungan language spoken in Western Australia, does not exist. In Extract 10, the interpreting strategy she uses is substitution of the word *cancer* with *mimi*[10] when interpreting the word into Walmajarri; she elaborates by saying that *mimi* roughly translates to 'sore' in SAE (lines 1, 7).

Extract 10:

1	Annie	00:35:51	We just say sore,
2			in language.
3			In Walmajarri,
4			it's mimi.
5			So,
6			we'd just explain,
7			the sore is here,
8			and it's spreading,
9			or whatever,
10			the doctor is saying.
11			If you have breast cancer,
12			you're like,
13			Mimi.

[10] **mimi** *Variant:* **jangka (E)**. *nom.* sore on skin; sickness, general (http://ausil.org/Dictionary/Walmajarri/categories/index.htm)

14			Sometimes we use,
15			hand gestures,
16			but we won't point,
17			straight there.
18			We'd point,
19			to ourselves.
20			You've got a sore here
21	Maria	00:36:37	Right, right.
22	Annie	00:36:39	So,
23			we use a lot of,
24			hand gestures,
25			and pointing to,
26			our body parts.
27			So,
28			if I'm interpreting,
29			I'll say .. yeah
30			[pointing] to myself.
31	Maria	00:36:50	So,
32			you'll point,
33			to yourself,
34			not to the patient?
35	Annie	00:36:54	Yeah.
36	Maria	00:36:54	Interesting.
37			Again,
38			it's not intrusive.

(AA18072017)

For Walmajarri speakers, the term *mimi* is accompanied by gesture to indicate the physical location of the cancer (lines 11-20) and where 'it is spreading' or where it has metastasised (line 8). Annie specifies that as an interpreter when discussing a patient's cancer diagnosis, she refrains from pointing to the patient's body part and instead utters the word *mimi* and indicates the locus of the cancer on her own body and this is in line with interpreting practices in sign-spoken interactions (Green, Kelly, & Schembri, 2014).

The absence of a word for cancer in Aboriginal communities in the Northern Territory is also attested by McGrath, Holewa, Ogilvie, Rayner and Patton (2006) who found that "the Western biomedical language that semantically constructs the notion of cancer is not widely understood" (p. 240). In Extract 11, interpreter Gary acknowledges this gap in understanding particularly with terms like diabetes and cancer.

Extract 11:

1	Gary	00:15:09	The full details—
2			It's tricky with terms like,
3			diabetes cancer.
4			I get this,
5			in legal interpreting,
6			a lot.
7			You know,
8			things like bail.
9			That they're terms,
10			like ^all Kriol speakers,
11			know and use.
12			But I guess—
13			You sort of—
14			So,
15			Those sorts of terms,
16			that you know,
17			^all Kriol speakers know,
18			and use,
19			there's an assumption—
20			You could easily assume
21			that they know,
22			what they mean.
23	Maria	00:15:37	Yeah.
24	Gary	00:15:38	And—
25			But that's an assumption.
26			They may not have,
27			the same understanding,
28			of what that is,
29			ah .. than what I have,
30			or the doctor has.
31	Maria	00:15:47	Yeah yeah.

(GG12062017)

He addresses the commonly held erroneous assumption that such terms are understood by ‘all Kriol speakers’ (lines 9-11) and points out that this is not always the case, as Kriol speakers ‘may not have the same understanding of what that is ah .. than what I have, or the doctor has’ (lines 26-30).

In Extract 12, ALO Rachel, discusses Aboriginal patients’ understanding of the trajectory of disease and narrates their response to a positive diagnosis of cancer.

Extract 12:

1	Rachel	30:57.7	Things that I'm learning,
2			is the trajectory of disease.

3			'Cause like,
4			when people,
5			Once—
6			some some people,
7			they get like,
8			⌉Oh .. I've got cancer.
9			and that was it,
10			⌉So I'm dead.
11			But it's like,
12			hang on.
13	Maria	31:06.6	Yeah.
14	Rachel	31:08.4	Hang on.
15			With treatment,
16			and with a healthy lifestyle,
17			you could actually live,
18			a bit further.
19			you could actually do this,
20			you could actually do that.

(RW06122017)

Typically, patients construe such a diagnosis as a death sentence and this is expressed through Rachel's animation of the voice of the patient in: '⌉Oh .. I've got cancer … ⌉So I'm dead' (lines 8-10). Here we can see that fatalism is represented in an overwhelming belief that cancer is a death sentence. In an additional study, Prior (2009) also attributes Aboriginal women's reluctance to follow up on and accept advice about treatment following cancer screening to a fatalistic view of cancer as a death sentence.

When faced with such fatalistic responses to cancer diagnosis, Trudy the Aboriginal Service Development Worker, in Extract 13, employs a range of strategies to facilitate such conversations.

Extract 13:

1	Trudy	00:23:38	Um ...
2			I think it's—
3			Well—
4			You know,
5			I mean,
6			I would have that conversation,
7			about those particular diseases.
8			Um .. you know,
9			share what knowledge,
10			and information,

that I have about it.
Um .. you know,
If they were—
You know,
obviously if—
if they were able to read,
then I would provide them with,
Aboriginal specific um,
information brochures.
Um ... I'd also um,
think about,
what other ^specialist services,
are available,
for the patient in—
Um .. say for instance,
you know,
if it was in,
the cancer area,
I'd make sure that,
the Aboriginal worker over,
at the X X,
was linked into the services.
Ah .. I'd also make sure
that Aboriginal Worker,
at Cancer Cancer Victoria,
would y' know—
So ... I'd make—
Draw in all the expertise of,
all of the Aboriginal workers,
to provide the information,
and support,
that the patient would need.

(TT04022017)

For instance, she initiates conversations, 'about those particular diseases' and shares[s] what knowledge and information [she] has about it' (lines 6-11). She builds on existing knowledge using culturally appropriate strategies such as the provision of written material; 'Aboriginal specific um information brochures' (lines 18-19). Trudy also draws on cross-departmental expertise and 'specialist services' to ensure the patient has adequate and appropriate information and support about their condition and ensuing treatment (lines 20-42).

As we have seen in section 5.5.5 the interpreters often have to employ a variety of strategies to ensure that Aboriginal patients understand medical terminology. For

instance, in the ‘I’m not sick one’ story, Jill an interpreter of Aboriginal languages including Gooniyandi, Walmajarri and Kriol, uses simplification to explain what the preventative screen test for cervical cancer is. Jill states that she speaks in more practical terms and interprets for them ‘in language … in simple way I interpret it to them’ (Extract, 19: line 102, lines 108-109). Jill explains the preventative nature of the screening test with ‘in case something might—, they might find something’ (Extract 19: lines 106-107). She also uses substitution of the word for the female genitals with the euphemistic phrase *wadi wadi* when she makes a reference to private body parts (Extract, 19: lines 56-62). Finally, Jill explains that her omission of the word *cancer* is a conscious decision to avoid using the taboo term. A fuller discussion on interpreting taboo topics is presented in section 6.2.4.

In Extract 14, ALO Melanie, also identifies culturally sensitive ways of conversing about cancer and highlights the sensitivity required to address the subject, particularly ovarian cancer.

Extract 14:

1	Melanie	00:26:05	So .. if you talk about,
2			women with survival,
3			and and ovarian cancer,
4			and you talk about,
5			women's business and stuff,
6			you know,
7			you need to be really—
8			as you would be,
9			with ^anybody,
10			quite sensitive about how—
11			The language,
12			they’re going to speak.
13			And sometimes,
14			the treating team,
15			takes a very cool,
16			and hard,
17			and very medical.
18			So .. sometimes,
19			it's just sort of,
20			saying as an ALO—

We sometimes intervene,
in those conversations,
to say,
]You can see the patients,
sitting there
looking puzzled.
Like,
]What are you,
talking about.
]You can see the patients,
sitting there,
feeling very uncomfortable.
And put their heads down.
And just,
]I can't deal with this.
It's too confronting.
Sometimes,
it's just talking,
to the treatment teams,
outside.
Or asking,
some of the questions,
you think the patient may,
may want to,
perhaps ask.
Maybe they've already,
alerted you to,
some of the things,
they want to know.
But they're too ashamed,
To ask it.
Because it's about,
women's business,
and it's a male specialist.
But cancer in itself,
is a a delicate topic,
all round.
It's a growing issue,
in the Aboriginal community.

(NBB01052017)

Melanie explains that talking about ovarian cancer would necessitate incorporating culturally appropriate behaviour in terms of adhering to the notion of 'women's business' (lines 1-5) This is supported by Reid (1979) who asserts that the cultural norm pertaining to women's business involves respecting traditional divisions that make clear-cut distinctions between women's and men's role in society. Melanie

advocates for the use of sensitive language ‘as you would do with anybody’ (lines 7-12) stressing that culturally sensitive language should be employed across the board. Melanie mentions that at times the treating teams approach is “cool and hard and very medical’ (lines 13-17) and to offset this disconcerting manner, she indicates what action she might take; for instance, intervening in those conversations and telling the treating staff ‘You can see the patients sitting there looking puzzled … you can see the patient sitting there feeling very uncomfortable, and put their head down’ (lines 24-33). Other strategies include ‘talking to the treating team outside’ and anticipating and asking questions the patient might want to ask (lines 38-49). The latter is done to pre-empt feelings of ‘shame’ as Melanie explains ‘they’re too ashamed to ask it because it’s about women's business and it’s a male specialist’ (lines 50-54). Finally, Melanie concludes that ‘cancer in itself is a delicate subject [and] … a growing issue in the Aboriginal community’ (lines 55-59).

During the same discussion about cancer, ALO Katrina points out that talking about cancer in remote communities in Western Australia is taboo. When presented with a diagnosis or when having to initiate or participate in a discussion on cancer, older women whisper. In Extract 15, Katrina animates the women’s hushed voices as they uttered the word (lines 15-16). Melanie also adds that the women would refrain from uttering the full word and alternative refer to cancer as the ‘C’ word (lines 19-21).

Extract 15:

1	Katrina	00:27:19	Can I—
2			Can I just interrupt,
3			with one thing,
4			that um I remember.
5			Um when I was,
6			in a remote community,
7			in Western Australia.
8			Um a lot of,
9			the older women—
10			Especially,
11			if I was talking to them,

12			about you know,
13			their diagnosis,
14			or their mother's diagnosis.
15			They'd whisper,
16			<WHISPER> ⌉Cancer.
17			You know.
18	Maria	00:27:43	They'd whisper?
19	Melanie	00:27:45	Or wouldn't say,
20			The full word.
21			They'd say C.

(NBB01052017)

Another biomedical health concept that was mentioned in the interviews is that of fungal infections. In Extract 16, Kriol interpreter Gary discusses an instance when he interpreted for an Aboriginal Kriol speaker.

Extract 16:

1	Gary	00:29:15	I think yeah.
2			I remember talking about,
3			fungal infections.
4			Someone had a fungal infection,
5			Um .. on their foot.
6			And it wasn't causing them,
7			any concern.
8			It wasn't affecting,
9			their health,
10			but it was visible.
11			And so ...
12			It's just like,
13			⌉Well .. what is that.
14			So .. trying to talk about,
15			what what that is.
16			And having the vocab,
17			to say,
18			⌉Well ...,
19			It's a fungus.
20			It's actually,
21			a different organism,
22			and it's growing there.
23			As soon as,
24			you start,
25			to say that,
26			it sounds terrifying.
27			So ...
28			To sort of,
29			try and explain,

30			what it actually is.
31			And then,
32			at the same time say,
33			it’s actually—
34			You can treat it,
35			if you want.
36			But it’s not doing,
37			anything to you.
38			I just found that,
39			kind of strange,
40			doing that.
41	Maria	00:30:12	It made it sound,
42			more serious.
43			Because of the way,
44			I had to interpret it,
45			into Kriol,
46			it sounded scary.
47			But it actually,
48			Wasn’t scary.

(GG12062017)

When the Aboriginal patient asked what a fungus infection was, the strategy Gary employs is an explanation; that ‘it’s actually a different organism, and it’s growing there’ (lines 20-22). When reflecting on this interpreting experience, Gary notes that interpreting this information in Kriol, made the condition sound more frightening than it really was (lines 43-48).

The following extracts discuss the challenges Aboriginal patients faced when diagnosed with diabetes and outlines the strategies interpreters and ALOs use to help facilitate their understanding of this health condition. For instance, several ALOs revealed that Aboriginal patients have a downgraded understanding of chronic diseases such as diabetes. Sarah, the ALO attests to this in extract 17 below.

Extract 17:

1	Sarah	00:02:19	We can see that,
2			the patient doesn’t—
3			Has a really distorted understanding,
4			of say,
5			it’s diabetes,
6			they’ve been admitted for.

(SD16012017)

In Extract 18, ALO Melanie, also talks about patients who have a limited understanding of the condition of diabetes. These patients are unaware of preventative measures that could reduce their risk of contracting type 2 diabetes or feel they do not need to manage their condition.

Extract 18:

1	Melanie	00:36:01	You know,
2			There's some people,
3			Who have had diabetes,
4			for three five years.
5			Never checked their sugars.
6			But they've got sugars.
7	Melanie	00:36:01	They just say,
8			I've got sugars.
9			I don't need to do anything about it.
10	Katrina	00:36:24	That's scary.
11	Melanie	00:36:26	We have a lot of people,
12			who actually,
13			aren't looking,
14			Preventative side of—
15			keep maintaining their health.

(NBB01052017)

In Extract 19, ALO Rachel discusses patients' misconceptions concerning being cured of diabetes after having had a gastric sleeve procedure.

Extract 19:

1	Rachel	12:57.3	When you say to a patient,
2			it doesn't cure diabetes.
3			Because you haven't,
4			cured the pancreas.
5			It's like,
6			<STRAINED VOICE QUALITY> ⌈Oh no.
7			I'll always have diabetes <STRAINED VOICE QUALITY>.
8			It's just—
9			Yeah,
10			it's always.
11			Y' know,
12			it doesn't go away.
13			But you can manage it.

(RW06122017)

Rachel imputes a strained voice quality on the voice of her patient to highlight the patient's sense of disillusionment following the realisation that the diabetes is incurable (lines 6-7).

ALOs Melanie and Katrina, offer strategies they use when they have discussions about diabetes prevention and management. The discussion in Extract 20 centres around the choice of language used to discuss the condition of diabetes.

Extract 20:

1	Maria	00:33:15	And how would you explain,
2			like,
3			a condition like,
4			diabetes.
5	Katrina		Mhm.
6			Well,
7			where I used to work,
8			up North again,
9			they used to call it,
10			sugar sickness.
11	Melanie	00:33:54	The language—
12			The language around—
13			as Katrina just mentioned.
14			Actually,
15			in Melbourne,
16			a lot say,
17			you know,
18			I've got sugars,
19			or check me sugars,
20			and that.
21			It's all about sugars.
22			If that's what,
23			The patient's speaking.
24			That's how you should start,
25			talking too.
26	Katrina	00:34:07	Exactly.
27	Melanie	00:34:08	If they're talking about sugars,
28			if that's
29			the terminology their using,
30			to describe diabetes,
31			I flow with it.
32			You're listening,
33			to the cues,
34			of the patient.
35			It's the cues,

of the patient.
And I think that,
That's you listening,
And acknowledging,
What they're saying.
They're giving you,
the cues,
to utilise that words.
'Cause that's how,
they're describing it.
When you start,
coming at me with,
you know,
cardiac disease,
or the word diabetes,
or nephrology
and things.
People are like,
What the hell,
you talking about.
SO .. you got to listen,
To the cues,
of the patient.
Because that's the language,
they're using.
And it doesn't mean,
they don't understand.
It's just the word,
they choose to use.

(NBB01052017)

Katrina mentions that 'up North … they used to call it sugar sickness' (lines 6-10). Melanie acknowledges the cultural relevance of this term and clarifies that it is used more broadly by drawing on the example of Aboriginal patient's use of the word and its derivatives in Melbourne (lines 14-20). Melanie elaborates on the conversational strategies she uses to discuss diabetes and asserts that she adopts the same terminology that the patient is using in: 'If they're talking about sugars, if that's the terminology their using, to describe diabetes, I flow with it' (lines 27-31). Melanie highlights the importance of 'listening to the cues of the patient' and 'acknowledging what they're saying' (lines 32-40). She contrasts this strategy with making use of medical terminology such as 'cardiac disease, or the word diabetes, or nephrology and things'

(lines 49-52). She explicates that this would elicit a bewildered response from the patient as in: ‘ˀWhat the hell, you talking about’ (lines 54-55). Melanie reiterates the necessity to listen to the patient’s cues ‘because that’s the language, they’re using. And it doesn’t mean, they don’t understand. It’s just the word, they choose to use’ (lines 59-64).

The avoidance of medical terminology is widely attested in the literature; as mentioned in section 3.6, medical discourse is often construed as a foreign language (McGrath & Holewa, 2007). In another study, Devitt and McMasters (1998) found that a high proportion of end-stage renal disease patients had a limited to poor understanding of their illness and associated treatment procedures. This limited understanding became a barrier to communication with consequent adverse effects on the health of the patient; for instance, an “overwhelming majority … failed to achieve maximum benefit of the medical treatments provided” (p. 137). This also underscores their finding that Aboriginal people do not do as well post-kidney transplantation as non-Aboriginal transplant recipients.

The strategies that the interpreters and ALOs employ when interpreting medical terminology may be explained by drawing on functionalist pragmatic theories to interpreting. The interpreters seem to be abiding by purpose-driven approaches to interpreting, namely Skopos theory where the main principle of a translation is its purpose and not equivalence between a source and target text (Reiss & Vermeer, 1984/2014). This is illustrated by Annie the Walmajarri interpreter’s rendition of the word *cancer* as ‘mimi-sore’. Thus, it is also possible for interpreters to have a pedagogical function, teaching ST terms along with the accepted TT adaptations. This pedagogical function has the function of empowering patients. The absence of the word for cancer in Aboriginal communities in the Northern Territory necessitates that the interpreter make lexical choices that are “functionally and communicatively adequate”

and along the lines of the purpose set out in the interpreter's commission or briefing session. (Munday, 2016, p. 84).

As we have seen, the interpreters employ a range of strategies when they interpret medical terminology and concepts that do not have equivalents in the Aboriginal language. These include substitutions, omissions, use of euphemisms, gesture, circumlocution, explanation, paraphrase and simplification. The ALOs also build on the Aboriginal patients' existing knowledge through the provision of written material to Aboriginal patients. They emphasise the importance of listening to the cues of the patient and adopting culturally relevant terms employed by the patients. The next section illustrates how the use of visual aids can further the understanding of fundamental health concepts.

6.2.3 Visual aids

In Chapter 5, we saw the emergence of Discourses associated with *educating* mainstream staff and patients in culturally sensitive ways. I have shown how these are interlinked with Discourses surrounding *culturally distinct communication patterns* that highlight the intricacies of communicating in healthcare settings when the different parties involved draw on distinct ways of talking. In particular, in section 5.6.5, the importance of using visual aids is expounded in several of the stories in the narrative data. For instance, in the 'teaching iPad' story and 'there's nothing that's Indigenous specific' story, where ALO Sarah emphasises the necessity of supplementing verbal interaction with visual aids.

In a similar respect, Lincoln, an ALO in Victoria, discusses initiatives that have been endorsed and developed to facilitate diabetes education across the nation. One such initiative involved the design of Aboriginal specific resources for the prevention of diabetes and associated complications in consultation with the community.

Extract 21:

1	Lincoln	00:10:30	You know .. our Aboriginal elders,
2			and our ancestors,
3			were denied an education,
4			after colonisation.
5			Um. So .. a lot of our elders—
6			Ah, they don't really understand,
7			the concept of,
8			when a doctor,
9			talks about diabetes,
10			Um talks about,
11			all the medical terms,
12			they've got,
13			the medical jargon.

(LL06032017)

Lincoln discusses the rationale for creating Aboriginal specific resources by making reference to the aftermath of colonisation. He goes on to introduce Feltman and Feltmum, a diabetes education tool, used to educate Aboriginal health workers. As we can see in Figure 2, Feltman is a life-sized body made out of felt that depicts the main organs of the body that are involved in digestion and metabolism and the organs that may be affected by diabetes. It includes attachments such as insulin discs and glucose add-ons.

Figure 2. Feltman - a diabetes education tool

In Extract 22, Lincoln demonstrates that Feltman is a hands-on visual and tactile interactive teaching resource that serves to simplify such physiological processes involved in diabetes as digestion.

Extract 22:

1	Lincoln	00:12:33	Yeah and so ..
2			The Feltman is,
3			Yeah.
4			More of a visual aid,
5			where we can show,
6			what's happening,
7			inside the body.
8			So .. for example,
9			the pancreas,
10			I can say,
11			]right.
12			That's the pancreas,
13			right there.
14			That produces pancreas,
15			in our bodies.
16	Maria	00:13:27	That’s wonderful.
17	Lincoln	00:13:29	Yeah so,

what it really does
is,
it just shows people
that we've got glucose
all through our bodies.
You know,
it's something
that's interactive.
and like I was saying
having visual aids
For Aboriginal people,
works far better
than explaining diabetes
in general.
because a lot of the mob,
just mightn't understand
what you're talking about
The medical jargon
that goes along with it …
can be confusing.

(LL06032017)

Lincoln also explains that Feltmum (Figure 3) was created in order to 'cater for both the men and the women in the community' (lines 5-8).

Figure 3. Feltmum - a gestational diabetes tool

This additional resource was designed to educate Aboriginal women of the prevalence of gestational diabetes. Lincoln explains that ‘Aboriginal women are four to five times more likely to get gestational diabetes’ than non-Aboriginal women (lines 14-17). These two interactive resources allow Aboriginal Health Workers and ALOs to discuss management and prevention of type 2 diabetes and gestational diabetes. In Extract 23, he demonstrates how Feltman is transformed into Feltmum.

Extract 23:

1	Lincoln	00:00:15	It was just,
2			a simple way,
3			of um you know,
4			um making a resource,
5			cater for both,
6			the men and the women,
7			in the community.
8			A lot of Aboriginal people,
9			are you know,
10			four or five times,
11			more likely,
12			to get diabetes,
13			than non-Indigenous.
14			While Aboriginal women,
15			are four to five times,
16	Maria	00:13:27	more likely,
17	Lincoln	00:13:29	to get gestational diabetes.
18			So we thought,
19			↴well,
20			we'd better create,
21			a gestational resource.
22			That's how Feltmum,
23			come into it.
24			Now what we do?
25			So roughly,
26			that's where,
27			the baby goes,
28			then .. we give Feltman,
29			some hair.
30			And boom.
31			There’s Feltmum.
32			And um.
33			We have the umbilical cord,
34			that goes in here.
35			And a diabetes educator,
36			a midwife—

They can do wonders,
with this resource.
To um,
To ensure that,
it's um,
conveying the right message,
to um,
future mothers.

(LL06032017)

Lincoln goes on to discuss potential complications of diabetes and illustrates how the resource is designed to help in the prevention of diabetic retinopathy.[11]

Extract 24:

1	Lincoln	00:01:36	So .. Feltman and Feltmum,
2			have eyes.
3			And the reason why,
4			we've done that is,
5			diabetes retinopathy problems,
6			in the Aboriginal community,
7			is also high.
8			So .. we're conveying,
9			to ah community ,
10			that if you have diabetes,
11			you need to have,
12			your eyes,
13			regularly checked.

(LL06032017)

Drawing the patient's attention to the damaged eye on the resources allows them to convey to 'community that if you have diabetes, you need your eyes regularly checked' (lines 8-13). As we can see in Figure 4, the inclusion of eyes on Feltmum allows the Aboriginal patient to visualise the growth of unnatural blood vessels or retinal haemorrhage.

Figure 4. Feltmum - a diabetic retinopathy tool

[11] Diabetic retinopathy which is "a retinal vascular disorder that occurs as a complication of diabetes mellitus, is a leading cause of blindness" (Kempen et al., 2004, p. 552).

Additionally, in Extract 25, Lincoln goes on to elaborate that the resource pack contains a training DVD that demonstrates how to utilise Feltman and Feltmum as well as a series of cards that are used to discuss the following topics: management, complications, prevention, risk factors and symptoms (lines 3-7). These cards are designed to be used alongside the Feltman and Feltmum resource (lines 9-12). The cards are presented in figures 5 and 6 below.

Extract 25:

1	Lincoln	00:11:52	Yeah.
2			We've got,
3			management cards,
4			complications,
5			prevention,
6			risk factors,
7			symptoms.
8			And just for foods.
9			And the idea of this,
10			is to sort of,
11			being interactive,
12			with Feltman.

(LL06032017)

Figure 5. Complications that manifest with diabetes

Figure 6. Preventative measures against diabetes

Browne, D'Amico, Thorpe, and Mitchell (2014) present an evaluation of "the acceptability" of this Aboriginal-specific resource pack. This evaluation was conducted via an online evaluation survey and the findings were largely positive. The authors conclude that "Feltman is an effective tool for communicating complex health information about diabetes. It has been embraced by Aboriginal health workers, who now feel more confident discussing diabetes with community members" (p. 320). Participants in the survey also requested more regular "refresher training" and having the opportunity to work "alongside a diabetes educator" (p. 320).

Several other studies have shown that the creation of interactive, culturally specific resources coupled with the training of Aboriginal health workers and ALOS has the effect of empowering the Aboriginal health workforce to conduct health programs for members of their own community (Clapham, Digregorio, Dawson, & Hughes, 1997; Hecker, 1997; Whiteside, Tsey, McCalman, Cadet-James, & Wilson, 2006; Zeunert et al., 2002). This section has illustrated the effectiveness of visual aids as a strategy for interpreting complex medical terminology and how this knowledge is transferred to Aboriginal patients in culturally appropriate ways. The following section deals with strategies interpreters and ALOs use to frame and resolve cultural difference when they are called to interpret taboo topics.

6.2.4 Interpreting taboo topics

In section 5.1, Discourses pertaining to *Professionalism and Accountability* are invoked when discussing the institution's responsibility to ensure that staff use culturally appropriate language when approaching taboo topics such as physical appearance, as evidenced in the 'you're a bit too fat' story. In addition, in section 5.4, we also see the emergence of Discourses pertaining to the necessity of *educating* mainstream staff on culturally acceptable ways of discussing taboo topics such as death. This section illustrates how interpreters and ALOs navigate taboo topics and the strategies they use when interpreting taboo topics so as to maintain cultural sensitivity and follow

customary law. Alongside cancer, there are other taboo topics that interpreters often have to contend with and adopt strategies that enable them to interpret in culturally safe and appropriate ways. The following section discusses interpreting of private body parts, sexually transmitted infection and the concept of death and dying.

Firstly, discussions pertaining to private body parts during medical interactions and within the community constitute taboo for Aboriginal and Torres Strait Islander peoples. In Extract 26, interpreter Annie initiates a discussion on taboos topics.

Extract 26:

1	Annie	12:43.3	Um .. with ours
2			we don't talk about like,
3			private parts.
4			So .. if you're going to interpret,
5			it gets a bit tricky.
6	Maria	12:50.6	Yeah,
7			how do you do that.
8	Annie	12:52.5	But um,
9			I usually,
10			I feel confident
11			in my role.
12			I always interpret for females.
13			If it's that subject.
14	Maria	12:59.7	Mhm.
15	Annie	13:00.5	So I think it's—
16			It's uncomfortable.
17			But .. y' know.
18	Maria	13:04.2	Do you—
19			use another word
20			for the private part.
21	Annie	13:10.5	Yeah yeah.
22			Yeah, because our—
23			in language.
24			it's swear words
25			The private parts.
26	Maria	13:14.3	Oh right.
27			Really?
28			I didn't know that.
29	Annie	13:17.5	Mm.
30			Yeah.
31	Maria	13:21.8	Interesting.
32	Annie	13:22.7	Mm.
33			So .. we don't usually,
34			say that.

35			'Cause the patient
36			may get offended.
37			Um .. so we just,
38			y' know
39			we use another word.
40			to just cover it up
41			Like,
42			so vagina.
43			We wouldn't say,
44			the language word for it.
45			We'd just say
46			wadi wadi
47			Which is like,
48			that type of thing,
49	Maria	15:17.4	So .. it's like a euphemism.
50			It's like some--
51			A nicer term for--
52	Annie	15:20.3	Yes
53			Yes yes.
54	Maria	15:23.0	The body part.
55			Yeah yeah yeah.

(AA18072017)

Annie reveals that in her community talking about private parts such as the genitals is forbidden (lines 1-3) and admits that interpreting such taboo topics can be ‘tricky’ (line 5). Annie elaborates on why this topic is particularly challenging and creates discomfort; she explains that ‘in language’ uttering a word pertaining to a private body part, like the genitals, is interpreted as a ‘swear word’ (lines 22-25). As this would be construed as offensive by the Aboriginal patient (lines 35-36), the interpreting strategy Annie uses involves firstly, omission of the taboo term and secondly, the incorporation of a euphemism. She offers the example of ‘vagina’ and clarifies that she would avoid uttering the equivalent word in the traditional Aboriginal language and instead would say ‘wadi wadi’ which translates to ‘that type of thing’ a euphemistic term for the genitals (lines 45-48).

In Extract 27, Annie provides the following indicative example of how she would interpret the private body part ‘nipples’.

Extract 27:

1	Annie	16:08.5	Yes ...
2			that's just reminded me,
3			of like—
4			Yeah,
5			what I'd do,
6			in that situation.
7			So instead of saying,
8			um like nipples,
9			or whatever.
10			Your nipple is sore,
11			from breast feeding.
12			I'd say,
13			just your—
14			Yeah.
15			Just around there.
16	Maria	16:24.2	Just around there.
17			Yeah I understand,
18			what you're—
19			what you're staying.
20			It's not as direct.
21	Annie	16:28.3	I wouldn't refer,
22			to somebody's nipple.
23			And even if,
24			I am interpreting,
25			it'd just be like,
26			gesture.
27	Maria	16:34.0	That's interesting.
28			And how about,
29			y' know,
30			when the doctors,
31			they actually use,
32			the word nipple.
33	Annie	16:41.7	They do.
34			They do.
35			So .. I just say,
36			like in that area
37	Maria	16:42.5	Yeah.
38	Annie	16:45.3	Yeah .. in that area.
39	Maria	16:45.3	Yeah.
40	Maria		In that area,
41			yeah yeah.
42	Annie	17:00.8	This is great.
43			I appreciate
44			what you're doing.
45			And I love it.
46			'Cause this is definitely,
47			our fight.
48			Every day,
49			y' know,

50			trying to,
51	Annie	17:11.8	um .. educate people.
52	Maria	17:14.0	That's right.
53			That's right.

(AA18072017)

Annie illustrates that she 'wouldn't refer to somebody's nipple' verbally but would employ gesture and say: 'just around there' by pointing to her own self (lines 10-15). The interviewer asks what the interpreter would do in instances when the doctor actually uses the term 'nipple' during an interpreter mediated medical encounter (lines 28-32) and Annie demonstrates that she would use interpreting strategies such as gesture, omission and paraphrase. For instance, she would avoid uttering the word the doctor uses – nipple – and resorts to a native language equivalent that translates roughly to 'in that area' (lines 35-38), while using a self-pointing gesture. In line with Johnston and Napier (2010), it seems that in addition to gesture, Annie uses an ad-hoc explanation and circumlocution in an attempt to manage communication difficulties that uttering the private body part would invoke.

In Extract 28, Melanie and Lennie also discuss culturally appropriate terms that Aboriginal people use to refer to private body parts.

Extract 28:

1	Lenny	0:41:54	There are certain words,
2			that the aboriginal community,
3			adopt .. and they use.
4			And it's and it's the—
5			the appropriate word,
6			for the community.
7			It might not be,
8			a word that um,
9			a mainstream white midwife,
10			finds palatable,
11			but—
12	Melanie	00:42:13	It doesn't mean it's wrong.
13	Lenny	00:42:14	It's doesn't mean—
14			It's not—
15			it's not the right word.
16	Melanie	00:42:18	We have words for genders,
17			of men and women,

18			we have pipi and mutcha.
19			And so,
20			pipi for a male's penis,
21			mutcha for the women's,
22			um—
23	Maria	00:42:38	M U C H A?
24	Melanie	00:42:39	M U T C H A.
25	Maria	00:42:40	M U T C H A.
26	Melanie	00:42:41	So that's—
27			that's a common term,
28			it's not to a particular tribe,
29			it's that Koori English.
30	Maria	00:42:45	Yeah.
31	Melanie	00:42:46	Yeah?
32			So .. you know um,
33			it's not tribal, it's not a um
34			the language of a particular tribe.
35			It's it's what they're using.
36			Or balls,
37			a man's testicles,
38			you know so [LAUGH]
39			It's not—
40	Lenny	00:42:50	That's what,
41			Aboriginal people use.
42	Melanie	00:42:51	So .. if we're talking about,
43			that stuff,
44			in front of you know,
45			Westerners,
46			they have no idea,
47			what we're talking about,
48			which can be nice.
49	Maria	00:42:58	[Yeah.]
50	Lenny	00:42:58	[LAUGH]
51	Melanie	00:42:58	Boom is for your bum.
52			<SINGING> Shake your boom,
53			to the left,
54			shake your boom,
55			to the right <SINGING>
56			That's what we know,
57			it's the language.
58			But you know,
59			there's some words—
60			some common words,
61			that Aboriginal people use,
62			in different states,
63			that could be the same.
64			The pipi and the mutcha,
65			that's quite common here.
66			But then tribes,
67			have their own names,

68			for things.
69			So .. it's up to what,
70			people choose to use.
71			And that's one thing,
72			as Katrina was saying,
73			that sometimes,
74			Western medicine,
75			or Western um,
76			you know,
77			health providers don't understand,
78			and they think it's, um.
79			What's the word?
80	Lenny	00:43:57	It’s it’s crude.
81	Melanie	00:43:58	It's crude,
82			or it's slang,
83			or crass, and like,
84			in whose eyes.
85	Lenny	00:44:02	Mhm.

(NBB01052017)

Lenny prefaces this discussion by saying that the word adopted and used by the community might be the ‘appropriate word for the community’ ‘but it might not be … a word that um, a mainstream white midwife finds palatable’ (lines 1-10). Melanie offers the following Kriol words for men’s and women’s genitals:

‘pipi’ for penis

‘mutcha’ for vagina

‘balls’ for testicles

‘boom’ for buttocks

She explicates that these are ‘Koori English’ terms and generally not specific to ‘a particular tribe’ (lines 28-29) and that tribes may ‘have their own names’ for private body parts (lines 66-68). As we have seen in the ‘titty feeding’ story and the ‘pipi and the mutcha’ story in section 5.1., Western health practitioners often exude negative responses to the terms Kriol speakers use when making reference to private body parts. These terms are characterised by mainstream staff as “crude, slang or crass” (lines 81-83). However, Melanie objects to these characterisations by asking ‘In whose eyes?’

which reinforces her earlier assertion that ‘it’s up to what people choose to use’ (line 69-70).

A closely-related taboo topic is talking about sexually transmitted infection (STI). In Extract 29, interpreter Annie remarks that this is not a topic that she has had to interpret and speculates on how she would undertake culturally appropriate interpreting.

Extract 29:

1	Annie	00:25:39	Even even as an interpreter,
2			I haven't come across,
3			this yet.
4			But I think um,
5			just telling someone,
6			you've got,
7			a sexually transmitted infection.
8			It's like,
9			how do you say that?
10	Maria	00:25:55	How ^do you say that,
11			I wonder.
12			You wouldn't even,
13			talk about sex.
14	Maria	00:26:05	But how would they know,
15			that it’s from that?
16	Annie	00:26:35	I would just say,
17			the last bloke,
18			you've been with,
19			or maybe the one,
20			before that,
21	Maria	00:26:41	was sick.
22	Annie	00:26:46	Yeah.
23	Maria	00:26:47	Oh,
24			I think …
25			I'm catching on.
26	Annie	00:26:50	You wouldn't say,
27			directly like,
28			that you have a disease.
29			They'd be,
30			⌉what?
31			You know,
32			⌉an infection?
33			⌉Am I gonna die?
34			Yeah.
35			It's really tricky.

(AA18072017)

Annie employs omission as an interpreting strategy when she points out that ‘you wouldn’t even talk about sex’ (lines 12-13). She continues to elaborate on more culturally respectful ways of addressing the topic. Firstly, she illustrates a discreet way of discussing cases where a patient may have ‘a sexually transmitted infection’ where she would use circumlocution and inform the patient that ‘the last bloke, you've been with, or maybe the one, before that, was sick’ (lines 17-21). She provides the rationale for why a direct approach is not befitting the subject by envisaging a patient’s hypothetical response to a diagnosis of an STI with: ‘You wouldn’t say directly like, that you have a disease, they’d be ˥What? You know, ˥an infection? ˥Am I going to die? (lines 26-33).

Annie proceeds to outline what she means by a culturally ‘respectful way’ of interpreting by providing the equivalent expressions in Kriol in extracts 30a and 30b.

Extract 30a:

Yu	noum	dat	boi	you	mitimbat
2SG	know	the	boy	2SG	meet.PROG
‘You	know	the	boy	you	were with’

(AA18072017)

Extract 30b:

Yu	mitimbat	with	dat	boi	imin	maiti	sikwan
2SG	meet.PROG	with	the	boy	3SG.PST	maybe	sick
‘You	were	with	that	boy	he	maybe	sick

(AA18072017)

Annie interrupts the interviewer to clarify that you wouldn’t say ‘the bloke you slept with’ or ‘had sex with’ but ‘you ^were with’. In Extract 31, Annie illustrates the sense that the word ‘meeting’ acquires in Kriol.

Extract 31:

1	Annie	00:27:00	Um .. you'd say,
2			Yeah .. you'd go about it,
3			in around about way.
4			In a more respectful way.
5			Like, your bloke,
6			or whatever.
7	Maria	00:27:07	So …
8			you'd say something like,
9			the bloke you slept with,
10			not had sex with
11	Annie	00:27:11	Was with.
12			Was with.
13			You ^were with
14			Oh,
15			you ^were with
16			Not even slept with?
17			No.
18			Oh really,
19			yeah?
20			How do you know,
21			that I wasn't …
22			drinking coffee with him? [LAUGH]
23	Annie	00:27:24	Oh um,
24			Just the way we communicate,
25			you know?
26			Yu noum dat boi,
27			you mitimbud.
28			So .. meeting,
29			that way.
30			That's another one,
31			Meeting is like,
32			a gathering.
33			Like we're having a meeting,
34			but then in Kriol,
35			it's …
36			you're with that person,
37			you're dating that person.
38			So …
39			Yu mitimbat,
40			with dat boi.
41			Imin maiti,
42			sikwan.
43	Maria	00:29:41	That is so good.
44			It really explains,
45			how you can talk about,
46			you know,
47			like …

48			Sexually transmitted disease,
49			without actually having to say
50			You've got—
51	Annie	00:29:52	An STI.
52	Maria	00:29:53	An STI,
53			yeah.
54	Annie	00:29:56	Because it's—
55			The message is still straight,
56			it's just,
57			in a roundabout way.
58			Because that's—
59			we don't talk—
60			that's not … us,
61			to speak like that.
62	Maria	00:30:04	Right right.
63	Annie	00:30:05	But—
64			You know,
65			even though my job,
66			is to interpret,
67			exactly what the doctor,
68			is saying.
69			I wouldn't say that,
70			Because of my culture.
71			Culture and interpreting,
72			kind of mixes in together.
73			You've also got to,
74			work out,
75			interpreting your culture.

(AA18072017)

Annie explains that the Kriol word *mitimbat* differs from that of SAE where 'meeting is like a gathering' (lines 31-33). In the context of discussing an STI, the word 'meeting' acquires sexual connotations as in 'you're with that person, you're dating that person' (lines 35-37). Annie highlights that making a direct reference to an STI when discussing the condition defies the cultural and conversational norms of Aboriginal people. She concludes that the message is still conveyed, despite taking about the condition 'in a roundabout way' (lines 54-61). It is important to point out that Annie asserts that even though the job of an interpreter is to 'interpret exactly what the doctor is saying' (lines 63-68), it appears that she is unable to fulfil the AUSIT Code of Ethics (2012) pertaining to the principle of accuracy as this would constitute a breach of her cultural responsibilities towards the Aboriginal patient (lines 69-75).

A subsequent taboo topic that is raised by the ALOs Melanie and Katrina, is that of death and dying: In Extract 32, ALO Melanie explains that it is a topic that Aboriginal people avoid addressing.

Extract 32:

1	Melanie	00:11:27	I mean,
2			Just the first one,
3			death.
4			A lot of our people,
5			don't want to hear,
6			that word.
7			So ...
8			It's looking at other ways,
9			and educating the staff,
10			on perhaps using,
11			different terminology,
12			where need be.
13			How—
14	Maria	00:11:41	How would you do that.
15			So.. there's words,
16			that the Aboriginal community,
17			have identified,
18			in consultations,
19			around passing.
20			Like,
21			going up to the sky camp,
22			or dream time.
23			So .. there's,
24			a whole range of,
25			different words.
26			It depends on,
27			that family.
28			How—
29			Each family,
30			and individual,
31			is different.

(NBB01052017)

ALO Melanie reveals that 'a lot of Aboriginal people don't want to hear that word' (lines 4-6) and as such it is necessary to incorporate 'other words' into conversations surrounding death and dying. Melanie suggests 'educating the staff on perhaps using different terminology' (lines 8-11). She offers culturally appropriate terms that have been 'identified in consultation with the community' including: 'passing, going up into

the sky camp, or dream time' (lines 15-22). It is important to bear in mind that these expressions are not common to all Aboriginal groups as Melanie notes 'each family and individual is different' (lines 29-31). Finally, in Extract 33, ALO Katrina discusses that it is a taboo to utter a deceased person's name out loud.

Extract 33:

1	Katrina	00:12:32	And generally like,
2			ways to speak.
3			Um .. especially
4			In the Northern Territory,
5			And in Western Australia.
6			It's after,
7			Someone has passed away.
8			It's taboo,
9			to say their name,
10			out loud.

(NBB01052017)

Euphemisms such as 'passing, going up into the sky camp, or dream time' are characterised by evasive expression and avoidance. Burridge (2012) argues that euphemisms "are verbal escape hatches created in response to taboos" and are employed when a speaker would prefer not to speak unrestrainedly in a given context.

To summarise, the interpreters and ALOs adopt interpreting strategies that ensure that their interpreting of taboo topics is functionally communicative for the Aboriginal patients. Like Reiss and Vermeer's Skopos theory, Holz-Mänttäri's (1984) "Model of translational action" requires that the TT conforms to what is functionally acceptable for the receiver. However, the Model of translational action theory also takes into consideration what is permissible in the TT culture (section 3.1). This is evident in the interpreters' and ALOs' renditions when interpreting taboo words including those for private body parts or the contraction of STIs. Interpreter Annie explains that she does not replicate the source text or doctor's output verbatim, instead she interpreters in "a roundabout way". This brings to fore the difficulty of abiding by the AUSIT (2012)

code of conduct that necessitates the provision of accurate renditions. Annie opts for a euphemistic term for the genitals and makes use of gesture to avoid using the equivalent expression which carries negative connotations and is construed as an expletive in the traditional Aboriginal language. In line with Wadensjö (2005b), Annie's omissions are part of her conscious choice to try and meet the communicative goal of the interaction. For instance, when contemplating on how to interpret the contraction of an STI, the interpreter would refrain from naming the disease or uttering any lexical item that makes reference to sexual intercourse and instead resorts to a more discreet ways of discussing such cases of STI diagnoses using paraphrase, circumlocution and explication. In this section, I have shown that the strategies the interpreters and ALOS use enable them to abide by the cultural and conversational norms of their clients. The following section explores typical ways of seeking information in Western societies as compared with Aboriginal ways of asking and answering questions.

6.2.5 Differences in syntactic question structure

It is widely cited that question-answer routines are a source of potential miscommunication for Aboriginal and Torres Strait Islander patients as they come across as impolite or confrontational (Cass et al., 2002; Eades, 1982; Lin et al., 2016; Trudgen, 2000). The interpreters and ALOs commented on the efficacy of several specific linguistic devices used when asking questions. As I have established in section 5.6, the interpreters and ALOs evoke Discourses that foreground *culturally distinct communication patterns* as evidenced in the 'I am not asking you to tell me what I wanna hear' story, and 'You need a Kriol interpreter' story. These stories highlight differing information seeking and giving strategies that stem from culturally distinct ways of talking. In the interviews, the interpreters and ALOs commented on the efficacy of several specific linguistic devices used when asking questions.

In Extract 34, Kriol interpreter Gary makes a comparison between English-speaking doctors and patients for whom such question-answer approaches are commonplace.

Extract 34:

1	Gary	00:18:51	It’s hard to predict,
2			but definitely,
3			there’s a different way,
4			of talking.
5			So .. where,
6			if it’s.
7			an English-speaking doctor,
8			and an,
9			English speaking patient,
10			those sort of,
11			question answer routines,
12			that they would go through.
13			They’re comfortable,
14			for both sides.
15			But if you—
16			But if you’re Kriol speaking,
17			you have a different,
18			way of talking.
19			So .. even just,
20			the basic fact,
21			that you’re doing,
22			a question-answer routine,
23			rather than,
24			kind of,
25			letting the Kriol speaker,
26			tell the story,
27			of what’s happened,
28			a bit more.

(GG12062017)

Gary observes that question-answer routines are ‘comfortable for both sides’ (lines 13-14). In contrast, interactions involving question-answer routines are more of a challenge for Kriol speaking Aboriginal patients as they are not part of the Aboriginal patients’ conversational routines. Gary concludes that Kriol speakers ‘have a different way of talking’ (lines 16-18) and offers a more culturally appropriate strategy involving ‘letting the Kriol speaker tell the story of what’s happened a bit more’ (lines 25-28).

The interpreters and ALOs commented on the effectiveness of a variety of question-answer approaches and there was general consensus that syntactic question structures such as use of closed questions, negative sentence construction, question tags, questions with rising intonation, and questions involving a choice, often impeded communication. It was particularly recommended that the use of closed-questions requiring a yes-no response should be discouraged. In Extract 35, ALO Sarah explains why yes-no questions constitute a problem because it is easy to answer in the affirmative.

Extract 35:

1	Sarah	00:24:32	'Cause it's just easy.
2			'Cause it's easy.
3			It's the answer that,
4			people wanna hear.

(SD16012017)

In Extracts 36 and 37, ALO Rachel and interpreter Annie, concur that closed-questions are ineffectual because they elicit responses that the patient thinks the health practitioners want to hear. Annie elaborates by adding that this tendency to answer in the affirmative is also a cultural sign of respect as Aboriginal people want to avoid causing offence.

Extract 36

1	Rachel	01:17:09	Sometimes people give you,
2			the answer they think,
3			you wanna hear.

(RW06122017)

Extract 37:

1	Annie	09:58.04	Where you know,
2			in hospital—
3			'Cause they have,
4			the authority.
5			We just say,
6			yes no.
7			And of course,

Aboriginal people,
are gonna do that.
Because it's in—
Y' know,
that's how we—
We we are as a people.
We don't like,
to offend people.

(AA18072017)

Negative sentence constructions are also a source of confusion due to their ambiguity. ALO Sarah acknowledges that such question structures are 'not effective communication at all' (lines 6-7) in Extract 38.

1	Maria	00:25:23	What about negative questions,
2			Like,
3			you haven't seen,
4			this doctor before.
5	Sarah	00:25:25	Yeah not effective.
6			Yeah not effective,
7			communication at all.

(SD16012017)

In Extract 39, Rachel agrees and elaborates that such negative sentence constructions have the potential to be confusing and ambiguous.

1	Maria	04:09.8	What about negative questions.
2			Like,
3			you haven't seen
4			this doctor before.
5	Rachel	04:22.7	I suppose—
6			I suppose.
7			in regards to,
8			it could be a,
9			um.
10			'Cause you can ask,
11			have you seen this doctor.
12	Maria	04:28.9	Yeah.
13	Rachel	04:28.9	And they can say no.
14	Maria	04:30.1	Yeah.
15			But asking,
16			You haven't seen,
17			this doctor before
18	Rachel	04:34.5	I think yeah.
19			But yeah.
20			On its own

21			It's—
22			Yeah.
23	Maria	05:48.9	Sounds a bit—
24	Rachel	05:50.2	Yes it's like—
25			Y' know,
26			you haven't seen,
27			this doctor before.
28			It it's a bit ambiguous.
29	Rachel	05:54.2	Like Yeah.
30			Nah.
31			Or why?
32			You—
33			Should I?
34			Shouldn't I have?
35			Like,
36			what do you want,
37			me to answer
38			to that one.

(RW06122017)

Rachel explains that the confusion and ambiguity, may result from the patient not knowing how to answer the question, as is evidenced in the responses that Rachel hypothesises could be going through the patient's mind (lines 29-38). In Extract 40, Kriol interpreter Gary also acknowledges that such negative propositions can be confusing as the ambiguity lies in how the proposition is interpreted particularly when the answer in the affirmative is 'yes, which means, yes I haven't seen this doctor before'.

Extract 40:

1	Gary	00:20:30	So,
2			a negative proposition.
3	Maria	00:20:32	Yeah,
4			you haven't seen,
5			this doctor before.
6			That kind of thing.
7	Gary	00:20:37	And then the answer is,
8			yes.
9			Which means,
10			Yes I haven't seen,
11			this doctor before.
12			That can be confusing.

(GG12062017)

Another syntactic question pattern that poses difficulties in comprehension is tag questions[12]. In Extract 41, interpreter Annie, highlights the ambiguity surrounding tag questions as the patient may answer in the affirmative or negative without necessarily understanding the premise of the question itself (lines 6-15).

Extract 41:

1	Maria	00:58:34	If they do use them,
2			are they a problem.
3			These tags.
4			If a doctor uses them.
5	Annie	00:58:42	Yes definitely.
6			Because they can say,
7			yes and no to that.
8			And not,
9			necessarily understanding.
10			So .. yep,
11			doesn't it.
12			Or,
13			no.
14			Because you're like,
15			doesn't it?

(AA18072017)

Holmes (1982, 1983, 1995) expounds the underlying difficulty in understanding question tags by illustrating the diverse function they may serve. For instance, Holmes (1995) identified two main types of tag questions that serve serval different functions; firstly, modal tag questions may be "speaker-oriented" in that they serve to fulfil the information needs of the interlocutor and have a confirmatory or informative function (p. 80). Secondly, affective tag questions may be "addressee-oriented" and serve several affective functions that reveal some information about the speaker's attitude toward the addressee. These include tag questions that serve a "facilitative" function that are employed to encourage the interlocutor to talk and thus serve as positive politeness

[12] "Syntactically, the English tag construction is typically described as a declarative sentence (the anchor or host) plus an abbreviated question (the tag). The tag agrees with the subject and auxiliary of the anchor, but it may either contrast in polarity (It's on the left, isn't it?; It isn't on the left, is it?), or coincide (It's on the left, is it). An essential component of the constructions is intonation" (Mithun. 2012, p. 2166)

strategies (p. 81); tag questions that have a "softening" function and are used to mitigate the force of "negatively affective utterances, such as directives … and criticism" (p. 81); and tags that serve a "challenging" function in instances when "confrontational strategies [which] may pressure a reluctant addressee to reply or aggressively boost the force of a negative speech act (p. 152).

A further syntactic question pattern identified as being challenging involves direct questions whose linguistic form is that of a statement with a rising intonation pattern. There was general agreement that this type of question pattern is misconstrued and is perceived as a form of 'sarcasm' or is considered 'offensive'.

Extract 42:

1	Maria	00:26:22	What about sentences,
2			which—
3			With a rising intonation.
4			Like,
5			it hurts?
6	Sarah	00:26:24	Yeah yeah.
7			That's um ...
8			pretty offensive.
9			Like any—
10			'Cause of ..
11			the language barrier.
12			Our mob are really sensitive,
13			to tone of voice.
14			Um and,
15			expressions,
16			and body language.
17			So yeah.
18			That's very—
19			That straightaway—
20			You'll just get,
21			someone shut down.

(SD16012017)

In Extract 42, ALO Sarah, evaluates sentences uttered with a rising intonation as 'pretty offensive' and explains that 'cause of the language barrier, our mob are really sensitive to tone of voice … and body language' (lines 10-16). She surmises that presented with such syntactic question patterns involving a rising intonation, an Aboriginal patient

would ‘straightaway … shut down’ (lines 19-21). In Extract 43, interpreter Annie also construes statements uttered with a rising intonation as ‘a kind of like sarcasm’ (lines 6-7) that would jeopardise communication or hamper rapport building with Aboriginal patients.

Extract 43:

1	Maria	01:01:58	How about sentences,
2			um ...
3			with a rising intonation.
4			Like,
5			it hurts?
6	Annie	01:02:11	It comes across,
7			kind of like sarcasm.
8	Maria	01:02:16	Really.
9			Wow.
10			Off putting.
11	Annie	01:02:18	Yeah,
12			so .. you’re off to,
13			a bad start already.
14			It’s like,
15			⌉You’re judging me already.
16			⌉Okay no worries.
17			I’m already,
18			getting irritated.

(AA18072017)

From the onset this syntactic question pattern is disconcerting as Annie confers that ‘you’re off to a bad start already’ (lines 12-13). This is reinforced as Annie animates the voice of a hypothetical patient’s response in ‘⌉You’re judging me already. Okay, no worries, I’m already getting irritated’ (lines 15-18).

The final syntactic question pattern discussed by the ALOs involves interrogative structures involving choices. This question pattern requires the interlocutor to choose from one of two alternatives. In Extract 44, Katrina and Melanie concur that a more effective strategy would be asking one question at a time.

Extract 44:

1	Maria	00:54:01	And what about choices.
2			When you got,
3			two things,
4			to think about.
5			Like,
6			has the medication,
7			made a difference.
8			Or ...
9			do you still,
10			feel the pain.
11	Katrina	00:54:09	See,
12			usually .. I'd ask,
13			one thing.
14			Like,
15			ask the first.
16			Ask the second.
17			Has the medication,
18			made a difference.
19			And then,
20			if they say,
21			a yes.
22			I would say,
23			So ...
24			are you still,
25			in pain.
26			You know.
27	Melanie	00:54:21	You need to do,
28			one thing,
29			at a time.
30	Katrina	00:54:24	Just be very clear.
31	Melanie	00:54:25	And really,
32			in in that situation,
33			I suppose.
34			You could ask him,
35			one question,
36			which can then,
37			elude you,
38			into the next question.
39			But one thing,
40			at a time.
41			That's just,
42			too much.
43	Maria	00:54:35	That's right.
44	Melanie	00:54:36	Because,
45			they've gotta think about—
46			They've got to think,
47			for a moment.

48 Has the medication,
49 made a difference.
50 And sometimes,
51 they've gotta,
52 think and think.
53]Yeah it has.
54 or.
55]No, it hasn't.
56 You know,
57 So um.

(NBB01052017)

Katrina demonstrates how she would ask the hypothetical question introduced by the interviewer: 'Has the medication, made a difference. And then, if they say, a yes. I would say, So ... are you still in pain' (lines 17-25). Melanie contributes to the discussion by asserting 'you need to do one thing at a time' (lines 27-29) and this is predominantly so as to allow the Aboriginal patients sufficient time to process the information in each of the question parts so as to be able to answer (lines 44-55). Liberman (1981) has shown that this syntactic pattern rarely occurs in Aboriginal varieties of English or in traditional Aboriginal languages. Liberman (Liberman, 1981) also notes that when asked an either-or question, an Aboriginal person's response typically is made with reference to the second alternative offered.

The interpreters and ALOs acknowledge there is cultural discrepancy in information seeking strategies particularly, those pertaining to the asking of questions using Western-oriented question-answer routines. They draw on their respective expertise to implement certain strategies to help patients overcome the hesitation and dysfluency that pervades much of their interactions with health practitioners. There is general consensus that it is necessary to allocate sufficient time for Aboriginal people and patients in general to process information when, as ALO Sarah explains, they receive 'a new diagnosis' (Extract 45).

Extract 45:

1	Sarah	00:02:38	It's just anybody,
2			that has a new diagnosis.
3			Um .. even if they are ..
4			English speaking,
5			will struggle to understand.
6			It takes a long time.

(SD16012017)

There are also instances when patients need to process the aetiology of their condition or 'why this has happened' (lines 6-7). In Extract 46, ALO Sarah, explicates that Aboriginal patients may also require additional time to absorb information to discern how to situate it alongside their 'spiritual and traditional belief'. As we have seen in the 'cut foot story' in section 5.2, patients often invoke discourses of payback and spirituality of the body where an illness may result from a 'curse' placed on the patient by someone seeking retribution.

Extract 46:

1	Sarah	00:30:16	So um.
2			And then,
3			even when you're de—
4			When you're giving that information,
5			from the beginning,
6			of why,
7			this has happened.
8			that patient then,
9			has to go and process it.
10			Because they've got,
11			that spiritual and traditional belief
12			as well.
13			About …
14			How did this come on me?
15	Maria	00:30:21	Yeah.

(SD16012017)

Interpreters Indigo and Annie, and ALO Rachel all agree that when asking questions, it is imperative that health practitioners allow the patients time to answer the questions. In Extract 47, Indigo identifies this strategy as an Aboriginal conversational strategy with: 'And our mob take our time' (line 8).

Extract 47:

1	Indigo	00:46:13	Allowing questions to be answered,
2			time for questions to be answered,
3			Um .. is very, very ..
4			important.
5			Very important with our mob.
6			'Cause they need to process it,
7			and then answer.
8			And our mob take our time.

(II19072017)

In Extract 48, Annie remarks that giving patients time to answer is especially relevant 'if you want a good answer'.

Extract 48:

1	Annie	00:44:35	Um,
2			There's not much—
3			So so if um—
4			and this is what I try,
5			to tell the staff.
6			Just take your time,
7			when you're asking a question.
8			Um …
9			Especially ..
10			if you want a good answer.

(AA18072017)

Finally, in Extract 49, ALO Rachel outlines the importance of allocating time and suggests that this is even more important than the syntactic structure of questions (lines 1-4). She also identifies the need to give Aboriginal patients physical space to retreat, 'sit quietly, and think about, what you asking' (lines 9-12).

Extract 49:

1	Rachel	09:46:07	Biggest one,
2			when it comes to questions,
3			is to give them time,
4			to answer.
5			So somebody mi—
6			they might want to go,
7			and and have,
8			have a chance,
9			to just sit quietly,
10			And …

```
11                  Think about,
12                  what you asking.
                                                    (RW06122017)
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As discussed in the ‘give her time to answer’ story in section 5.4, Rachel draws on the multiple roles that the use of overt directives afford; for instance, invoking her professional status as ALO, her expertise in cultural and communicative competence and her positioning as educator when discussing ways to talk with an Aboriginal patient in order to underscore the importance of allocating time to answer.

When health practitioners are not aware of Aboriginal verbal communicative strategies, cross-cultural misinterpretations may have implications on a patient’s understanding of their condition and subsequent treatment. As discussed in the following section, this is also true of non-verbal behaviour of Aboriginal people which is often construed as difficult, passive or deceptive (Brant, 1993).

6.2.6 Paralinguistic features

There are different modes of communication within cultural groups and these extend beyond verbal communication and include paralinguistic features including loudness of voice, tone, body posture, gesture and facial expressions (Christie, Harris, & McClay, 1987). Christie et al., (1987) found that “when members of two cultures are trying to communicate, there are all these same [paralinguistic] factors present, except that the 'same' factors may mean something different in the second culture” (p. 11). As Neuliep (2017) has found, such paralinguistic features may be either culturally universal or culturally specific. The findings in this thesis have highlighted the cultural specificity of some non-verbal communicative features. For instance, in Extract 50, Trudy, the Aboriginal Service Development Worker, asserts that ‘prolonged silence within a conversation with an Aboriginal person is okay’ (lines 3-6). She adds that communication extends beyond words and explains that ‘it’s not just, the verbal that um … an Aboriginal person is in tune with’ (lines 12-16).

Extract 50

1	Trudy	00:35:08	But also,
2			Um ...
3			That prolonged silence,
4			within a conversation,
5			with an Aboriginal person,
6			is okay.
7			Because that's,
8			a communication—
9			That's another way,
10			of communicating.
11			And um,
12			and it's not just,
13			the verbal,
14			that um ...
15			An Aboriginal person,
16			is in tune with.

(TT04022017)

In Extract 51, interpreter Annie also refers to silence as a discourse feature that is a salient feature of Aboriginal interactions.

Extract 51:

1	Annie	01:01:16	Aboriginal people.
2			We only talk,
3			if we have to.
4			Western culture—
5			You have to talk.
6			Otherwise,
7			it's uncomfortable.
8			You know.
9			Yeah.
10			Whereas us,
11			it's more respect,
12			and it's um.
13			That's just how we are.
14			We don't necessarily,
15			talk all the time.
16	Maria	01:01:18	You don't have to,
17			fill the gaps.
18	Annie	01:01:20	No.
19			I'm just thinking—
20			On a medical,
21			like medical term.
22			Like yeah.
23			If I go in,
24			and I'd say hello.
25			Greet the person,
26			and we just,

27			sit there,
28			in silence.

(AA18072017)

She explains ‘we only talk if we have to’ and contrasts this with non-Aboriginal Western culture where ‘you have to talk, otherwise it’s uncomfortable’ (lines 2-7). Annie demonstrates the salience of silence when she describes an interpreting session with an Aboriginal patient where she would ‘say hello, greet the person, and we just, sit there, in silence’ (lines 24-28).

In Extract 52, What is of particular interest is interpreter Annie’s inner dialogue which animates the thoughts of the health practitioners as they muse over why the interpreter and patient are sitting in silence (lines 29-37). Annie concludes that ‘we’re just comfortable in our silence’ and reiterates ‘we just talk if we need to’ (lines 43-44).

Extract 52:

29	Annie	01:01:31	And they’re like,
30			⌋Oh.
31			Don’t they come,
32			from the same community.
33			Why don’t they talk,
34			like,
35			while we’re,
36			you know,
37			discussing other stuff.
38			Like the doctors.
39			But we’re just comfortable,
40			in our silence.
41			You know.
42			Ah okay.
43			We just talk,
44			if we need to.

(AA18072017)

In Extract 53, interpreter Indigo concurs that Aboriginal patients ‘don’t have a problem with silence … [and are] confident when silent. She continues to offer another interpretation of the function of silence in Aboriginal interactions; she explicates that Aboriginal patients practice active listening so as to absorb information and resolve to

make contributions to interactions ‘if it is necessary for them to speak’ (lines 11-15). Indigo outlines that Aboriginal listening behaviours ‘can be interpreted as agreeing or listening so you can understand more about it’ (lines 32-36).

Extract 53:

1	Maria	00:22:28	What about silence.
2	Indigo	00:22:32	Yeah no.
3			They don’t have,
4			a problem with silence.
5			I think they’re confident,
6			when silent.
7			Like,
8			I’m listening things in.
9			And there’ll be people,
10			like that.
11			And they listen.
12			And take things in.
13			And they don’t speak.
14			If it’s necessary,
15			for them to speak.
16			If that certain—
17			Whatever was being discussed,
18			is of interest to them.
19			Or—
20			or they have some knowledge,
21			about it.
22	Maria	00:22:44	Yeah yeah.
23	Indigo	00:22:45	And they speak.
24			Otherwise,
25			if they know,
26			what being talked about,
27			and discussed,
28			they will just listen.
29			Listening is sort of,
30			in a way of um.
31			You know,
32			it can be interpreted,
33			as agreeing.
34			Or you’re listening,
35			so you can understand,
36			more about it.

(II19072017)

The interpreters also identified the pragmatic function of pauses and silence in the context of storytelling. In Extract 53, interpreter Gary discusses pauses and silences

as pragmatic features in conversation, particularly in the legal and health context when Aboriginal people may choose to adopt a ‘yarning’ style of communication.

Extract 54:

1	Gary	00:30:58	Ah yes.
2			The pause,
3			Yes.
4			Because um yeah.
5			If if and Aboriginal person,
6			in interpreting,
7			is trying—
8			They are trying
9			to actually switch into,
10			a more narrative,
11			mode of talking,
12			about what’s going on.
13			And then,
14			that traditionally,
15			that usually,
16			pauses are longer.
17			So so,
18			I might start talking,
19			and then,
20			just because naturally,
21			pauses are a bit longer,
22			when you’re telling stories,
23			or conversing,
24			and stuff.
25			So oftentimes,
26			this is in any,
27			interpreting setting.
28			Like,
29			I’ll sort of hear,
30			an Aboriginal person,
31			sort of start,
32			to actually convey,
33			good information,
34			and go into,
35			this narrative mode.
36			And I kind of know,
37			that this is where,
38			the lawyer or the doctor,
39			is wanting to go,
40			with the discussion.
41			But they might talk,
42			for a bit.
43			And then,

44			they might pause,
45			for a bit.
46			And then,
47			‘cause the doctor,
48			or the lawyer’s,
49			in a hurry,
50			and—
51			Or they just—
52			And they don’t really know,
53			about the— [LAUGH]
54			The pause,
55			a longer pause,
56			is acceptable for Aboriginal,
57			language speakers.
58			But they start—
59			They’ll cut them off.
60			And they’ll actually,
61			cut their story off,
62			sometimes.
63			When they’re actually,
64			starting to switch into,
65			being quite informative,
66			by telling,
67			a bit of a narrative.
68			Do you know what I mean.
69	Maria	00:32:41	Yeah yeah yeah.
70			It’s a shame.
71			Because they miss out,
72			on important details.
73	Gary	00:32:44	Yeah details.
74			Details.
75			And also,
76			um you know,
77			that the Aboriginal person,
78			feeling like,
79			they’re being listened to.
80			Because if they get cut off,
81			if makes them feel like,
82			they’re probably,
83			not being listened to.
84			Whereas,
85			if they’re allowed,
86			to keep—
87			When they’re allowed,
88			to keep going,
89			and they’re like,
90			]Oh yeah.
91			This doctor’s,
92			gonna listen to,

93 what I've got to say.

(GG12062017)

As Gary explains, Aboriginal people often 'switch into narrative mode of talking' to share 'what is going on' (lines 5-12). This is in line with Lin et al., (2016) who argue that yarning is a means of conversing about important information. Typically, this important information is embedded within a story. Gary highlights this in his description of what typically unfolds in an interpreting session. He delineates that pauses are generally 'a bit longer when you're telling stories or conversing' (lines 21-22). Drawing on his expertise as a Kriol interpreter, Gary discerns that during the course of the narration, 'an Aboriginal person, sort of start, to actually convey, good information' (lines 25-33). The Aboriginal person's interactional patterns may involve 'talk[ing] for a bit and then they might pause for a bit' (lines 41-45) and it is during these pauses that the doctor or lawyer typically interrupts the Aboriginal person because they are 'in a hurry or they don't know—' (lines 49-52). As Gary points out 'they'll cut them off … And they'll actually cut their story off sometimes, when they're actually, starting to switch into being quite informative by telling a bit of a narrative' (lines 59-67). This has an adverse impact on the interpreter-mediated encounter as the doctor or lawyer 'miss out on important details' and the Aboriginal person is left 'feel[ing] like they're probably not being listened to' (lines 80-83). That Aboriginal people tend to slip into a yarning style of communication is supported by Lin et al., (2014) who found that Aboriginal patients valued a yarning style of communication, which involved a 'two-way interaction and careful listening … [that] is conversational and non-confrontational" (p. 323). This is also attested for patients in general by Slade et al., (2015) who highlight the necessity of "opening the interaction for patient participation and allowing [patients] the space to tell their story" (p. 73).

6.3 Summary

This chapter has established that interpreting in medical settings for Aboriginal and Torres Strait Islander people is impacted by the following structural and institutional

barriers: service availability, low levels of utilisation of interpreters and time constraints. The interpreters and ALOs relay the difficulties that such barriers cause; for instance, the inability to access accredited interpreters, or interpreters that are in the right kinship relationship, the preferential use of ad hoc interpreters, and the placing of time constraints on interpreter-mediated sessions. They highlight how these structural and institutional barriers tend to impede communication between health practitioners, Aboriginal and Torres Strait Islander patients and interpreters. The analysis has also identified communication differences and difficulties between Aboriginal patients and western health practitioners; these include interpreting of medical terminology pertaining to key foundational health concepts such as cancer, fungal infections and diabetes; interpreting of taboo topics like cancer, genitals, STIs and death and dying. It has illustrated language-specific differences between traditional Aboriginal languages, Aboriginal English and Standard Australian English (SAE). The interpreters and ALOs demonstrate that interpreting traverses beyond the translation of isolated words from one language to another and highlights that oftentimes there may not be a direct equivalent of a single lexical item in the traditional Aboriginal language or Kriol. The participants have also proffered certain strategies that help Aboriginal patients' understanding of key foundational health concepts pertaining to the microscopic world of disease, taboo topics such as cancer and STIs. They have also discussed the inefficacy of question-answer routines and offered culturally appropriate non-verbal communicative practices. Together these findings forefront the difficulties that ALOs and interpreters face as they interpret or advocate for Aboriginal and Torres Strait Islander patients, but at the same time, they showcase the strategies and culturally appropriate communicative practices they adopt to enhance the communication experience of these patients.

The following chapter, the Discussion, shows how the findings from Chapter 5, narrative positioning analysis and the findings from this chapter are interrelated and

together address the two primary aims of the study. Firstly, that story telling is the primary means that interpreters and ALOs use to talk about how they do their work; and secondly, the strategies that are used to navigate the culturally distinct communication patterns that emerge during interpreter-mediated interactions.

Chapter 7 Discussion and Conclusion

7.1 Introduction

The overarching aim of this thesis has been to investigate ways in which interpreting practice in healthcare settings can be enhanced so as to better facilitate communication with Aboriginal and Torres Strait Islander patients. As seen in the previous chapters, there are four important findings that emerge from the analysis of the interviews with narrative and non-narrative data:

1) In this interview setting storytelling is one of the primary communication devices the interpreters and ALOs use to talk about how they do their work within the framework of a guided interview.
2) As highlighted by the narrative positioning analysis, the interpreters and ALOs contribute their understandings of the complexities of interpreting for Aboriginal patients in medical settings. This is achieved through the multiple, shifting positions they attribute to themselves as well as other social actors in the stories they tell. These positions are reinforced in the ongoing interaction but are also located across the data set, illustrating that *D*-discourses are invoked to frame the role, skills and attributes of the professionals in this study.
3) The analysis of the non-narrative parts of the interview data brought to the fore the tension between abiding by the AUSIT (2012) Code of Ethics that stipulates the need for accuracy, neutrality and maintaining clear boundaries and the interpreter's responsibility to uphold their cultural responsibilities towards patients in accordance with customary law.

4) The interpreters and ALOs put forward strategies for the framing of and dealing with cultural difference as they contend with culturally distinct communication patterns while interpreting for Aboriginal patients.

These key findings closely relate to the research questions the study sought to address. With respect to the first research question, how interpreters and ALOs talk about how they do their work when they interpret or advocate for their clients, storytelling emerges as the primary vehicle that the interpreters and ALOs use to talk about their professional practice. It is through the telling of stories and the positions they claim that they construct a sense of their professional identity. The second research question that explores the strategies and actions interpreters and ALOs report they employ to resolve potential communication differences, is addressed through the interpreters' and ALOs' input on the strategies they use to negotiate and resolve cultural difference as they take into account culturally distinct communication patterns while interpreting for Aboriginal patients.

7.2 Major findings

7.2.1 Storytelling

The primacy of storytelling in this thesis is evidenced by the frequency with which stories appear in the data set, as 25 stories were offered by the interpreters and ALOs. Although this propensity to shift into story mode may also occur in other professional contexts, in this interview setting, it may emanate from the interpreters' and ALOs' specific way of knowing that draws on a strong oral tradition of sharing knowledge. This is primarily because in Australian Aboriginal societies storytelling tends to be a habitual practice that constitutes an integral way of life; "it is used to inform past histories, kinship structures, beliefs, values, morals, expected behaviour and attitudes (Batchelor Institute of Indigenous Tertiary Education & Ober, 2017, p. 10). Outside of the Australian context, for First Nations and Métis peoples in Canada, Iseke (2013) also

supports that"[s]torytelling is a practice in Indigenous cultures that sustains communities and validates the experiences and epistemologies of Indigenous peoples" (p. 559). Indigenous scholars, Archibald (2008) and Kovach (2010) utilise storytelling as an approach to research because it is "congruent with an Indigenous paradigm. It involves a dialogic participation that holds a deep purpose of sharing stories as a means to assist others" (Kovach, 2010, p. 40).

This study is the first to use small story theory and narrative positioning analysis to explore stories that are told by interpreters of Aboriginal languages and ALOs when they discuss how they do their work. As discussed in Chapter 2.1, the small story approach has been used in a wide range of contexts; in studies of identity claims that emerge in interview and non-narrative data (Georgakopoulou-Nunes, 2009); in studies of ethnic identities among migrants (Barkhuizen, 2010; Galasińska, 2009); to illustrate the presentation of hybrid and emergent identities in intercultural encounters (Lee, 2015), and in social media as a salient aspect of online communication practices (Georgakopoulou, 2017; Georgakopoulou, 2016; Georgakopoulou-Nunes, 2017; Page, 2018).

Small story research has also been conducive in the analysis of professional practice (Armon & Georgakopoulou-Nunes, 2017; Barkhuizen, 2010; Ehrlich, 2015; Holmes & Marra, 2011; Juzwik & Ives, 2010; Oostendorp & Jones, 2015; Pomerantz & Kearney, 2012; Rugen, 2013). In terms of narrative positioning analysis, Watson (2007) examines the construction of the professional identities of two student teachers, De Fina (2013) illustrates how Bamberg's level 3 positioning can be used to link "local identity displays to marco social processes" (p. 42). One recent study by Runcieman (2018) adopts a small story approach coupled with a narrative positioning analysis to explore the manner in which higher education institutions contribute to constructing the identity of the professional interpreter from a student perspective. However, exploration of

stories told by professional interpreters of Aboriginal languages and ALOs appears to be a novel area of research.

For the interpreters and ALOs in this study, the telling of a story is a relational practice; it becomes a dialogue between the teller and listener, who are actively involved in the telling. This active involvement manifests in the manner in which the participants step out of both their professional roles as interpreters and ALOs, and their situated roles as interviewees and adopt the role of narrators as they shift from argumentative sequences into story-mode. Therefore, these shifts into storytelling mode are not haphazard. They are as Bamberg (2016) notes, offered intentionally and "are embedded in previous and subsequent turns, that is *interactive befores and afters*" (p. 1292, emphasis in the original). At times, the researcher also shifts roles from interviewer to co-participant, as she relates to the story in various ways: questioning, predicting and imagining and in effect at times contributing to the co-construction of the story. Approaching stories from a small story, practice-based approach, sees language "performing specific actions in specific environments and as being part of social practices, shaping and being shaped by them" (Georgakopoulou, 2015, p. 257). This practice-based approach closely relates to the way in which stories are perceived in Aboriginal communities in Australia. The participants in the study thus share a cultural understanding of the role that stories plays in their lives and this is in line with Bamberg (2016) who explains that this shared cultural understanding is "due to continuous bodily and verbal practicing of their social interactions in mundane and everyday activities" (p. 1292). It is this propensity to use stories in their everyday interactions that may have motivated the interpreters' and ALOs' offering of stories in the situational context of the interview.

Storytelling is also a means of validating an Aboriginal self. Ober (2017) explains that storytelling or *yarning* is deeply rooted in "the processes and structure of Aboriginal society" (p. 8). It is the discursive means by which the "deep cultural and

historical knowledge that make up the social and cultural identity of Aboriginal people" is imparted (p. 8). Collins and Cooper (2005) also suggest that "storytelling becomes a vehicle for discovering who we are, for making sense of our world, for enhancing our learning/teaching, and for plain old fun" (p. 1). Through the exchange of stories, the interpreters and ALOs in this study contribute their understandings of the complexities of interpreting for Aboriginal patients in medical settings and in doing so demonstrate the construction of not a single identity but multiple shifting identities. Therefore, the interpreters' and ALOs' identity emerges not as a static attribute of individuals or as associated with comparatively fixed social categories such as gender or race, but as Bucholtz and Hall (2005) assert identity is framed as a dynamic, hybrid, fragmented construct that is established in relation to other social actors or identity positions.

7.2.2 Interpreter and ALO positioning

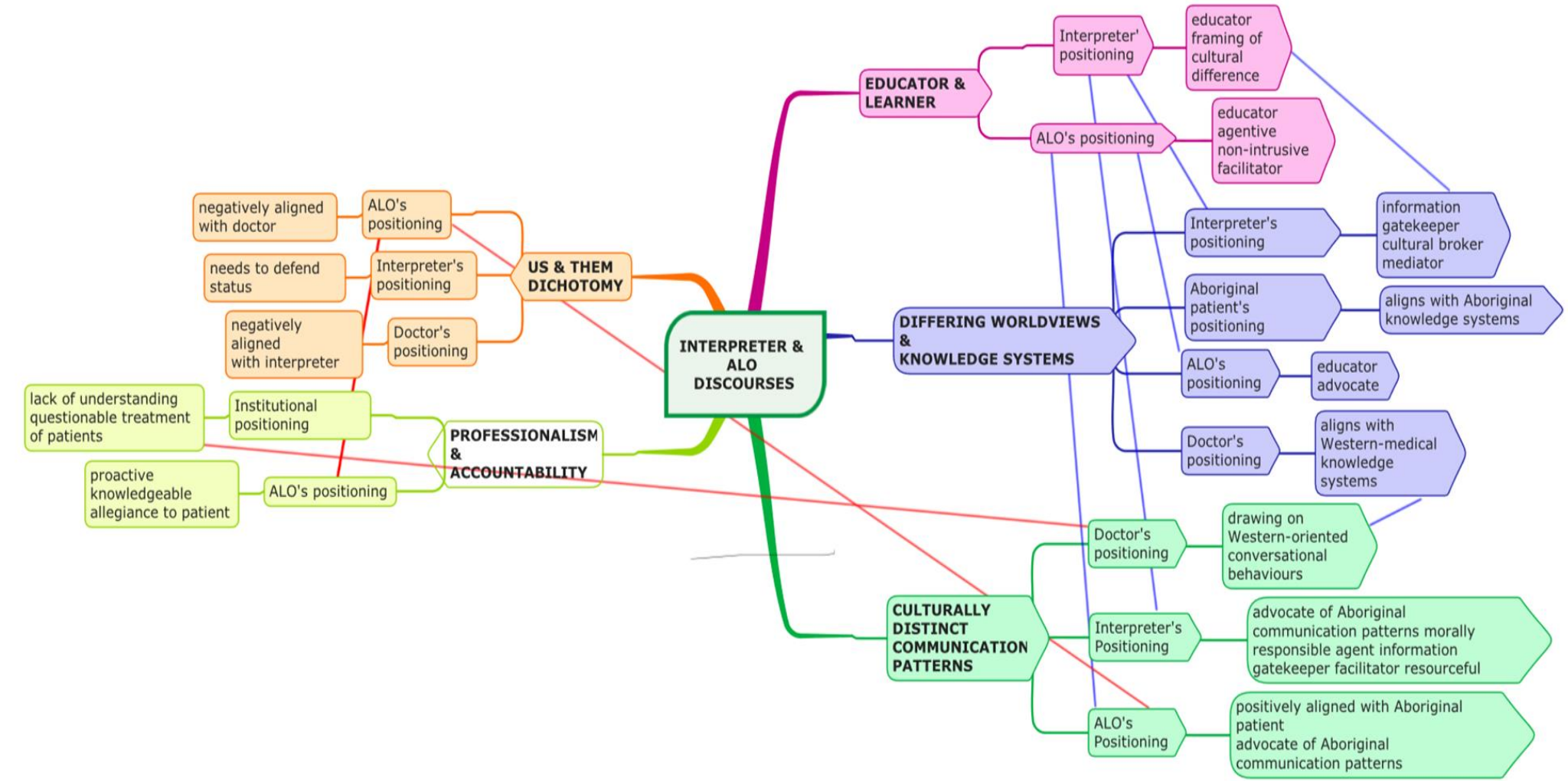
The narrative positioning analysis has brought to the fore five distinct yet interrelated Discourses which as discussed in Chapter 2.3 and illustrated in Chapter 5, perceive identity as being determined by societal macro conditions, which in this study are closely tied to health institutional contexts. The Discourses that are invoked highlight the diverse positions that the interpreters and ALOs claim for themselves and other social actors in the stories they narrate. These Discourses are also reinforced in the non-narrative data and include:

1) professionalism and accountability
2) differing worldviews and knowledge systems
3) us and them dichotomy
4) educator and learner
5) culturally distinct communication patterns

Although analysed as distinct Discourses in Chapter 5, what becomes evident is that these Discourses overlap and interact with one another and showcase the challenges the

interpreters and ALOs face as they fulfil their respective roles. These Discourses also bring to light the multifaceted positions the interpreters and ALOs attribute to themselves as well as other social actors as they negotiate their professional identities. Figure 2 was constructed by identifying the positions that the interpreters and ALOs report they adopt in the stories they tell. I then show how these positionings are related to the Discourses that were invoked by the participants. Figure 7 shows that the Discourses invoked by the interpreters and ALOs are constructed in relationships of complicity with other Discourses, particularly when the positioning of the storytellers aligns across the data set.

Figure 7. Multiple positionings and interrelated Discourses



For instance, we see this alignment in stories where the positioning of the interpreter or ALO, is positively oriented towards the doctor and the institution. For instance, the positioning of educator and advocate is invoked in Discourses surrounding *differing worldview and knowledge systems*, *educating and learning* and Discourses related to *culturally distinct communication patterns*. However, Discourses also arise out of contestation with other Discourses, and this emerges in contexts when competing Discourses are invoked; for instance, when interpreters' and ALOs' positioning is negatively aligned with the doctor and institution in Discourses pertaining to *an us and them dichotomy, differing worldview and knowledge systems* and *culturally distinct communication pattern.* The following section highlights the interrelatedness of the Discourses constructed by the interpreters and ALOs, which they invoke to showcase aspects of their professional identity.

7.2.2.1 Professionalism and accountability

With respect to Discourses surrounding *professionalism and accountability,* the stories offered by four ALOs invoke a Discourse pertaining to a lack of institutional accountability that is manifest through the ALOs' evaluation of the health institution's deficiency in the provision of appropriate care to Aboriginal patients as evidenced in the 'Failure to thrive story'. This Discourse is made relevant through the identification of repeated story-lines and patterns in other stories in the data-set (De Fina, 2013; Georgakopoulou, 2013). For instance, related Discourses invoked are that of the problematic treatment of Aboriginal patients that comes across in the 'You're a bit too fat' story and the institution's lack of understanding or cultural competence with regards to the use of cultural appropriate terms in 'The peepee and the mutcha' story. In positioning the health institution as accountable for this questionable behaviour, ALOs Sarah, Melanie and Lenny also invoke a Discourse of *professionalism* that is extended to construct their professional sense of self. They are positively oriented towards their

patients and position themselves as proactive, culturally aware and knowledgeable. They frame these attributes as a symbol of professional conduct, which is integral to their identity, and this is juxtaposed with the perceived unprofessional conduct attributed to the health institution.

In the stories discussed here, the ALOs' allegiance seems to align with the patient and overrides their allegiance to the institution. Reasons for this alignment can be found in wider Discourses that highlight in-hospital disparities in care experienced by Aboriginal and Torres Strait Islander people. Ilton, Walsh, Brown, Tideman, Zeitz and Wilson (2014) discuss disparities in acute coronary syndromes care and identify "inadequate cultural competence of health care providers and hospitals" as one of the potential reasons for why this segment of the population is less like to "undergo angiography in hospital and receive PCI or CABG surgery[13] than non-indigenous patients" (p. 641). A recent study on rheumatic heart disease in pregnancy also exhibited similar findings where it was perceived that "[p]oor communication and unsatisfactory, culturally inappropriate unsafe interactions with healthcare providers contribute to the poor outcomes for remote dwelling Aboriginal women" (Belton et al., 2018, p. 429). Seen in this context, it is not surprising that in this study some of the ALOs' assert that their duty of care and subsequent allegiance lies with the Aboriginal patient and not the institution.

[13] PCI - Percutaneous Coronary Intervention
CABG - Coronary Artery Bypass Graft

7.2.2.2 Professionalism and Accountability & Differing worldviews and knowledge systems

Throughout the dataset, the institution's accountability is also brought into question with respect to competing Discourses, in particular when Western medical knowledge systems do not align with Aboriginal knowledge systems. The narrative positioning analysis has highlighted the *differing worldviews and knowledge systems* as a central Discourse that pervades most stories and is reinvoked in the non-narrative data. For instance, the institution is held accountable for the health practitioners' resistance and or lack of knowledge concerning holistic medicine and traditional healing practices, such as consulting a traditional healer, as expressed in the 'Absconding from ED story'. Through the telling of several other stories, including the 'cut foot' story, the 'talking with ancestors' story, the 'alternative ways of healing' story and the 'bush medicine' story, we come to see collective representations of the interpreters and ALOs navigating the clashing worldviews and knowledge systems that co-exist in the competing worlds of the health practitioners and the Aboriginal patients.

In narrating these stories, the interpreters and ALOs lay claim to multifarious positions that are central to the construction of their professional identities. In the 'cut foot' story and the 'absconding from ED' story, for example, the ALO Sarah positions the doctors as negatively oriented to the Aboriginal patients' by virtue of their failure to recognise that their respective patients were drawing on Aboriginal knowledge systems. These include: traditional and spiritual belief systems about curses and retribution; ideas on causation and the use of traditional and holistic medicine. Conversely, Anglo-Celtic Discourses concerning health and the propensity to conduct evidence-based medicine construct the perceived objective medically oriented stance that pervades the doctors' positioning. However, in stories where doctors are positioned as being open to incorporating culturally sensitive care, interpreter Annie and ALO Trudy position themselves positively vis-à-vis the doctor and in turn the institution is positioned as

'forthcoming' in incorporating alternative ways of healing. The ALO, Sarah, also positions herself as advocate for Aboriginal people through her claim that the representation of Aboriginal patients' health beliefs as counter normative is a recurrent issue. In taking on this stance of advocate, Sarah establishes her subjective alignment with Aboriginal people and this is reinforced via her reference to 'our mob', which constructs a sense of shared identity with her people. Similarly, ALO Rachel adopts a stance that normalises traditional Aboriginal health and spiritual beliefs and behaviours in the 'talking with ancestors' story.

One of the central sources of miscommunication in the stories discussed above, which stems from clashing worldviews, is the understanding of causation form two competing positions; one emanating from Western medical knowledge systems and the other from Aboriginal knowledge systems. This source of communication is analysed with relation to wider social process that are located in the literature (De Fina 2013; Georgakopoulou, 2013). As Maher (1999) claims for Australian Aboriginal people, health beliefs attribute meaning to events. This means that "explaining health, illness, and their causation, so that they are embedded in a wider context, is part and parcel then of any attempt to provide meaning" (Boddington & Räisänen, 2009, p. 16). According to Boddington and Räisänen (2009) a closely connected notion is that the health of an Aboriginal person is intricately linked with the health of their community. This very notion may become the source of some perplexity in discerning "how an individual's health status could be so intimately bound up with something external to the individual," which marks a stark contrast with prevailing Western concepts of health that perceive that "the health of an individual is a descriptor only of that individual" (p. 13).

7.2.2.3 Professionalism and Accountability & Us and them dichotomy

The narrative positioning analysis underlying the research presented here, accentuates the notion of accountability, which is once again invoked in Discourses pertaining to an *Us and them dichotomy.* These polar positionings manifest in repeated storylines that portray the routinised construction of a doctor's repeated resistance to the use of interpreters, which sometimes extends on an institutional level. Interpreter Gary exhibits his negative alignment with the doctor who undermines his status as a professional interpreter by requesting his services unofficially, in the 'unofficial Kriol interpreter story'. Interpreter Annie is also negatively oriented towards the doctor who is portrayed as dismissive as he trivialises the work performed by interpreters and challenges the utility of interpreting for Aboriginal patients in the "you need a Kriol interpreter' story. While Annie showcases the multifaceted positions that are central to her professional identity in the 'bush medicine' story, namely that of an information gatekeeper, cultural broker and mediator, she is forced to defend her professional status and practice in the "you need a Kriol interpreter' story. What becomes evident in the telling of this story, is the power differentials that come to bear as Annie succumbs to pressure and instead of continuing to contest the doctor's refusal to use an interpreter, she placates the doctor via the provision of strategies the doctor could use while conversing with Aboriginal patients. In hindsight, she construes these strategies as ineffectual, reclaims her initial positioning and asserts her identity as a professional interpreter. The impact of shifting power relations on the identity of a professional interpreter falls beyond the scope of this thesis but it is presented here to highlight the power differentials that may impact on their professional practice.

Interpreters Gary and Annie invoke Discourses pertaining to resistance or the low uptake of interpreters by health practitioners, where the interpreter is negatively oriented toward the health practitioner. However, interpreter Francesca illustrates how an *Us and them dichotomy* is constructed when interpreters are positioned in direct

opposition to ALOs. This is evidenced in the 'we'll ring you when we need you' story where there is a preferential use of unofficial interpreters, including ALOs, family members or friends, and interpreters are only commissioned as a last resort, following the breakdown of communication.

Discourses related to the preferential use of informal interpreters are also offered in the argumentative sequences in the non-narrative data. Interpreter Annie firstly orients positively to ALOs by acknowledging the value they bring to the medical encounter and foregrounds the importance of the ALOs' cultural competence when communicating with patients. She then adopts a more critical positioning and expounds the rationale behind refraining from drawing on ALOs to interpret for Aboriginal patients by asserting that being of Aboriginal descent does not automatically equate to being proficient in an Aboriginal language. Interpreter Francesca explains that there is an added difficulty when interpreting traditional Aboriginal languages as even geographically proximate language groups may exhibit differences. Therefore, geographical proximity does not necessitate mutual intelligibility. Francesca also raises the issue of breaching the AUSIT (2012) code of ethics by illustrating the potential conflict of interests that may arise when family members or friends interpret. A final consideration is that of the unofficial interpreters' lack of competence as they do not have the necessary training to understand and interpret medical terminology and concepts.

As we have seen in Chapter 6, the low uptake of accredited interpreters may be attributed to barriers to access given the "unique challenges" that are associated with Aboriginal language interpreting (Commonwealth Ombudsman (Australia), 2016, p. 1). Some of these barriers include the unavailability of an interpreter in a minority Aboriginal language, the non-completion of an assignment by an interpreter or being in an avoidance or poison relationship (Butcher, 2008; Ralph et al., 2017). Several studies

support these findings as the uptake of interpreters in Australian hospitals varies from site to site (Bonacruz Kazzi & Cooper, 2003; Mahmoud et al., 2011; Garrett et al., 2008). There is also a preference for ad hoc or unofficial interpreters including untrained bilingual staff, family and friends (Ralph et al., 2017; Garrett et al., 2008; Zimbudzi et al., 2010).

An important finding emerged in the non-narrative data concerning the distinction ALO Melanie makes between linguistic interpreting and adopting the role of 'cultural interpreter' for Aboriginal patients. Culture brokering is defined as "the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change" (Jezewski, 1990, p. 497). In the health context, it involves "bridging gaps in cultural meanings or gaps in understanding between health professionals, the patient, his/her community and the broader social system" (p. 80). Melanie provides instances when she would position herself as 'cultural interpreter'; for instance, when health practitioners are unaware that their communication or behaviour is not culturally sensitive and comes across as 'offensive'. This is when she would educate staff on a 'better way to approach our clients' (Extract 16, lines 24-29). This self-proclaimed positioning as 'cultural interpreter' is potentially interlinked with ALO or Aboriginal Health Worker (AHW) roles[14]. The systematic review by Topp, Edelman, and Taylor (2018) has identified that AHW roles replicate the roles attributed to community or primary health workers in an international context; namely, roles "with a focus on primary health care tasks such as education, basic health care, and community health action" (p.2) However, as the role of the AHW evolved in the Northern Territory, it has been extended to include that of

[14] According to State of New South Wales NSW Ministry of Health (2018) "[t]he Aboriginal Health Worker category includes the roles of Aboriginal Community Health Workers, Aboriginal Hospital Liaison
Officer and Aboriginal Liaison Officer. These roles are non-clinical and provide a variety of services in a community and/or hospital setting. These services include advocacy, support, liaison and health promotion.

'cultural brokerage' and "the focus on provision of culturally safe and comprehensive care services to Aboriginal and Torres Strait Islander people" (p. 2). Therefore, the ALOs as culture brokers act as a go–between, advocating or intervening on behalf of Aboriginal patients.

7.2.2.4 Educator vs Learner and Culturally Distinct Communication Patterns

This positioning as advocate is closely associated with Discourses pertaining to the education of the broader non-Indigenous hospital staff. The narrative positioning analysis brings to the fore ALOs' and interpreters' positioning as educators of treating teams and Aboriginal patients, and this central theme emerges in the non-narrative data in terms of strategies interpreters use to frame cultural difference when interpreting for Aboriginal patients. In the 'don't make assumptions story', the 'give her time to answer story', and the 'acutely ill' story', the ALOs make claim to the position of educator and the treating teams adopt the respective position of learner. The ALOs' stance come across as agentive, non-intrusive, non-patronising as the objective is to facilitate treating teams' engagement with Aboriginal patients. Therefore, the ALOs' positive alignment with the treating teams opens up channels of communication and the treating teams' positioning as learners manifests through their willingness to firstly, request assistance to overcome communication barriers and secondly, to seek counsel on how to broach culturally sensitive topics of conversation such as death.

In turn, the interpreters take on the position of educator to help reconcile the cultural differences between Aboriginal patients and health service providers. In the "I am not sick one' story, interpreter Jill educates Aboriginal women in the community about a preventative screening test for cervical cancer. We have seen that interpreters may also have a pedagogical function, teaching ST terms along with the accepted TT adaptations. This pedagogical function has the function of empowering patients. Acknowledging the prevalence of cultural difference that stems from differing

worldviews, interpreter Jill approaches the subject in ways in which the Aboriginal women can understand. This entails drawing on their shared cultural heritage and espousing perceptions related to cultural appropriateness by using euphemistic terms to avoid taboo topics such as private body parts. Beyond the negotiation of taboo topics, Jill takes into consideration Aboriginal women's cultural beliefs and practices that pertain to classificatory relationships that guide communication and . As McGrath et al., (2005) assert, this involves having an understanding of network relationships in a particular community and knowing to whom it is appropriate to dispense information. Another key consideration when interpreting for Aboriginal people relates to negotiating differing ideas on what it means to be sick. For instance, the Aboriginal women's understanding of the causal relationship between visiting a doctor and being diagnosed as sick, may potentially act as a deterrent against participating in preventative screening tests for cervical cancer. As discussed in Chapter 5, the Aboriginal women construct a causal relationship between visiting a doctor and receiving a positive diagnosis, which may stem from continuous media coverage of Aboriginal and Torres Strait Islander peoples' poor health outcomes (Taylor et al., 2010). A further explanation put forward by Fogarty et al., (2018) associates Aboriginal social identity with narratives of deficit and disadvantage that may serve to disempower Aboriginal people. Although interpreter Jill is cognizant of the cultural and medical salience of her positioning as educator, she does not diminish the Aboriginal women's agency and autonomy and ultimately allows the women to take control of the decision-making process.

The interpreter's positioning as educator also extends to the education of health practitioners in the 'we don't make decisions in one day' story. Interpreter Alicia draws on her professional expertise as interpreter of Aboriginal languages including Gooniyandi, Walmajarri and Kriol and educates health practitioners on the

cultural appropriateness of allowing Aboriginal patients and their families time to absorb information presented to them during their clinical encounters. In initiating discussions with health practitioners, interpreter Alicia's positioning as educator allows her to construct a shared way of talking for Aboriginal people and in doing so underscores the significance of the work of interpreters of Aboriginal languages in the hospital settings.

Much of the work that interpreters of Aboriginal languages and ALOs do involves navigating culturally distinct communication patterns stemming from distinct linguistic and paralinguistic differences between Aboriginal- and Western-oriented conversational behaviours. The findings from the narrative positioning analysis illustrate the intricacies of conversing with Aboriginal patients. In the 'sitting, listening and talking story' and 'I can't read' story, the Aboriginal Service Development Worker, Trudy, adopts the dual positions of patient advocate (Drennan & Swartz, 2002) and informational gatekeeper (Davidson, 2000, 2001) as she tries to bridge the communication differences that exist between health practitioners and Aboriginal patients. She draws on her professional identity as Aboriginal Service Development Worker to reorient prevailing communication practices in healthcare setting to ensure that a more patient and person-centred framework for communication is implemented. For instance, she suggests the adoption of more culturally appropriate communication and active listening behaviours for doctors that typically employ Western-oriented conversational patterns and behaviours during beside consultations. This section shows how the positions of advocate and informational gatekeeper are also intertwined with the ALOs' self-disclosed Aboriginal identity which is closely linked with being conversant with Aboriginal ways of talking. This section illustrates how the ALOs utilises their knowledge and positive alignment with the patients through the positions

they claim to enhance communication and establish close connections with their patients.

7.2.3 Positioning of Interpreters & Code of Ethics

The multiple and shifting positions that interpreters take up as they interpret for Aboriginal patients is often in conflict with their responsibility to abide by the AUSIT (2012) Code of Ethics and Code of Conduct. Firstly, in espousing a position which seeks to elucidate contextual and sociocultural knowledge surrounding the use of traditional medicine, in the 'bush medicine' story, Annie forefronts the multifaceted positionings that are integral to her identity as a professional interpreter. This results in her enacting not a single identity as an interpreter but shifting identities as information gatekeeper, cultural broker and mediator. It has been widely cited that interpreters assume these roles as well as one or more of the following: chairperson and gatekeepers (Fenton, 1997; Linell, 1997; Wadensjö, 2005); co-diagnosticians and informational gatekeepers (Angelelli, 2004; Davidson, 2000, 2001); cultural broker (Butow et al., 2011; Dohan & Levintova, 2007); patient advocate (Drennan & Swartz, 2002); professional and manager (Hsieh, 2008; 2016).

In this study, we have seen that the interpreter's role goes beyond the relaying of information in the traditional sense of a conduit that portrays the interpreter as a "supposedly neutral or passive third party" (Roy, 2000b, p. 103). In the context of bilingual health communication and in this case interpreting for Aboriginal patients in medical settings, the complex nature of interpreting as communication entails a necessity to contend with differing traditional and spiritual belief systems. These pertain to discourses of payback and spirituality, having to interpret taboo topics and taking into consideration patterned differences that incorporate the use of English expressions with a non-standard meaning. Therefore, as Sleptsova et al., (2014) explain, interpreting

entails “the exchange – and transfer of multiple, interwoven layers of information” (p. 168).

Although Hale (2004, 2007) warns against shifting into roles of advocacy, mediation, and gate-keeping so as to maintain impartiality and neutrality, some of the interpreters acknowledge that abiding by the AUSIT (2012) Code of Ethics and Code of Conduct contravenes their cultural responsibilities towards the patient. The principle that calls for clarity of role boundaries, which specifies that interpreters are not to “engage in other tasks such as advocacy, guidance or advice” (p. 6), does not seem to translate into practice. The multiple, shifting positions the interpreters adopt also finds expression in the aforementioned literature on interpreter roles. It becomes evident then that the boundaries between maintaining impartiality and neutrality, and advocacy roles becomes blurred when interpreting concepts that stem from clashing worldviews. The related principle of impartiality which states that “[i]nterpreters and translators observe impartiality in all professional contacts …[and] remain unbiased throughout the communication exchanged between the participants in any interpreted encounter” (p. 5) is a stipulation that as Cooke (2009) suggests virtually impossible to uphold. This is primarily because of the close kinship ties Aboriginal interpreters have with members of the community which entails being cognisant of their “rights and obligations under customary law according to the kinship category” (p. 90). The interpreters acknowledge that there is a tension between abiding by the AUSIT Code of Ethics and Code of Conduct and their cultural responsibilities towards the patient and this is motivated by a need to advocate for cultural appropriacy and security.

The underlying tension lies in that traditional conceptualisations of the role of the interpreter as conduit, which is the role that the AUSIT code essentially postulates, has as Hsieh (2016) argues, three erroneous presumptions. Firstly, that “all participants are competent speakers who can communicate effectively and appropriately” (p. 27).

This study has established that this is an erroneous assumption particularly when considering that health practitioners and Aboriginal patients draw on different conversational patterns or knowledge systems in their interactions. This is evidenced when Aboriginal patients struggle with question-answer routines which do not align with the Aboriginal people's conversational routines. The story, 'it's not part of the storyline' also illustrates the fallacy inherent in this assumption. For instance, in this story, ALO Sarah explains that when doctors inquire about the onset of a particular symptom, Aboriginal people of Arnhem land do not interpret this as a question that is designed to elicit vital biomedical information during the history taking stage of the consultation. Instead, what is of primary concern is when the illness becomes part of their storyline or song line. Therefore, what is communicatively effective and appropriate is dependent on the conversational norms that are relevant to the parties in the interpreter-mediated encounter. The second erroneous assumption Hsieh (2016) proposes is that "there are minimal differences between speakers' cultural knowledge and social practices" (p. 27). As we have seen, this assumption is undermined repeatedly in this study as the interpreters and ALO discuss the prevalence of competing Discourses that stem from divergent worldviews; for instance, beliefs in traditional and holistic medicine and associated social practices that require partaking in smoking ceremonies or consulting traditional healers. The final assumption suggests that "it is desirable to maintain the existing structure of relationships and patterns of communication" (Hsieh, 2016, p. 27). The findings from this study illustrate that this assumption undermines the relational nature of much of Aboriginal communication behaviours; Interpreter Gary, explains that in the legal and health context, Aboriginal people often slip into a yarning style of communication and this is congruent with Lin et al., (2016) who support that yarning is a means of conversing about important information, which is typically embedded within a story. Lin et al., (2014) assert that

yarning necessitates relationship building, 'two-way interaction and careful listening … [that] is conversational and non-confrontational" (p. 323). Discounting such conversational norms may as Gary asserts adversely impact on the interpreter-mediated encounter as the doctor or lawyer 'miss out on important details' and the Aboriginal person is left 'feel[ing] like they're probably not being listened to' (Extract 53, lines 80-83). Hsieh (2016) concludes that little is known about when, how or why interpreters move from one role or function to another. However, the findings from this study suggest that interpreters working with Aboriginal patients have extended their role to function as advocate and as a bridge between cultures. The motivating force driving these shifts in role and identity are what appears to be the interpreters' sense of cultural responsibility towards the patient and their responsibility under customary law. The next section deals with the final major finding which illustrates the strategies put forward by the interpreters and ALOs for the framing of and dealing with cultural difference as they contend with culturally distinct communication patterns.

7.2.4 Culturally distinct communication patterns and strategies

The analysis of micro issues foregrounds some of the challenges the interpreters face as they deal with culturally distinct communication patterns and also bring to the fore the communication strategies they use to navigate these challenges. As Vass et al., (2011) explain English words or concepts that are often perceived to be straightforward by English speakers may "carry significant conceptual information" for which there may not be an equivalent in English or vice versa (p. 34). The insights that the interpreters offer on English expressions with non-standard English meaning further our understanding of the complexities involved in finding word-for-word equivalents when interpreting in medical settings. The following single-word equivalents were discussed to highlight that words do not have static meanings that are mechanically interpreted from one language to another: *shame, risk, deadly, grab and Koori*. Chapter 6

delineates the source of ambiguity and confusion that these words may cause for Aboriginal people and the difficulty interpreters face when the quest for equivalence fails.

Searching for equivalence between texts, whether they be written or oral, presupposes as Pym (2008) explains that two languages "do or can express the same values" (p. 272). However, this is not always feasible as a concept or single-word may be absent or have a different meaning in the target language (Vass et al., 2011). How does the interpreter achieve equivalence on grammatical, semantic, aesthetic and pragmatic levels when languages are as different as English, Aboriginal English, Walmajarri, Fitzroy Valley Kriol and Kimberley Valley Kriol? Hatim and Mason (1990) perceive this search for one-to-one equivalents as a futile exercise; on a lexical level they argue:

> It is erroneous to assume that the meaning of a sentence or text is composed of the sum of the meanings of the individual lexical items, so that any attempt to translate at this level is bound to miss important elements of meaning; [and on a grammatical level they conclude:] It is beyond doubt that this lack of a one-to-one relationship between grammatical categories [i.e. in different languages], including tense systems demonstratives, and adverbs of time and place creates problems for the translator (p. 3-4; p. 27).

In Chapter 6, the interpreters have identified challenges they face in their efforts to locate equivalent meanings of singe-word equivalents such as *shame, risk, deadly, grab* and *Koori*. They draw on the surrounding cultural context to offer an interpretation of these words. This is achieved by moving away from a focus on the form of a message to focusing on the response of the recipient. As Nida (1964/2003) suggests. the focus is on studying a text in context, where meaning is essentially negotiated between interlocutors. Such a focus on the recipient, which in the context of this study is the Aboriginal patient, ensures "comprehension of intent and enhances the general efficacy

of the communicative process" (Nida, 1964/2003, p. 182). For instance, a common strategy the interpreters use is "adaptation" which Vinay and Darbelnet (1995) proposes is a "kind of situational equivalence" (p. 39). With respect to the word 'shame' the interpreter Annie makes cultural adjustments to illustrate the use of the word in context with 'ɭHey stop getting shame. Like, don't be shy. Just go and get a feed.' (Chapter 6, Extract 1, lines 3-6). Moore (2014) and Harkins (1990) as well as other researches have also attested to the difficulty of offering a one-to-one interpretation of the word 'shame' given that , 'shame' does not carry the English denotation of having done something wrong or inappropriate. Instead, the Aboriginal English word 'shame' is used to refer to a variety of situations including being "singled out from a group, whether for rebuke or for praise" (Harkins, 1990, p. 10; Morgan et al., 1997; Spencer & Schlemmer, 1997).

The interpreters identified another English expression which does not appear to exist in Aboriginal English or Kriol; the word *risk* that is central to Western preventive health measures including "screening, certain chronic disease medications and behavioural strategies" (Vass et al., 2011, p. 36). This absence of a corresponding word for risk has also been attested by Vass et al., (2011) for the Yolŋu, the Aboriginal people of north-east Arnhem land. The strategies Annie the interpreter makes use of as she searches for an equivalent expression correspond to target-oriented and functionalist approaches to interpreting that focus on sense making. She explains, paraphrases and simplifies by associating the word *risk* with the word *warning*. In Kriol *warning* has an underlying connotation of *a sense of readiness*. What is particularly revealing in this segment is that the interpreter clarifies that even the word 'warning' has a different sense in English and denotes a sense of danger. She concludes that the Kriol understanding of 'risk' is to be ready' or 'prepare yourself' (Chapter 6, Extract 5, lines 8-9). This marks a contrast with the Western understanding of risk that carries negative connotations of "danger, hazard or threat" (Tulloch & Lupton, 2003, p. 320).

Like Nida and Taber (1969), Seleskovitch (1994) proposes striving for accuracy through the interpretation of meaning and not the transcoding of words by orienting the target message to the recipient. Therefore, the different senses that *shame* and *risk* acquire in Aboriginal English and Kriol require taking into consideration the speaker's intention and context when interpreting so as to be able to discern what meaning is used in a given context.

A related finding emerging from the non-narrative data is the importance of recognising taboo terms and the ability to interpret these terms in a culturally sensitive manner. Theoretical approaches to interpreting have as we have seen in Chapter 3, generally advocated for a focus on an ideal standard of "accuracy, completeness and fidelity" (Pöchhacker, 2016, p. 135). For instance, Tebble (1999) asserts that '[t]he medical interpreter needs to convey both what was said and the way it was said, remaining as close as possible to the physician's style" (p. 188). In the legal context, Hale (2007) argues that the interpreter's role is to express the illocutionary force and point of the ST as well as the ST's stylistic features which include: register, discourse markers, repetitions, backtracking and hesitations. Hale (2007) explains that these features "are important cues that help reveal the speaker's attitudes, commitment to the truth of the utterance, level of education, and even social and regional membership" (p. 11).

However, in this study, where interpreting takes place amongst culturally and linguistically diverse settings involving, Western health practitioners, Aboriginal patients, interpreters of Aboriginal languages and at times ALOs, it appears that the interpreters are compelled to attend to several competing tensions. In line with Taibi (2016) and Cooke (2009) these include: firstly, conveying "the meaning and pragmatic effect" of the doctors' utterances; secondly, ensuring that "intercultural and interpersonal relationships" are upheld; thirdly, striking a balance between the

interpreters' "professional roles and their responsibilities and restrictions under customary law"; and finally accommodating the expectations and requirements of the health institution (Cooke, 2009, p. 85; Taibi, 2016, p. 79).

The interpreters demonstrated how these competing tensions interact when interpreting taboo terms such as private body parts, STIs, and death and dying as well as the biomedical concepts of cancer and diabetes. The interpreters Jill and Annie discussed the complexities involved in interpreting private body parts that manifest in the context of screening for cervical cancer and the diagnosis of an STI. In both contexts the interpreters employ euphemistic language to make reference to the patients' genitals. For instance, interpreter Jill refrains from giving a word-for-word rendition of the word 'vagina' as uttered by the doctor and remains faithful to cultural appropriateness by using the terms 'wadi wadi'. The interpreter Annie discloses that when interpreting for a patient diagnosed with an STI, she would not broach the topic of sexual intercourse and instead would use circumlocution that involves a euphemistic paraphrase such:

Yu	mitimbat	with	dat	boi	imin	maiti	sikwan
2SG	meet.PROG	with	the	boy	3SG.PST	maybe	sick
'You	were	with	that	boy	he	maybe	sick

(Chapter 6: Extract 30b lines: 39-42)

Of interest is the Kriol equivalent of the verb 'meet' as in 'mitimbat', which acquires sexual connotations and is used to euphemistically reference having a sexual relationship with a person. In both cases the interpreters omissions are part of a conscious decision to meet the communicative goal of the interaction and remain faithful to the cultural and conversational norms of their clients for whom the biomedical terms for genitals are construed as expletives in the traditional Aboriginal language. Previous research supports the use of politeness terms and euphemism when

interpreting utterances that contain taboo topics. Berk-Seligson (1988) support that interpreters tend to offer renditions of the ST that are often more polite in the TT. Similarly, Jacobsen (2008) found that the interpreter tended to modify "face-threatening and face-protecting utterances in an attempt to protect her own face and/or the face of one of the primary participants" (p. 128). Therefore, when confronted with taboo topics, the interpreters may employ euphemisms or omit culturally offensive utterances in an attempt to maintain cultural sensitivity and abide by cultural constraints.

In terms of maintaining intercultural and interpersonal relationships, interpreter Jill highlights the challenges associated with dispensing information to the right person with 'because they were my mums, I couldn't really .. force them' (Chapter 5 Extract 19 lines 125-126). As discussed in Chapter 5, the maintenance of intercultural and interpersonal relationships entails having an appreciation of the salience of network relationships that are governed by age and classificatory relationships. Firstly, the age of the interpreter may affect the interpreter mediated encounter. Cook (2009) posits that "mature" legal interpreters who are held to high esteem in their communities are "more likely to be accepted as interpreters than young people (and particularly young women)" (p. 89). Secondly, customary law prescribes adherence to kinship norms as they are "the basis of Aboriginal philosophy, social structure, social behaviour, interpersonal behaviour and law" (Cooke, 2009, p. 88). Thus, being in an avoidance or poison relationship has the potential to breakdown communication and may become an impediment to direct interpreting (Butcher, 2008).

The interpreters have overtly referenced the challenge of striking a balance between their professional roles as interpreters and their cultural responsibilities towards their clients. Interpreter Annie discloses that despite the fact that the job of an interpreter is to 'interpret exactly what the doctor is saying' (lines 63-68) she finds it difficult to abide by the AUSIT (2012) Code of Ethics pertaining to the principle of

accuracy consistently. More specifically the stipulation relating to accuracy prescribes "optimal and complete message transfer into the target language preserving the content and intent of the source message or text without omission or distortion" (p. 6). This is a conscious choice made by the interpreters as a literal rendition would constitute a breach of their cultural responsibilities towards the Aboriginal patient or a breach of Aboriginal customary law. Cooke (2009) outlines customary restrictions that may guide or place limitations on Aboriginal interpreters interactions with Aboriginal clients:

- Respectful language is used when interpreting for an elder.
- Some relatives must be addressed in the plural form (just as respect is signified in French by addressing people using vous instead of tu for you).
- Vulgar speech must not be used in many circumstances (as one interpreter said, "you put it another way").
- During periods of ceremony people may be further constrained in who they talk to and how they talk (p. 93).

As Cooke (2009) posits, the consequences of not abiding by such cultural specifications are two-fold; firstly, they may compromise the quality of police or courtroom interviews and secondly, if the interpreter choses to ignore customary law and employ Western-oriented question-answer routines, "then the course of the interview would still be impacted by dynamics of embarrassment, hostility or even a reluctance to proceed on the part of the interviewee" (p. 93). Eades (2008) also argues that preoccupation with rigid discourse patterns such as question-answer routines are designed to elicit specific answers to the questions asked during legal proceedings. It has been widely attested that witnesses' efforts to step into story mode are silenced resulting in a disempowering of Aboriginal witnesses (Eades, 2008, 2015). Such unintended communicative effects may also be present when interpreting for Aboriginal patients in medical settings and they also have the potential to compromise accuracy and disrupt the interpreter-mediated encounter.

There are also tensions stemming from the interpreters' having to accommodate the expectations and requirements of the health institution. This typically means interpreting under tight time constraints. Interpreter Gary acknowledges that in an interpreting situation, 'most of the time, you're pressed for time' (Chapter 6, Extract 17, lines 3-4). These time constraints compromise quality in the sense that interpreters are not always able to provide verification of patient understanding so that as Gary explains "you don't have time to verify that their understanding is the same as yours' (Chapter 6, Extract 17, lines 21-24). This finding is in consonance with Sturman et al., (2018) who found that the placing of time constraints on interpreters was a systemic practice that resulted in interpreters, general practitioners and patients all "feeling rushed in some consultations, which tended to reduce their effectiveness, particularly if the doctor appeared impatient to the others present" (p. 235). Thus, there is general agreement that more time needs to be allocated for interpreter-mediated consultations for them to be effective.

With respect to key foundational health concepts including the microscopic world of disease, particularly, cancer and diabetes, the interpreters and in some cases the ALOs employed a variety of different strategies. In Walmajarri, when interpreting the word *cancer*, it was common to use a euphemism such as *mimi* which roughly translates to 'sore' in English. The interpreter Annie would accompany *mimi* with a pointing gesture directed towards her own body to indicate the locus of the cancer. Interpreter Gary explains that he uses paraphrase and explication in instances when the doctor uses medical terminology to discuss "a certain type of cancer" (Chapter 6, Extract 17, lines 25-30). Gary also makes a salient point related to interpreting biomedical language such as *cancer* and *diabetes*; that there is a commonly held erroneous assumption that such terms are understood by all Kriol speakers (Chapter 6, Extract 11, lines 9-11). Drawing on his experience, he clarifies that Kriol speakers 'may

not have the same understanding of what that is ah .. than what I have, or the doctor has' (lines 26-30). This is widely attested in legal interpreting. On a lexical level, ALOs, Katrina, Melanie and Trudy discuss having to contend with Aboriginal patients refraining from uttering the word 'cancer' altogether. Some Aboriginal patients make use of prosodic features such as whisper when uttering the word 'cancer'. This gap in understanding is substantiated in literature pertaining to legal interpreting where even small phonological, syntactic and lexical differences may confound communication (Cooke, 2002; Eades, 2012). Eades (2012) attests that such differences may "impact on communication with Aboriginal speakers of English as their first language (and often their only language of regular usage) …" (p. 477).

As we have seen in section 6.2.4, the interpreters use a range of strategies when they interpret taboo topics or medical terminology and concepts that do not have equivalents in the Aboriginal language. These include omissions, use of euphemisms, gesture, circumlocution, explanation, paraphrase and simplification. The interpreters' decision to use one or more of these strategies is in line with purpose-driven approaches to interpreting. For instance, these strategies follow Skopos theory whose guiding principle is the purpose of the translated message and not equivalence between source and target text (Reiss & Vermeer, 1984/2014). This allows for interpreting to be "functionally and communicatively adequate" along the lines of the purpose as specified in the interpreter's commission or briefing session (AIWA, 2018; Munday, 2016, p. 84).

A corresponding finding that emerges in the non-narrative data is the interpreting of question-answer routines and pragmatic features including silence. The interpreters and ALOs commented on the ineffectiveness of a variety of question-answer approaches and it was generally recommended that closed-questions requiring a yes-no answer should not be used as patients tended to answer in the affirmative driven

by a desire not to causes offence. These findings are in line with Liberman (1980, 1981) who has identified gratuitous concurrence as a strategy common to Aboriginal people who "choose to avoid confrontation in interaction, even among themselves" (1980, p. 74). Eades (1992, 2008, 2015, 2016) attests to this tendency to respond to direct questions or closed questions in the affirmative by discussing this sociolinguistic feature of Aboriginal witnesses' evidence statements in the criminal justice system. Bain (2005) also asserts that English speakers may discern such agreement responses as genuine answers when what is occurring is agreement for the sake of maintaining harmony between conversational participants. Eades (2008) and Berk-Seligson (2009) point out that gratuitous concurrence is not limited to Australian Aboriginal people, but is also found among "U.S. Hispanics, Mexicans, and Americans of European ancestry … exhibiting a phenomenon known as 'acquiescence response set' [where they] will answer "yes" to both the negatively and positively worded questions" (Berk-Seligson, 2009, p. 103). There is consensus that question-answer routines are construed as impolite and confrontational and can have serious implications for Aboriginal people in the realm of criminal justice as well as in tribunals and court proceedings that relate to native title claims. (Berk-Seligson, 2009; Cass et al., 2002; Eades, 2008, 2015; Lin et al., 2016; Trudgen, 2000).

The interpreters and ALOs also noted the difficulties surrounding the use of negative-sentence constructions, English-tag constructions and interrogative structures involving choices. They were all deemed to be ambiguous and a source of confusion. They also identified direct questions whose linguistic form is that of a statement with a rising intonation pattern to be problematic. Using an affirmative statement with a rising intonation was misconstrued as a form of 'sarcasm' and thus considered to be 'offensive. It was concluded that these syntactic question structures would jeopardise communication or hamper rapport building with Aboriginal patients. Walker (1993)

asserts that negative questions pose greater comprehension difficulties than positive ones for both adults and children. Cooke (2002) and Eades (2010) have also identified that negative sentence constructions are a source of confusion due to their ambiguity. For instance, In *the Elcho Coronial,* Yolŋu witnesses would typically respond in the affirmative to confirm the validity of a negatively framed proposition regardless of their understanding of the question or their belief concerning the veracity of the proposition being questioned (Cooke, 2002).

Finally, with respect to interrogative structures involving choices, that require the interlocutor to choose from one of two alternatives, Liberman (1981) has shown that this syntactic pattern rarely occurs in Aboriginal varieties of English or in traditional Aboriginal languages and an Aboriginal person's response is often made with reference to the second alternative offered.

Typical ways of seeking information in Western societies draw on the assumption that the asking of direct questions is the most efficient way of gaining information (Eades, 2000). In the medical setting, such question-answer routines are evident in the history taking stage of a medical consultation where the doctor asks questions during the presentation of the complaint, elicits past medical, drug, family and social history before moving onto undertake a systemic enquiry which is more focused on the patient's current complaint and condition (Fishman, Fishman, & Grossman, 2005). However, as we have seen there are differences between Aboriginal and non-Aboriginal ways of asking and answering questions. As Eades (2014) attests "[w]hile questions are frequently used in Aboriginal conversations in certain contexts and functions, there are constraints on their use which serve to protect individual privacy" (p. 240). The difference lies in the function direct questioning serves in Aboriginal conversations. Eades (2014) argues that direct questions are typically employed to "seek orientation information" in instances where clarification is sought

about a topic of conversation, or background information about a person. Other times direct questions clarify the setting of a particular event (p. 240). In such instances, the linguistic structure is that of a statement with a rising intonation, which is "consistent with the indirectness" typical of Aboriginal patterns of social interaction (Eades, 2014, p. 240). When "substantial information" is sought Aboriginal speakers do not use questions; they employ more subtle approaches that "involves the person seeking information contributing some of their own knowledge on the topic, followed often by silence" (p. 240). There is no obligation on the part of the knowledge carrier to impart the information nor is there an expectation for them to do so. As Walsh (2014) and Simpson (2014) explain there are certain restrictions on the provision of secret or personal knowledge and information is imparted only to those individuals who have a right to receive such information. Therefore, information seeking constitutes a conversational strategy that entails speakers to have "an ongoing reciprocal relationship" (Eades, 2014, p. 241).

Finally, the findings from this study confirm the cultural specificity of some non-verbal communicative features including pauses and silence that function as salient discourse features in Aboriginal interactions. Eades (2000, 2010, 2014) contends that Aboriginal people speaking Aboriginal English, or a traditional Aboriginal language incorporate lengthy silences or pauses that are considerably longer than those that "non-Aboriginal people typically feel comfortable with" (2014, p. 441). Harkins (2000) discusses Aboriginal English conversational patterns and outlines the diverse function that silence serves; for instance, 'as a sign of comfortable deepening of communication, of preparation for a seriously considered response to the other, or a choice not to express some knowledge or opinions' (p. 74). The lengthy pauses highlighted by Eades (2014) become important in interpreting for Aboriginal people in health settings as identified by the Kriol interpreter Gary. Gary foregrounds the use of pauses and silence

as pragmatic features in the context of storytelling in the legal and health context when Aboriginal people 'switch into narrative mode of talking' (Chapter , Extract 53, lines 9-10), or a yarning style of communication. Gary posits that breakdown in communication occurs when doctors or lawyers interrupt the Aboriginal person during such lengthy pauses. In fact, Gary concludes that such interruptions 'cut their story off sometimes, when they're actually, starting to switch into being quite informative by telling a bit of a narrative' (Chapter 6, Extract 53, lines 59-67). The literature supports the varied functions that pauses and silence serve in discourse. For instance, Pauses and silence typically reflect general cognitive processing (Butterworth & Goldman-Eisler, 1979). Additionally, it has been found that there is a relationship between pausing and narrative structure and pausing and discourse structure (Esposito et al., 2007; Gee & Grosjean, 1984). For instance, Gee and Grosjean (1984) observed that pauses may signal plot units, have the tendency to increase as characters, plots and other story elements are introduced toward the middle of the story, and length of pauses decrease as the story comes to a conclusion. Mushin and Gardner (2009) also attest to the occurrence of longer silences during storytelling amongst the Garrwa speaking people that reside in two remote Aboriginal Australian communities in Northern Australia. What the authors find particularly interesting is the absence of any attempts to fill gaps between turns with the co-participants' assessments, non-verbal gestures or minimal responses. Eades (2014) has illustrated that Aboriginal non-verbal features such as silence may be "be interpreted as evasion, ignorance, confusion, insolence or even guilt" in the legal settings (p. 243). In addition, a misunderstanding of the meaning of silence can lead to unwarranted interruptions. These findings are mirrored in this study where the health practitioners' failure to understand the salience of silence and do not partake in active listening behaviour often means that the conversations between Aboriginal patients doctors do not have the desired outcome.

This chapter has brought together the analysis of Chapters 5 and 6 of this thesis and highlighted important findings: firstly that the interpreters and ALOs tend to use storytelling to talk about their professional practice; secondly, the interpreters and ALOs discuss the complexities of interpreting for Aboriginal patients in medical settings and do so through the multiple, shifting positions they attribute to themselves as well as other social actors in the stories they narrate. The positions that the interpreters and ALOs adopt emerge in the ongoing interaction and are also located across the data set. These positions highlight the Discourses that are invoked to frame their professional identity; thirdly, the interpreters discuss the tension between abiding by the AUSIT (2012) Code of Ethics that stipulates the need for accuracy, neutrality and maintaining clear boundaries, and their obligation to uphold their cultural responsibilities toward patients in accordance with customary law; finally, the interpreters and ALOs propose strategies for framing and resolving cultural difference as they discuss culturally distinct communication patterns they encounter while interpreting for Aboriginal patients.

In the following section, the conclusion, I acknowledge current limitations of this study and raise questions that this study has left unanswered that future studies could address. I finally discuss ways in which this research could be employed to guide interpreter training and educate health practitioners on culturally safe interpreting practices.

7.3 Overall conclusion:

The analytical tools employed in this study to investigate ways in which interpreting practice in healthcare settings can be enhanced to better facilitate communication with Aboriginal and Torres Strait Islander patients, are unique to the field of interpreting. The utilisation of interview data to examine how interpreters frame their experiences and interactional roles has the potential to further theories and practices pertaining to healthcare interpreting. Analysing the participants' stories through the lens of narrative positioning analysis provides valuable insights into how interpreters and ALOs perceive and position themselves within the context of story, the ongoing interaction, and with regards to wider Discourses that are drawn upon to frame the role, skills and attributes of the professionals in this study. It also brings to the fore the positions the interpreters and ALOs adopt as they navigate the complex challenges of cross-cultural interpreting. We have seen that the interpreters and ALOs bring their previous professional experiences and culturally distinct communication patterns into discourses surrounding healthcare interpreting. In effect, raising awareness of the multiple, shifting positions interpreters and ALOs adopt in the stories they tell, may help these professionals become better aware of the assumptions they may have of themselves as interpreters, and better understand how they ascribe positions to other social actors such as doctors and Aboriginal patients. This study also reveals patterns or repeated storylines that recur across the stories of a single narrator or across stories of multiple narrators, and as De Fina (2013) asserts these patterns often reveal "collective representations and inventories" which can be "related to wider social processes" or the overarching Discourses that ALOs and interpreters orient to, to construct multiple, shifting professional identities (p. 45).

Therefore, it is increasingly necessary for health institutions and policy makers to acknowledge the multi-faceted role of the medical interpreter. One means of achieving this is by engaging in discussions around positioning in interpreter education

programs as this has the potential to help interpreter candidates to critically analyse and challenge the positions, storylines and associated Discourses interpreters invoke to converse about the work they do or to showcase their professional identity (see section 7.2.2). Medical health practitioners may also draw on these findings to better understand storylines that support 'differing worldviews and knowledge systems', Discourses that invoke an 'us and them dichotomy', highlight a 'lack of accountability' or showcase 'culturally distinct communication patterns'. Moreover, raising awareness of these multiple positions and interrelated Discourses may also enhance health practitioners and interpreter collaboration as the former come to better understand the multifaceted role that interpreters and ALOs serve.

Although, the use of narrative positioning in the analysis of interviews is unique to the field of interpreting studies, there are limitations to relying on interview data as opposed to actual naturalistic interpreting sessions. Hammersley and Gomm (2008) acknowledges this limitation with:

> what people say in an interview will indeed be shaped, to some degree, by the questions they are asked; the conventions about what can be spoken about; … by what … they think the interviewer wants; by what they believe he/she would approve or disapprove of" (p. 100).

As discussed in the methods section, where I presented some self-reflection on the use of interview data to conduct a data-driven narrative positioning analysis, the *observer's paradox* (Labov, 1972) becomes evident. The participants' contributions in the interview setting were limited to what they were prepared to disclose about their perceptions of interpreter-mediated interactions. Therefore, the perspectives and positioning of the interpreters and ALOs might be subjective and have the potential to change over time according to circumstance. It is also the case that when placed into a research setting the interpreters and ALOs were likely to offer ethically appropriate or

training-induced contributions. In addition to this, the participants were often keen to offer 'good examples' so as to ensure that I collect suitable data. My role as a doctoral student and my encouraging and supportive attitude may also have precipitated such responses. Despite these limitations, the use of small story research and narrative positioning analysis has given etic insights into aspects of the professional lives of the interpreters and ALOs in this study.

Though beyond the scope of this study, future research could be enriched by including a linguistic ethnographic perspective. This would permit an analysis of small stories over time coupled with insights gained via systematic ethnographic observations recorded in field notes. These combined approaches would enable the researcher to trace the progression of the participants' projected identities and thus provide additional insights into the Discourses the participants are invoking in order to make sense of their professional identity. A linguistic ethnographic perspective would also situate the research in its direct socio-cultural context. This could involve supplementing the existing interview data with a study of actual medical interpreting practice that examines the strategies the interpreters use in-situ as they interpret for Aboriginal patients. Moreover, a more holistic perspective could be gained if the perspectives of health practitioners and Aboriginal patients is included in the study.

This study draws several realistic and pragmatic conclusions that could potentially inform health policy documents and medical interpreter guidelines. Firstly, the findings support previous research that has identified potential sources of difficulty in interpreter-mediated interactions, as the interpreters and ALOs identified specific language and cultural differences as well systemic features of health institutional procedures and practices that contribute to ineffective communication in healthcare settings. The findings from this study also counter one of the dominant Discourses that see the interpreter as a conduit or invisible and passive vessel for the channelling of

language from one language to another. This Discourse is invoked and challenged by the interpreters and ALOs in this study. However, it leaves the following question unanswered: How do interpreters reconcile the tension created by abiding by the language restrictions imposed by customary law while being expected to remain faithful to the principles of accuracy and impartiality? This question has been raised for legal and healthcare interpreting and some guidelines have been proposed; however, the problem remains. The findings from this study go some way towards addressing this problem through the analysis of the interpreters' suggestions of ways to alleviate these challenges; particularly, through the strategies the interpreters and ALOs use to frame cultural difference and navigate culturally distinct communication patterns. These strategies can potentially inform health policy documents and interpreter guidelines and are presented below.

Interpreting in the legal context has highlighted the importance of using accredited interpreters, ensuring that an interpreter is in the right kinship relationship and that an interpreter be briefed prior to an assignment. These recommendations are also relevant for interpreting in health settings. The findings from this study, however, suggest that further steps need to be taken.

One suggestion is to educate health providers, health practitioners and interpreter candidates of the different contexts in which culturally sensitive interpreting is required by customary law. This study has identified difficulties interpreting single-word equivalents such as *warning* and *risk*, key biomedical health concepts pertaining to *cancer, diabetes* and *fungal infection* and taboo topics including interpreting *private body parts, STIs* and the concepts of *death and dying* as areas that could be included in guidelines for health interpreting. Further research could identify additional areas from a more diverse range of Aboriginal languages to supplement these findings, and also investigate whether, this population of Aboriginal patients is different from immigrant

or refugee patients. Secondly, it is increasingly necessary for health institutions and policy makers to officially expand the role of the professional interpreter; this would involve allowing increased flexibility in the scope of interpreting and the level of assistance offered to the patient. This could enhance the interpreter-mediated encounter given that the target text would meet the communicative needs of the patients and by extension the health practitioner. This recommendation also needs to be given due weight in interpreting theory. We have seen that the interpreters and ALOs make use of interpreting strategies that ensure that the interpreted message is functionally communicative for the Aboriginal patients. This is in line with Reiss and Vermeer's Skopos theory and Holz-Mänttäri's (1984) "Model of translational action" which require that the TT conforms to what is functionally acceptable for the receiver and what is permissible in the TT culture (section 3.1). However, the key challenge interpreting researchers contend with is how to navigate the mismatch between interpreting theory and interpreting practice. This is particularly relevant when considering the AUSIT (2012) Code of Ethics and Code of Conduct and NAATI guidelines for interpreting. We are compelled to ask how close these guidelines are to reality when the boundaries between maintaining impartiality and neutrality, and the advocacy roles interpreters often adopt become increasingly blurred. Future research could investigate ways of reconciling this discord between interpreting theory and practical application.

Another potential recommendation is the creation of informative leaflets or information kits that provide written as well as visual information that outlines the different verbal and non-verbal communication patterns that Aboriginal people use that could become reference points during cultural awareness training sessions or referred to on an as needed basis.

This study has important implications for the Aboriginal health sector and health outcomes for Aboriginal and Torres Strait Islander peoples. The research presented here highlights the need for health institutions to respond to the challenges proposed by the professionals working as interpreters and ALOs and work collaboratively to enhance the experience of Aboriginal patients.

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Appendix A: Interview guide

Title: Communicating in medical settings: Strategies & challenges for effective cross-cultural interpreting

This is a study of language in medical interpreting settings and examines the challenges and possibilities interpreters of Australian Indigenous languages face when English medical terminology and concepts have no or minimal equivalent in Aboriginal languages or vice versa.

I would like to invite you to help me in my efforts to collect spoken language data as part of my research into interpreting in medical settings. The aim of this project is to explore what actions and strategies interpreters of Australian Indigenous languages use to ensure the communication works. This project has approval from the Human Research Ethics Committee at the University of Melbourne (Ethics ID 1646989.1)

Topics for inclusion in semi-structured interview:

- Biographical details
- Languages spoken
- Languages you help Aboriginal patients with communication
- Who medical clinicians call to act as an interpreter
- Health literacy of Aboriginal and Torres Strait Islander people
- Health beliefs which differ from those common in Western medicine
- Cultural responsibilities of patient/family during interpreter-mediated medical encounters
- Asking & answering questions
- key biomedical health concepts not present in the Aboriginal patients' worldview
- What it means to be sick
- The notion of risk
- Concepts/things that are difficult to translate due to their cultural content
- Paralinguistic features that may pose cultural translation difficulties

Appendix B: Interview questions

1. What is your age?

2. What is your gender?

3. What is your level of education?

4. What is your place of residence?

5. Are you of Aboriginal or Torres Strait Islander descent?

6. What languages other than English do you speak?

7. What is the main language spoken in your home?

8. Do you have an Aboriginal and/or Torres Strait language that you speak or understand?

9. Which Aboriginal and Torres Strait Islander language/s do you help Aboriginal patients with communication?

10. Who do medical clinicians usually call to act as an interpreter?

11. In terms of your experience communicating for and with Aboriginal and Torres Strait Islander patients, how often do these factors make communicating with a patient difficult during the medical consultation?

Prompts:

Literacy & numeracy

Scientific knowledge

Community literacy

Cultural literacy

12. Have you assisted Aboriginal and Torres Strait Islander patients whose health beliefs differ from those common in Western medicine?

13. Are cultural responsibilities of the Aboriginal or Torres Strait Islander patient/family relevant during the medical encounter?

Prompts:

kinship-relationship positions or perspectives on death and dying

14. Research has shown that some patients find some doctors' questions difficult to answer. In your experience, do patients find some question-formats more difficult to answer?

Prompts:

a) Wh-questions - When did the symptoms appear first?
b) Yes/No questions - Have you ever had surgery?
c) Tag questions - Your left knee hurts, doesn't it?
d) Negative questions - You haven't seen this doctor before?
e) Choices - Has the medication made a difference or do you still feel the pain?
f) Sentences with rising intonation like a question - You work?

15. Does this alter how you phrase or rephrase questions to the patient?

16. How do you deal with key biomedical health concepts that are not present in the Aboriginal or Torres Strait Islander patients' worldview?

Prompts:

e.g., the microscopic world of disease – understanding diseases such as cancer, renal disease, heart disease and rheumatic fever
e.g., understanding circulation and digestion – diabetes

17. In your experience are there different ideas about what it means to be sick among Aboriginal and Torres Strait Islander patients?

18. Is the notion of risk as presented in Western medicine considered relevant to Aboriginal and Torres Strait Islander patients?

19. What difficulties arise with concepts that involve understandings that are not shared by the Aboriginal or Torres Strait Islander patient?

20. How do you deal with things that are difficult to translate because of their cultural content?

21. Do these things pose cultural translation difficulties when working with Aboriginal or Torres Strait Islander patients?

Prompts:

Intonation
Tone of voice

Tolerance of
silence
Rate of speech