

The power of suggestion: examining the impact of presence or absence of shared first language in the antenatal clinic.

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Keywords: Prenatal care/testing; conversation analysis; doctor-patient communication/interaction; midwifery; shared decision making; language/linguistics.

Abstract

Healthcare encounters involving participants from diverse linguistic backgrounds are becoming more common due to the globalization of healthcare and increasing migration levels. Research suggests that this diversity has a significant impact on health outcomes; however less is known about how it is managed in the actual consultation process. This paper presents an analysis of antenatal screening consultations video-recorded in Hong Kong, using Conversation Analysis. We consider how use of a second or subsequent language impacts on these consultations, and on discussions and decisions about further action. Presence or absence of shared first language did not appear to affect the extent to which particular courses of action were promoted or recommended. Recommendations were a common occurrence across consultations with and without shared first language. However, we argue that the routine use of recommendations can be consequential, as second language speakers may have more limited resources to interrogate or contest these. This finding has implications for the ability for professionals to maximise patient involvement in decision making.

Introduction

This paper reports on data collected as part of a study to address key issues in the practice of antenatal screening for fetal abnormality in Hong Kong. The ethical issues raised by antenatal screening and testing programmes have long been of interest to sociologists, and it has been argued that state-sponsored programmes targeted at specific fetal anomalies have the potential to enact a form of 'weak eugenics' (Shakespeare, 1998). In this context, the issue of individual choice, and how this choice

can be enacted, becomes particularly significant. Empirical sociological work which examines this issue highlights the impact that professional/client interaction can have on whether and which tests women undergo (e.g. Rothman 1988; Williams et al. 2005; Remminick 2006; Markens et al. 2009; for a meta-synthesis see Reid et al. 2009). However, this work has largely been interview based, so that whilst it provides a useful picture of the way pregnant women feel about their antenatal care, and the extent to which they report being aware of optionality in decision making, it cannot shed light on how these issues are negotiated interactionally during consultations. In response to this, some researchers, including the current authors, have carried out studies using audio or video recordings of actual consultations, in order to assess the way in which issues are foregrounded, concerns are raised or decisions are made in real time (Nishizaka 2011, 2014; Pilnick and Zayts 2012, 2014, 2016; Zayts and Pilnick 2014). However, this work has been carried out in largely mono-lingual settings, or (in the case of our own previous work) has focused on analysing those consultations in which language is shared. This paper represents a first attempt to make linguistic diversity the focus of our analysis. Data collection across several years in Hong Kong has resulted in a dataset representing 9 spoken languages or dialects as the first language of the participants. It also means that we have consultations that can be categorised into three distinct groups: those that are conducted in the first language for both parties; those conducted in a second or subsequent language for one party; and those conducted in a second or subsequent language for both. Through analysis of this data set, we aim to shed light on *how* linguistic diversity is managed in these consultations and to identify the impact this has on the way test results are discussed and decisions are made.

Background

Healthcare encounters involving participants from diverse cultural and linguistic backgrounds are increasingly becoming everyday realities due to globalization processes and an increasing migration of professional workforce and clients around the world (Carlson et al 2017). Over recent years, there has been a proliferation of research in medical sociology, medical anthropology and medical education examining the role of culture in healthcare more generally, and in a genetic counselling context more specifically (for an overview, see Zayts and Pilnick 2014). In these contexts, culture generally refers to geopolitical or ethnic boundaries, and language is seen as an important component. However, (and with some notable exceptions discussed below) these studies do not generally address the specific ways in which language operates in practice in healthcare, or the impact that presence or absence of a shared first language has. The existing literature on intercultural communication in healthcare does include recommendations for health care professionals' practice. However, this tends to be

framed in terms of general principles or recommendations such as understanding and respecting the values, beliefs, and attitudes of others (Kreps and Kunimoto 1994) or the dangers of stereotyping (Kirschbaum 2017). Recommendations based on empirical evidence tend to be tied to very specific settings (e.g. Bronner 1994; Moore 1992). There is also a tendency to focus on the outcomes of interactions rather than the process, for example miscommunication causing dissatisfaction and stress for both providers and patients (Kreps & Thornton 1984, Ulrey and Amason 2001).

As Lewis (2002) notes, the paucity of empirical data from actual consultations 'makes it difficult to document the extent of challenges, ... and their effects on ... experiences' (Lewis 2002:194). Language is a significant component of culture, but it is also important to recognise, as Moss and Roberts (2005: 413) point out, that language use and understanding is as dynamic as the notion of culture itself, and that there is "no obvious marker denoting a language barrier with Patient A but not with Patient B". It follows that any attempt to examine the impact of presence or absence of shared language on consultations needs to employ an interactional approach that can reflect and capture this dynamism.

Studies in other health-related contexts using the sociological method of conversation analysis (CA) have demonstrated the benefits of a close examination of the way in which professionals elicit decisions from clients, and how this can influence client choice (see for example Collins et al 2005, Toerien et al 2013). There is a growing body of work on interpreted interactions (see Karliner et al 2007 for a review) including work informed by CA. However, this work demonstrates that interpreters are rarely 'simple conduits' (Rivas et al 2014) and that the resulting interaction is co-constructed by all participants (Stevenson 2014), meaning that its straightforward application to non-interpreted interaction is problematic. There is also a small but growing body of discourse analytic work which specifically examines intercultural¹ healthcare encounters (e.g. Roberts 2007; 2009; Roberts et al 2004; 2005); these studies stress the interplay of contextual variables and do not assume culture or language as significant variables in the unfolding of a consultation *a priori*, unless participants themselves are orienting to it in more or less specific ways. Significantly, Roberts (2009) highlights that these analyses challenge much of the received wisdom about good communication skills in the general healthcare literature, by demonstrating that factors such as increased explanation giving are more likely to generate further misunderstandings. In addition, conversation analytic based work that has specifically sought to assess differences between consultations with participants of different ethnicities has found that non-white participants are less likely to be selected to answer questions by white doctors than their same-aged white peers

(Stivers and Majid, 2007). As Stivers and Majid note, since question asking generally reflects the questioner's judgement that the recipient is able and willing to respond (Heritage 1984; Labov and Fanshel 1977; Searle 1969), this can have far-reaching interactional implications.

However, and while there is clearly a growing recognition amongst interactional researchers of the importance of this field, there is still little conversation analytic research that seeks to focus on presence or absence of shared language in the specific field of healthcare. This is in contrast to the field of education, where there is a large and established body of work on the use of first and second languages in classrooms, from which a number of useful findings can be gleaned. These include the practical impacts of the use of English as a *lingua franca* (e.g. Firth and Wagner 1997; 2007; Markee 2000; 2004; Sert 2015), which is a scenario common in healthcare in Hong Kong and beyond. There is also a growing body of work which considers first and second language use in other organisational contexts such as the workplace (Hazel 2015; Firth 2009; Torras 2005; Clifton 2006)), or in social contexts such as gaming or chatrooms (e.g. Piirainen-Marsh (2010)). What this work shows is that whilst there are no interactional phenomena that are exclusive to first or second language use, there are observable differences in some specific patterns, such as the frequency of use of some phenomena in first and second languages. For example, Gardner and Wagner (2004) note that certain types of phenomena (e.g. repairs, corrections, delays or reformulations) may occur more in second language use. They also observe that second language speakers display versatility in their use of interactional resources, and while mistakes and errors do occur they rarely have interactional consequences. However, the differences between the fields of education and healthcare mean that these findings cannot be imported unproblematically into a health care context; for example a mistake that may not be consequential in social or classroom interaction could have more significant consequences in a healthcare setting, where decisions to initiate, accept or reject treatment or intervention are being made (see Svennevig 2012). Sociological work on migratory trajectories has highlighted the importance migrants place on language as a tool of integration, and particularly as a means of enacting power and agency (Cederberg 2013). Foreign language skills are a significant component of 'transnational cultural capital' (Carlson et al 2017); the ability to exercise agency in relation to health is a significant manifestation of this. In addition, many healthcare encounters are between two individuals who have not met before, and as Hazel (2015) illustrates, the negotiation of language choices on the spot can be a delicate undertaking. As a result there is a need for work that examines the specifics of this issue in actual interaction in healthcare settings.

Methods

The data presented here have been collected through three separate but linked research projects, as part of an ongoing collaboration between the University of Nottingham (UK) and the University of Hong Kong. As we have considered previously (Pilnick and Zayts 2014), while there are detailed Guidelines from both the Hong Kong College of Obstetricians and Gynaecologists and the UK National Screening Committee concerning the provision of antenatal services, they do not provide professionals with detailed information about how the antenatal process should be managed at an interactional level.

Though we did not set out to purposively sample, the consultations video recorded in Hong Kong (currently more than 120) represent a wide diversity of participant backgrounds: they include English and Cantonese speakers originating from various parts of Asia (e.g. Hong Kong, Mainland China, Philippines, Thailand and Indonesia), North and South America, Europe, New Zealand and Australia. They also represent a wide socioeconomic diversity, from migrant domestic workers to senior management level staff in large multinational organisations. All women attending the clinic on days when a researcher was present were given information about the study and invited to participate. Consultations were conducted primarily in either English or Cantonese, though, other languages were sometimes used for short periods during the course of the consultation, for example between a pregnant woman and her partner. With ethical approval from the relevant Hospital Authority, recordings took place in one public University hospital in Hong Kong; this setting is noteworthy because its clients do not display the typical socio-demographic divisions found in Hong Kong healthcare. Whilst it is typically the case that more affluent residents of Hong Kong would choose private healthcare, the reputation and status of this particular hospital, related to its links with the University, mean that it has a much more mixed clientele in terms of both socio-economic status and country of origin.

We have taken a conversation analytic approach to these data, in order to respond to Biesecker and Peters' (2001) call to investigate the 'interior of practice' in this setting, with particular regard to the presence or absence of shared language. Significantly, this is new territory for CA research in healthcare. As we have noted, work by Stivers and colleagues has begun to address interactional differences specifically in relation to ethnicity (Stivers and Majid 2007) but there is no straightforward relationship between ethnicity and language use. Therefore, in this paper we report an overview of our initial findings, in order to address the following question:

How does presence or absence of a shared first language impact on these consultations, in term of the delivery of screening test results to pregnant women, and their subsequent decision making?

A key underpinning principle of a CA approach is that it focuses only on phenomena which are interactionally observable. Factors such as gender and ethnicity, which might be considered of *a priori* significance in other kinds of sociological analyses, are analysed in terms of the ways in which they are made visible by participants' interactional orientation towards them. Accordingly, we did not start from an *a priori* view that interactions where shared first language was present would in every case differ from interactions where it was not. Instead, we treated this as an empirical question, to establish firstly whether we could identify differences, and secondly whether these differences showed any patterns or regularities. In that sense our approach is similar to West's use of CA to explore gender differences as they are manifested in talk-in-interaction (for example West 1992; 1993).

In our analysis for this paper we focus specifically on consultations following nuchal translucency (NT) screening², with women in Hong Kong who have screened 'positive', i.e. whose risk results are higher than the threshold set by the clinic (at the time of the study, greater than 1 in 250). These women are asked to return to clinic for a discussion of their test results where options that are available to them for diagnostic testing, usually either amniocentesis or chorionic villus sampling (CVS), are outlined. Since both procedures are invasive, there is a risk of miscarriage associated with them, which is a factor in the discussion over decision making. The discussion may be held with a doctor, or a specialist nurse, and both groups of professionals are represented in our dataset. This focus on consultations with a shared purpose was to allow appropriate comparison of the ways results and options were considered.

The main body of all of these consultations was conducted in either English or Cantonese, though there was variation as to whether these were the first languages of participants. Consultations conducted in Cantonese were initially transcribed and then translated into English. As we have considered previously (Pilnick and Zayts 2012), we are aware of the social, cultural and political challenges involved in any act of transcribing. This is particularly acute when transcribing translated data (Bucholtz, 2007). Initial transcriptions and translations were carried out by two bilingual research assistants, before being checked by a bilingual member of the research team. We have

also followed the procedures for 'validation' as suggested by Peräkylä (2004:216) in that we have paid particular attention to "the next speaker's interpretation of the preceding action" in our translation and analysis. Our analysis of consultations conducted in Cantonese has used 4 line transcripts. These present firstly the Cantonese characters, followed by a pinyin representation which represents the phonetic sounds of the Cantonese speech in the Roman alphabet. The third line is a literal translation from the Cantonese, and the fourth and final line is a representation which makes sense in spoken English. As far as was possible, given the grammatical differences between the two languages, features of speech such as 'stretching' of sounds, emphasis, and pauses have been retained in this final translation. However, in some cases, where particles of speech are not directly translatable, such features have been lost. For reasons of space in this paper, where data have been translated into English, we have presented only the final translation here.

In order to apply CA to the study data, recordings were initially transcribed verbatim, with sequences of interest subsequently transcribed using standard CA procedures (Jefferson 2004). Given the nature of the study, it was important also to consider non-verbal and paralinguistic features such as gestures and body movement; these were noted alongside the transcriptions and are referred to where relevant to our analyses in this paper. Transcriptions were used alongside the original video recordings as an analytic aide. Data were analysed in data sessions attended by the authors, and in additional data sessions with expert CA analysts in the UK, to guide further analysis and in order to increase robustness and reliability (Sidnell 2010).

To begin a comparative study of the impact of presence or absence of shared language, we divided our corpus into three categories: those where both participants were using their first language (L1/L1); those where one participant was using their first language and the other a second or subsequent language (L1/L2); and those where both participants were using a second or subsequent language (L2/L2). Though these categories are commonly used in the sociolinguistic literature, we are aware that they can gloss the complexity of language acquisition and competence, and our data provided a valuable reminder of this. Whilst the Hong Kong based professionals in our sample (three doctors and one nurse specialist³) identified themselves as L2 English speakers, they were in practice so fluent in spoken English that consultations they conducted with clients who had English as a first language were little different analytically from those involving two first language speakers. We reflect on this issue in more detail at the end of this paper.

Findings

a) How results are delivered:

We first consider the way in which test results were actually delivered to women in these consultations. In all consultations in our corpus, the overall structure is very similar: the results are delivered; they are often contextualised in relation to factors such as the patient's age or the general population; the possibilities for further testing are outlined; and the need for a decision is presented. On comparing L1/L1 consultations with those where a second language was being used by pregnant women and their partners, we did find some small differences, as the CA literature on L1/L2 use in educational settings would predict. These were related to turn length and degree of complexity in the way test results were delivered. Extracts 1 and 2 below are examples of this, with Extract 1 being from the L1/L1 corpus and Extract 2 from the L2/L2 corpus:

Extract 1: SLY (L1/L1 Cantonese)

1. D: .hh 咁, 之後, 呃十月頭,,
.hh then, after that, uh in early October,
2. 呃十月九號, 上個禮拜你番咗嚟驗血
uh the ninth of October last week, you came to have the blood test.
3. 你番過嚟驗血
you came back to have the blood test.
4. .hh 咁我地綜合咗你嘅年齡, BB 嘅後頸皮下透明層,
.hh So we have combined your age, your baby's nuchal translucency,
5. 同埋你驗血呢兩份報告 [呢度]
and blood test these two reports [here], =
6. P: [ʔMm ʔ]
[ʔMm ʔ].
7. D: =就咁嚟計算呢 (.) 你 BB 有唐氏綜合症嘅機會
=to calculate (.) the chance of your baby having Down syndrome
8. 大唔大. .hh 咁嗰個血嗰度呢我哋就驗既呢就係叫做 AFP (.)
is large or small. .hh so for the blood what we test is called AFP (.)
9. 就嗰個 BB 出既一種蛋白叫做胎甲蛋白吓 (.)
that is a protein released from the baby called alpha-feto protein (.)
10. .h 咁另外一個呢就係 HCG 就係胎盤出既荷爾蒙嚟既
.h the other one is HCG which is the hormone released from the placenta
11. (.)吓(.) .hh 咁我哋綜合咗呢 d 指數呢計出嚟呢你 BB
(.) ok (.) .hh so we combine these readings and calculated that your baby
12. 有唐氏綜合症嘅機會呢就係二十七個有一個 (0.1)
has a one per twenty seven chance of having Down Syndrome. (0.1)
13. ((D looks at P))

14. 咁咪即係比較高囉 (.) 係咪?
That means it is relatively high (.) right?
- 15.P: ((nods))

Following greetings sequences (not recorded or transcribed here) the doctor's turn that begins the consultation is complex, and extended. She begins by summarising the woman's previous visits to the clinic, eventually arriving at the most recent visit where the screening test was conducted. Continuing over the pregnant woman's acknowledgement of the doctor's gesturing towards the paper on her desk (lines 5-6), the turn deals with all three components of the calculations underpinning the results at once (age, nuchal translucency and blood test) and also describes how the blood test has two further components. It does not give the pregnant woman any opportunity to respond until both the actual result ('one per twenty seven'), and an evaluation of what it should be taken to mean ('relatively high'), have been delivered in lines 12 and 14.

Comparing this extract with Extract 2 below, which is conducted by the same doctor but in English, where the pregnant woman is Filipino, we can observe some differences. Again, it begins after greetings sequences, when the video camera is switched on:

Extract 2: VIB (L2/L2 English)

(D – doctor ; P – pregnant woman)

1. D: Screen positive. (.) Okay? But no. (.) Don't be too worry, okay?
2. .h um nah, there are two um problems with the result.
3. Um:m one is the mm: AFP is: a bit high, Okay?
4. ((looking at P)) [this is alpha fetoprotein].
5. P: [°>What is it mean?< Okay°]
6. D: I'll explain to you, okay?
7. (0.2)
8. D: The other is the .h HCG (.) which is the
9. placental hormone (.) which is also a bit high, okay?
10. P: °Mmm.°
11. D: .h if we base on these blood test result and
12. your age=
13. P: =°Mm hmm.°
14. D: to calculate the chance that your baby have
15. Down syndrome=
16. P: =°Mm hmm.°
17. D: The chance that the baby have Down
18. syndrome is (.) about one in two hundred.
19. P: ° (xxx) ° ((exclaims in Tagalog)), okay.

The doctor begins this consultation by stating the official clinic verdict on the results (and so the reason why this woman has been recalled to the clinic); that she has screened positive. The video shows that the pregnant woman appears very anxious, covering her face with her hands before the consultation begins, and the doctor's subsequent utterance 'Don't be too worry, okay?' seems to respond to this. She then proceeds to give

the information about the test results. Comparing this extract with Extract 1, the overall informational content contained is very similar, in that the two components of the blood test are named and explained, and it is also explained that these blood tests form only part of the overall result. However, this information is also packaged differently. In Extract 2, the pregnant woman's overlap in line 5 responds to the use of the abbreviated term 'AFP' by the doctor in line 3, though it actually overlaps with the doctor expanding on this, and this expansion is receipted with an 'okay'. Subsequently, the doctor breaks down her information giving sequence into components. No response is received to her proposal to explain the results in line 6, which she treats as an acceptance and continues. She subsequently pursues a response to the next component of the information delivery (lines 9-10, 'okay?'). Her following components of explanation are also receipted by the woman, until she arrives at the delivery of the numerical result in lines 17-18. Overall, then, this consultation seems to follow the same 'script'; however the doctor does appear to tailor her delivery to take potential language issues into account. This process of dividing up the information into smaller sub-components, and seeking acknowledgement for one before moving on to the next, recurs in our L2/L2 corpus, and echoes the 'chunking and checking' advice that doctors are given in training (Kurtz et al 1998; Silverman et al 1998).

b) Formulations for decision making

We next considered the way that decision-making was framed in these consultations, in terms of the broad formulations that were used to present a decision. In previous work (Pilnick and Zayts 2012;2016) we have outlined the types of formulations that occur in these data. These include

i): *offers* of further testing, as shown in the example below:

VIB (L2/L2)

30. D: .hh Em but it's up to you whether you want the amniocentesis?

In this setting, this kind of utterance usually followed directly from a summary of the screening test results and the further testing options available. Whilst the CA literature on offers in everyday interaction suggests that there is a general interactional preference to accept an offer (see Pillet-Shore 2017 for a review of preference organisation in interaction), an offer might be more usually framed as 'Do you want X?'. As this example shows, offers in this setting are generally framed as 'Do you want X (or not)?' through the foregrounding of client agency ('it's up to you'), so that neither acceptance nor refusal are explicitly indicated as preferred options.

ii) *Recommendations* for further testing, as shown below:

LYMY (L2/L1)

- 185.N: With the whole population, the chance is one in seven
186. hundred, yours is a bit higher
186.P: Mmm[um
187.N: [right. .h the report turns out to recommend you to have <that>
188. further investigation.

As this example illustrates, recommending (sometimes framed as 'suggesting') indicates a clear institutionally preferred course of action. As in this example, the recommendation is usually framed with the agency of the institution or the test results, rather than the agency of the individual doctor or nurse.

iii) what Toerien et al (2013) have described as '*option listing*', where more than one possible future course of action is described:

LTMA (L1/L1)

56. D:It depends on whether you and your husband::: (.) are (0.3) worried, (0.4)
57. and want to go for amniocentesis. Or (.) we can have an ultrasound, to see
58. if roughly (0.9) eh::: we don't see anything special,
59. P: Mm.

As this example shows, option listing used alone does not necessarily suggest a preferred course of action from the options that are presented.

In our analysis we found examples of all these types of formulations across all categories of presence or absence of shared language. Sometimes these formulations were used in isolation, but sometimes in conjunction, e.g. a professional might first list options but then recommend an amniocentesis. We have also previously analysed this dataset in terms of (non) directiveness (Pilnick and Zayts 2012); mapping that analysis to our L1/L2 categorisations showed that, across all categories, there were overtly nondirective presentations which emphasised the ownership of the decision lying with the woman/partner and did not promote or 'recommend' any particular action.

c) How pregnant women respond and contest

We turn finally to what we found was the most significant difference in our dataset. Perhaps surprisingly, this difference was not found in the professionals' talk: as we have already shown, there were relatively small differences in the presentation of information, and no differences in the types of formulations used for presentation of decision making, in the presence or absence of a shared first language. Recommendations from professionals regarding testing were common both where first language was shared and

where it was not. However, we did identify differences in how these recommendations regarding testing were received by pregnant women, and –significantly given the ethical framework that surrounds this specific context- what linguistic resources patients brought to bear in responding to or contesting these recommendations. Extract 3 comes from the same consultation as Extract 1, conducted in Cantonese (L1 for both parties).

Extract 3: [SLY contd] (L1/L1 Cantonese)

25. D: 吓(.)咁即係其實話呢百分之九十(0.5)以上
ok (.) so that means actually, ninety percent (0.5) above
26. 或者百分之九十六呢其實個 bb 都係正常既(0.6)
or ninety six percent then actually the baby is normal (0.6)
27. .hh 但係呢個比數嚟講啦都算係比較高嫁啦(.)
.hh but this percentage we say, is still <relatively high> (.)
28. 即係話有四個 percent 機會 bb 係
that means there is a four percent chance of the baby having
29. 唐氏綜合症既話呢
Down syndrome, so to speak,
30. .h 都係比係一般嚟講比起你
.h is still relatively, generally speaking, compared to
31. 譬如你平時三十六歲一般人如果我哋
for example a normal thirty six years old, in general, if we
32. 無做過呢 d test 淨係單睇你個年紀呢(.)h
have not done these tests, solely considering your age (.) .h the chance of
33. bb 有唐氏綜合症就講緊呢即係.h 大約三
the baby having Down syndrome .h is, that is .hh about three
34. 百個，三百五十個先會有一個嫁(.)
hundred a- (.) just one per three hundred and fifty people
35. (1.2)
36. 明唔明白呀? (0.4) ((while looking at the woman)) 咁所以嚟講呢
do you understand? (0.4) ((looking at the woman)) so to speak, it still is
37. 都係比較高 d 嫁喇(.)咁所以我哋呢都會建議
relatively higher (.) so, we recommend
38. 你係抽胎水。(0.7).h 即係其實
you to have amniocentesis. (0.7) .h that means actually,
39. P: em:: 都考慮咗我 (0.3)應該
em:: um:: you have already considered my (0.3) .h it is probably
40. 唔係因為我個風濕性關節炎，
not because of my rheumatoid arthritis? =
41. D: [我諗唔關事[°喇°]
=I think this is not related [then]
42. P: [吓]
[I see]

In Extract 1, the doctor has given the result initially as a '1 in x' figure. Here, in lines 25-9, the doctor transforms it into a percentage likelihood. In situating this knowledge for the woman, she then draws a comparison of the age-related risk alone for someone who is 36- approximately 1 in 350- which works to establish that the figure of 1 in 200 should

be considered high in this context. She ends with a recommendation for amniocentesis (lines 37-38) which is presented as arising from this higher risk. However, the woman's initial response is not to engage with the recommendation per se, but to seek further information about the reliability of the test results. Though she frames this tentatively, with both a negative polarity (Raymond, 2003) and with an orientation to the greater expertise of the doctor (ten Have, 1991; Heath 1992), she nevertheless demonstrates an ability to engage with the recommendation, and question the evidence on which it is based.

By contrast the following extract is taken from a consultation where Cantonese is a second language for the pregnant woman; she is from Mainland China and an L1 speaker of Mandarin.

Extract 4: LMY (L1/L2 Cantonese)

146. N: .h 咁要我地綜合埋歲數啦，頸皮啦，同埋驗血指數，就
.h we combine age, nuchal thickness, and measurement of blood test, it is
147. 二百五十分之一。即係話二百五十五個人，
one in two hundred and fifty five. Meaning two hundred and fifty five people,
148. .h 其中一個就有事既。
.h one has the problem.
149. P: 唔。
Mmm.
150. N: 咁相對黎講埋，就二百五十四個係有事既。
Well, comparatively speaking, two hundred and fifty four people are fine.
151. P: 唔
Mhmm.
152. N: 咁當然啦，睇呢個報告其實係
Of course, according to this report, actually
153. 有事既機會大過有事既。
the chance of having no problem is higher than having a problem,
154. P: 唔唔 [唔]
Um um[um]
155. N: [但]係話 em (.) 對比
[but] em (.) compare=
156. P: 唔
Mmm.
157. N: 全人口黎講呢，就七百分一個機會埋，你就
=with the whole population, the chance is one in seven hundred, yours is
158. 稍為高啲。
a bit higher.
159. P: 唔唔 [唔].
Mmh [mm].
160. N: [係喇]。 .h 咁呢個報告埋就變左建議你去做<嗰個>進一步
[Right.] .h the report turns out to recommend you to have <that> further
161. 既檢驗啦。
investigation,

162. P: 唔
Hmm.
163. N: 咁因為你依家都十八週啦，
because you are now at eighteen weeks,
164. P: 唔
Hmm.
165. N: .h 咁如果要做進一步既檢驗，入侵性既檢驗呢，就
.h if you want to do further investigation, invasive investigation, then
166. 要做羊水既。
((you)) would have to take amniocentesis.
167. P: 唔唔↓唔↑唔
Umum ↓um ↑um.
168. N: 咁囉。 .h 咁呢個係建議架啫。始終做唔做都係
That's it. .h it is only a recommendation. To do it or not in the end is
169. 由你同先生決定既。
decided by you and your husband.
170. P: 唔唔
Mmm.

In this instance, the recommendation (lines 160-166) is once again made as arising directly from the higher risk indicated by the test in this case as compared to the general population risk for someone of the woman's age⁴. In addition, in this example the agency for the recommendation is initially located not with the nurse herself or with the institution, but with the report (line 152). What is noteworthy is that the pregnant woman makes only very minimal acknowledgements throughout, including to the expanded delivery of what the results should be taken to mean (line 149), and the initial recommendation for further testing (line 162). The nurse pursues further discussion by clarifying that, because of the stage of the woman's pregnancy, further investigation will mean amniocentesis, but again receives only a minimal response (line 167). She subsequently places the final decision firmly in the domain of the woman and her husband, by minimising the status of the official recommendation to 'only' a recommendation in line 168, but this also does not result in a more extended response (line 170). Throughout this extract, then, the minimal responses made by the woman mean that neither her understanding, nor her views about further testing, are made explicit. However, as this consultation continues (not shown here for reasons of space) the nurse first outlines two different possible timescales for testing, and then moves to appointment making for further testing, and the woman assents to this appointment.

Comparison of Extracts 3 and 4 suggest that the use of recommendations in relation to decision making may be particularly consequential where there is an absence of shared first language. As Toerien et al (2013) suggest, by recommending a course of action, a professional claims to know both what *can* be done and what the client *should* do. In other words they claim not only medical knowledge but also the right to advise the

patient. While advice can be resisted, it can be interactionally tricky to do so, and this difficulty is likely to be exacerbated in a professional/client context. We have previously observed that professionals may be more likely to offer advice where there is a lack of response from women at the outset of encounters (Zayts and Pilnick 2014). However, we have not previously considered how this maps to presence or absence of shared first language. In general terms, we suggest that clients using a second language are more likely to have fewer, or less readily available, resources to bring about resistance to advice.

Our next example is taken from our L2/L2 corpus, where the pregnant woman is a Nepalese speaker of English as a second language. This example again shows a response to an institutional recommendation (in this case framed as a 'suggestion').

Extract 5: THK (L2/L2) English

285. N: However, if the report (.) em:m
286. estimation shows that your risk
287. of having Down syndrome baby is
289. high, =
290. P: [((Nods))
291. H: [((Nods))
292. N:=it doesn't mean that your baby
293. is X but it is suggested you can
294. go for further investigation,=
295. P: [((nods))
296. H: [((nods))
297. N:=to confirm whether baby's
298. Down syndrome or not.
299. P: [((Nods))
300. H: Mm hmm
301. (2.0)
302. N: And we can have amniocentesis
303. to confirm (.) whether baby's
304. [Down syndrome or not
305. P:[((nods))
306. H:[((nods))

Comparing this example with Extract 4, again we see a pattern of minimal (and in this case often non-verbal) acknowledgements from the pregnant woman and her husband,

which begin before the nurse formulates a suggested course of action in lines 292-4. This minimal contribution continues after the completion of the nurses's turn at line 298, leading to silence in line 301 and then an attempt by the nurse to clarify what form the suggested confirmation would take (302-304). Once again there is a minimal (in this case purely non-verbal) response from both the woman and her husband. Whilst the remainder of this consultation is not reproduced here for reasons of space, this pattern of minimal responses continues, and the consultation ends with the nurse booking an appointment for further testing.

Though space precludes us from presenting more examples here, these differences in response to recommendations across categories of language use are evident elsewhere in our data. Pregnant women using their first language are better able to engage with the advisory character of recommendations, and better able to contest them and/or to articulate reasons for resisting them. In our data examples of this include questioning the reliability of the screening test itself, or pursuing the impact of greater maternal age alone (see Pilnick and Zayts 2014, where data illustrating this has been presented to illustrate discussion of uncertainty). Those women in receipt of recommendations in their second language are more likely to produce minimal acknowledgments of the kind seen in Extracts 4 and 5 above, and to ultimately go along with what is recommended (for more examples, see Zayts and Pilnick 2014)⁵.

However, we noted earlier that though recommendations are common in our data, they are only one of several kinds of formulation that may be used. Extract 6 is a continuation of Extract 2, conducted in the patient's second language, which we have considered above in our discussion of how test results were presented. In this continuation, the doctor presents the need for a decision:

Extract 6: VIB (L2/L2)

31. D: .h so um it's up to you (.) We- we- we still call it
32. screen positive. (.) Because there is a small possibility
33. that the baby may have Downs.
34. (0.2)
35. P: Um hmm.
36. D: .hh Em but it's up to you whether you want the amniocentesis?
37. (.) em: to check if [the baby]=
38. P: [is it the-]
39. D: = has Downs.
40. P: the one that put inside?
41. (0.2)
42. D: Yes, yes. ((while nodding))

43. P: Hhh ((nasal laugh)) I've discussed it with my husband. (.)
44. He said he doesn't want. (.) Heh heh=
45. D: =Right. ((while nodding))

In this extract, then, the decision is clearly presented as an offer (line 36), which the pregnant woman can accept or decline, in the absence of any official recommended action. The phrase 'it's up to you', which has been used to open the discussion of decision making in line 31 is also repeated in this offer. At line 37 the woman interrupts to clarify her understanding of the amniocentesis procedure. When this clarification is received, the amniocentesis is rejected; this rejection is presented as the outcome of a prior discussion between the woman and her husband and is accepted by the doctor. In this example, the woman is able to articulate her views and it is clear that the end decision (to reject amniocentesis) is grounded in her and her partner's wishes. Our analysis suggests that it is not participation in decision making *per se* that is an interactional issue for clients using an L2; instead it is the resisting of a recommended or suggested course of action that causes difficulties. Since an offer framed as in Extract 6 above does not have a clear interactionally preferred response, it is less delicate, and hence requires less interactional effort, to refuse.

Conclusions

There is clear evidence from our data that professionals are sensitive to the contingencies of dealing with clients with whom they do not share a first language, and that they make attempts to tailor their interaction accordingly. Contrary to what the small amount of existing literature might suggest, whether, or how strongly, a particular course of action is forwarded or promoted does not seem in this setting to depend simply on presence or absence of a shared language. Recommendations or suggestions for further testing are commonly seen across L1/L1, L1/L2, and L2/L2 consultations, sometimes alone and sometimes occurring alongside other formulations for decision making such as option listing. However, there are interesting and significant differences in our dataset in terms of how these are responded to by pregnant women. Where a particular course of action is promoted or recommended, the resources patients have for responding to and engaging with the recommendation may not be equivalent. In our sample, women using a second language are more likely to make minimal responses, and ultimately to go along with the course of action that is suggested. Women using their first language may eventually go along with the recommendations, but can take the opportunity to debate and discuss these before arriving at a decision. Our data provide a practical illustration, then, of Cederberg's (2013) suggestion that use of a second language can set boundaries for self-representation that may in turn impact on agency.

However, caution is needed in drawing conclusions from these findings; in particular, it does not necessarily follow that women using their second language have their choices determined as a result of interactional factors. It is of course possible that these women may have had a desire or intent to undergo diagnostic testing from the outset. What is significant from a research point of view is that it is not always apparent from the way that these consultations unfold that these women are exercising choice. What these results suggest, then, is that for practitioners who want to maximise engagement in decision making in their consultations with women using a second language, making recommendations may not be the best way to do this. Even where it is made explicitly clear (as in Extract 4 above) that a recommendation can be rejected, such rejection rarely occurs, and acceptance is often signalled through very minimal responses. Simple offers of testing procedures, or option listing which does not conclude with a recommendation, may be better approaches to ensure that active choice is foregrounded. This has particular resonances for the antenatal screening setting, given the significance of choice in defending against accusations of both 'strong' and 'weak' forms of eugenics (Shakespeare 1998), but is also relevant for healthcare more broadly in the context of an increased emphasis on Shared Decision Making (see for example the Rightcare SDM programme in the English National Health Service, <http://sdm.rightcare.nhs.uk/>).

In terms of the sociological study of language, and how diversity is managed in interaction, we would suggest that there is a further conclusion to be drawn here. As we have noted, a simplistic characterisation of these consultations into L1/L2 speakers masked the fact that those consultations where HK professionals were speaking English to first language English speakers shared more characteristics with those between two L1 speakers; in the absence of the coding information it was unlikely to be apparent that professionals were communicating in a second language. To paraphrase Moss and Roberts (2005), it may therefore be more useful to think in terms of a continuum of ability, in which what matters is whether language ability maps to context, as opposed to a simplistic L1/L2 distinction.

Acknowledgements:

The research reported here was fully supported by a grant from the Hong Kong Research Grants Council of the Hong Kong Special Administrative Region, China (project no. HKU 754609 H). We would like to thank the participants who allowed their interactions to be recorded. We would also like to thank the medical research team for their continuous support of our interactional study of antenatal screening, in

particular Ms. Vivian Chan, Dr. H.Y.M. Tang, and Dr. C.P. Lee. We are grateful to Spencer Hazel for his assistance in navigating some of the L1/L2 literature using conversation analysis. Thanks are also due to the anonymous referees who provided insightful and valuable comments on the initial version of this paper.

Footnotes

1. For these studies, the term 'intercultural' is used to describe situated encounters between two or more participants who represent different linguistic and cultural backgrounds (Sarangi, 1994/ 2011)
2. NT screening is a form of antenatal screening which uses ultrasound to assess the fluid at the nape of the fetal neck at between 11 and 14 weeks of pregnancy. Increased nuchal translucency is associated with increased risk of chromosomal abnormalities. It can be carried out alone, or as in these data, combined with maternal blood tests (<https://www.nhs.uk/conditions/pregnancy-and-baby/screening-amniocentesis-downs-syndrome/>).
3. The nurse specialist was a senior level nurse who had undergone specialist training in the field of antenatal screening. As part of our wider analysis, we compared nurse led consultations with doctor led ones, but did not find any recurring differences in structure, content or interactional practices.
4. It is interesting to note that there was no clear link in our data between the level of risk a test result suggested, and the extent to which a professional recommended a particular course of action. It did not follow that consultations involving higher risk were more directive.
5. An alternative interpretation of Extract 5 might be that what is at issue here is socioeconomic status rather than the interactional formulation of possibilities. The women is a migrant domestic worker, and an alternative kind of sociological analysis might relate this to the way women respond to a health professional's assumed authority. However, Extract 6 is also taken from a consultation with a migrant domestic worker, and in this instance she is able to exercise choice, suggesting the picture is not this straightforward.

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