

REPETITION AND REPHRASING IN ENGLISH AS A LINGUA FRANCA MEDICAL CONSULTATIONS IN HONG KONG

SHAWNEA SUM POK TING AND ALESSIA COGO

Introduction

Communication in healthcare is crucial, as good communication can safeguard safe and quality healthcare (Slade et al. 2016) while poor communication may jeopardise patient safety (Roat and Crezee 2015). In a globalised world, the scenario where patients and healthcare providers do not share the same first language and thus need to communicate with a lingua franca is becoming more common (Landmark et al. 2017), and the lingua franca used is often English. Yet, most existing research that looks at medical encounters in English with linguistically diverse participants comes from English-dominant contexts (e.g., Bagheri, Ibrahim, and Habil 2015; Roberts 2009; Svennevig et al. 2019). Health communication research that adopts an English as a lingua franca (ELF) framework for analysis, or ELF research that focuses on the healthcare setting is still limited.

The newly proposed research direction in Medical English as a lingua franca (MELF), referring to the (dominant) use of ELF in interactions in medical and healthcare settings (Tweedie and Johnson 2018, 2019), will hopefully contribute to filling this gap, with examining ELF pragmatic strategies in MELF interactions as a starting point (Tweedie and Johnson 2019). Previous ELF studies have shown how ELF interactants apply pragmatic strategies to achieve accurate understanding, which is essential in high-stakes ELF communication (Kaur 2017) where miscommunication will lead to serious consequences, such as that in medicine (Harding and McNamara 2018). Learning about the use of pragmatic strategies in MELF interactions will further deepen our understanding of ELF (Amery, Tweedie, and Johnson 2019) and strengthen the foundation for potential interdisciplinary research between ELF and health communication. As an early investigation in MELF, the current chapter reports from an exploratory study examining pragmatic strategies that local doctors and patients in Hong Kong employ in medical consultations conducted in ELF. Through analysing naturally occurring medical consultations with a conversation analytic approach, the current chapter will show how repetition contributes to meaning negotiation.

Repetition in ELF research

Repetition, which in this chapter includes broadly repetition of exact words, and rephrasing (e.g. Mauranen 2012), paraphrasing (e.g. Cogo and Pitzl 2016), and reformulation (e.g. Kaur 2012), has been observed as one of the pragmatic strategies that is most vigorously applied by ELF users (Matsumoto 2018a). Various studies have explored the roles that repetition plays in ELF interactions, including averting non-understanding, enhancing clarity, confirmation of understanding and showing alignment.

To start with, speakers may avert potential non-understanding and enhance clarity through self-repetition. A non-understanding refers to instances where a listener is aware that s/he cannot understand the speaker (Bremer 1996, 40) and/or a speaker realises that the listener(s) cannot understand what is being said (Young 1999, 5; see also Cogo and Pitzl 2016, 340). So, a speaker may reduce ambiguity by altering partly or completely his/her utterance that is perceived to be potentially unclear to the other interlocutor(s) (Cogo 2009; Kaur 2017). Speakers may also rephrase themselves simply with an intention to make their intended meaning clearer and more explicit, thus easier to be understood, without specific regard of whether there was or will be a non-understanding (ibid).

Further, speakers may co-construct the conversation and keep the rhythm of the conversation via other-repetition. Other-repetition (also “[r]epresents” (e.g. House 2010, 373) and “echo” (e.g. Mauranen 2012, 221–29) refers to the strategy “when the interlocutor replicates *part of or all* the utterance produced by a previous speaker within the *same conversation*” (Cogo 2009, 260 emphasis original). Other-repetition often comes after an utterance completion (Mauranen 2016) where after an interlocutor has supplemented the needed item for the original speaker, the original speaker and/or other interlocutors repeat the item. Repeating the utterances jointly constructed by all interlocutors helps the conversation progress (Cogo and House 2018). Especially when the repetition is produced as latching onto to the original utterance, the development of the conversation will be kept smooth, sustaining the rhythm of conversation (Cogo 2009).

Speakers also show alignment to the content and signal affiliation to the speaker by other-repetition. ELF speakers other-repeat to verify to an interlocutor that they are in line with what is said, to acknowledge and confirm understanding of the original turn (Mauranen 2012, 222–23; Cogo and House 2018; Cogo 2009). There can also

be repetition after a non-understanding is solved, where speakers exhibit their alignment to the content by re-affirming shared understanding over the previous unclear item before they carry on with the conversation (Watterson 2008, 399). This also helps speakers show attentiveness and support to the other interlocutors, which boosts consensus and creates solidarity and affiliation among all interlocutors (Cogo 2009; Cogo and House 2018). It is, however, important to note that showing alignment to the content through repetition does not necessarily equal showing affiliation to the speaker. For example, a person may repeat the lexical choice of another interlocutor in the conversation, but does not agree with or affiliate to that interlocutor (Mauranen 2012, 227–28).

The ELF research explored here mainly comes from academic and other social settings, and little is known about how repetition and other pragmatic strategies are employed in healthcare settings (Tweedie and Johnson 2018) where efficiency and accuracy of information exchange is crucial (Street 1991; Tweedie and Johnson 2019), specifically, about how patients and doctors apply these strategies to co-construct understanding with ELF (Nozawa 2017). The current chapter aims at investigating the role of repetition in the negotiation of meaning in MELF doctor-patient communication.

Repetition in healthcare communication between patients and professionals

In an earlier study in MELF investigating communication between patients and medical professionals using ELF, Nozawa (2017) analyses the information-gathering stage in simulated medical interviews between student doctors and simulated patients in a Japanese university. She finds that repetition and rephrasing are typically employed for clarification and confirmation of understanding. For instance, doctors self-repeat and/or self-rephrase to preempt potential non-understanding, or to proactively ease understanding for the patients. Doctors also frequently repeat and/or rephrase patients' utterances to affirm mutual understanding, namely, to confirm what a patient has said. Through enhancing understanding, the delivery of patient-centred care is also enhanced by the usage of repetition and rephrasing.

In health communication, Jin and Watson (2020) enquire into the use of *playback* in naturally occurring traditional Chinese medical consultations between doctors and older adults in China from the angle of Communication Accommodation Theory (CAT). *Playback*, originally coined by Merritt (1977) to refer to the reiteration of the name of a requested item in service encounters typically as a confirmation check, is adapted by Jin and Watson (2020, 3) as “a form of immediate repetition built on a prior statement made by the interlocutor.” They find that both doctors and patients use repetition to complement or converge to each other. In particular, patients use playback to signal attentiveness and to acknowledge the doctor's expertise, while doctors use playback to confirm their understanding, to indicate agreement or attentiveness, to invite the patient to expand on the topic, and/or to show empathy. In short, playback contributes to the efficient completion of medical tasks and rapport building, both of which are important in medical consultations. Although this study does not apply an ELF framework in its analysis, it nonetheless sheds light on how repetition contributes to the medical consultations, which is the focus of the current chapter.

Context, data, and participants

The data collected for this study of MELF doctor-patient communication include: video-recordings of 9 naturally occurring ELF medical consultations between 4 doctors and 9 patients at a general out-patient clinic in Hong Kong, and audio-recordings of retrospective interviews with the 13 participants. All 4 doctors (3 males, 1 female) speak Cantonese as L1; the L1 of the 9 patients (1 male, 8 females) include Castellano Spanish, Tagalog, Ilocano, and Indonesian. The medical consultations lasted from around 3 to 18 minutes, with a total of around 99 minutes. The interviews lasted from 3 to 22 minutes, totalling approximately 124 minutes. The current chapter will mainly focus on the consultations, which are transcribed using Conversation Analysis conventions (see Appendix).

Written consent and demographic details were sought from the doctors who agreed to participate.¹ The doctors then looked at their advance appointments and informed the first author to go to the clinic on days when they had patients who might be ELF users. On days of data collection, the first author went to the clinic and waited for patients who were ELF users. Upon encountering a suitable participant, the first author approached him/her to explain the study and invite participation. At the end, 9 patients gave their consent and demographic details to join the study.

¹ After ethics approval was obtained from the Institutional Review Board of the University of Hong Kong / Hospital Authority Hong Kong West Cluster (HKU/HA HKW IRB), the study was explained to the doctors of the clinic.

After getting the patient's consent, the first author set up a camera in the consultation room. To reduce the observer's effect (Blommaert and Jie 2010, 27–28; Pun, Chor, and Zhong 2019, 199) and as restricted by the ethics approval, the first author left the room before the consultation started. After the consultation ended, the first author interviewed the patient in a separate room. The doctors were interviewed at the end of their shift. Anonymity, confidentiality, and their right to withdraw from the study were emphasised to all participants.

Other-repetition as confirmation of intelligibility and understanding

When doctors are in the process of obtaining information from patients, they regularly other-repeat at the beginning of their turn. After the patient has responded to a question, the doctor will first repeat (part of) the patient's answer, before asking a further question. It forms a cycle of "asking, answering, repeating," which recurs often in the information-gathering phase in the medical consultation. An illustration is shown below with Excerpt 1, where a doctor (d3, male) is trying to understand more about a patient's (p7, female) complaint of chest pain.

Excerpt 1:

01 d3 ((looking at the computer)) so: does the pain=
 02 p7 =it looks like (.) ((pointing to the right side of her chest with her fingers;
 03 d3 turns to p7)) I think (.) inside
 04 d3 → inside (.) okay is it ((pointing at individual spots with a finger)) eh eh eh
 05 eh particular one spot or ((opening his palm and move in a circular
 06 motion over the whole chest)) [over the whole chest?]
 07 p7 [and then, I feel heavy] on my chest
 08 ((putting an open palm over her chest and made a circle))
 09 d3 → ((turning to the computer and nodding once)) feel heavy on your
 10 chest (.) so what were you doing when you feel the pain?
 11 p7 ((looking at d3)) I just ((d3 turns to p7)) drinking water
 12 d3 → you're drinking water (.) ((turns to the computer)) so (.) drinking water
 13 makes the pain worse or makes it ((turns to p7)) better?
 14 p7 ((p7 and d3 looking at each other; p7 nodding)) make it better
 15 d3 → make it ((turns to the computer)) better (.) ((starts to type)) okay
 16 (3) but (.) does the pain occur when you are doing ((turns to p7; p7 and
 17 d3 looking at each other)) exerci:se when you are walking (.) climbing
 18 up stairs?
 19 p7 (1) easy tired (1)
 20 d3 but ((patting his chest with an open palm)) for the pain=
 21 p7 =for the ((patting her chest once with her palm)) [pain I-]
 22 d3 [it occur] when you
 23 are at rest or when doing exercise?
 24 p7 n- when I am resting (.) and then I feel (.) [pain]
 25 d3 → [when you rest] ((nodding
 26 and turns to type at the computer; P7 nods)) okay (3)



Fig. 1. Lines 5-6



Fig. 2. Line 8

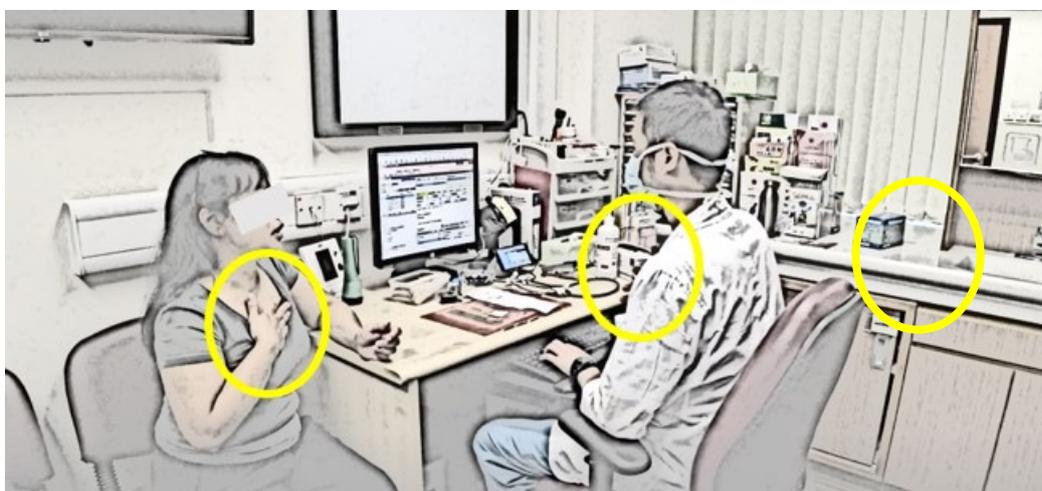


Fig. 3. Lines 20-21

Excerpt 1 starts with the doctor attempting to ask about the chest pain (line 1), with the patient already responding that the pain comes from “*inside*” (line 3) before the doctor finishes a possible question. Upon receiving the patient’s response, the doctor first other-repeats “*inside*” (line 4), thus confirming his understanding of the patient, before asking about how the pain occurs (lines 4-6). To this the patient answers “*and then, I feel heavy on chest*” (line 7). At first glance, there seems to be a non-understanding, for the patient’s response does not match the question. But looking at the non-verbal elements, we will see that the doctor supplements the two options in his question with two gestures—“*particular one spot*” with a pointing gesture (line 4-5) and “*over the whole chest*” with an open palm moving over his chest (lines 5-6; circled in Fig. 1)—and the patient indeed answers the question non-verbally by mirroring the doctor’s second gesture with her open palm (line 8; circled in Fig. 2). Her repetition of the doctor’s gesture exhibits her understanding of the question. (More on negotiating meaning with non-verbal resources is discussed in a later section.)

Receiving the patient’s non-verbal confirmation of her understanding and her verbal response (“*feel heavy on my chest*” in line 7), the doctor again provides an other-repetition (“*feel heavy on your chest*” in lines 9-10) to acknowledge the patient’s response and signal accurate hearing before posing another question, “*so what were you doing when you feel the pain?*” (line 10), to which the patient replies “*I just drinking water*” (line 11). As indicated by the doctor’s question in the next turn—which suggests that the doctor knows “drinking water” is a remedy that the patient took but not what the patient was doing when the pain occurred—understanding seems not to have been achieved. Even so, rather than repairing the non-understanding, the doctor still gives an other-repetition (“*you’re drinking water*” in line 12) to address the patient’s reply and shows his alignment to the content, and asks if “*drinking water [...] makes it better?*” (line 13).

This time, the patient understands and answers the question by other-repeating the doctor (“*make it better*” in line 15). The doctor then confirms her response and his understanding by other-repeating “*make it better*” (line

16). Afterwards, the doctor goes back to his unanswered question posed in line 10. This second attempt (lines 16-18) is still not successful as the patient's reply (line 19) does not answer how the pain occurred. With a third attempt (lines 20, 22-23) where the doctor fronts the topic (Mauranen 2012, 191-198) of his question ("for the pain" line 20) and gives a gesture modifying the one that denotes chest pain earlier in lines 5-8 with an open palm patting his chest (line 20; circled in Fig. 3), the patient eventually grasps the question. She repeats the gestures on herself (line 21; circled in Fig. 3) before answering that the pain occurred "when I am resting" (line 25). The doctor then produces the last other-repetition in the excerpt "when you rest" (line 25), together with nods from both the patient and himself (lines 25-26), and one more final "okay" (line 26) to indicate his understanding and confirm the patient's answer.

Excerpt 1 shows how the aforementioned cycle of "asking, answering, repeating" takes place with the doctor frequently beginning his turn by an other-repetition to affirm his hearing and understanding before he presents another question to the patient (lines 4, 9, 12, 15, 25). Therefore, beyond confirming understanding (Cogo and House 2018), other-repetition also facilitates the flow of the medical consultation by keeping the rhythm of the conversation (Cogo 2009), as if it is an "introduction" to the question or content that follows. This rhythm enables the doctor to address the patient's response by showing him/her that "I heard you" while leading the conversation. Excerpt 2, focusing on the verbal aspect, also exemplifies how other-repetition signals intelligibility and understanding, and keeps the rhythm of the interaction. In this excerpt, the doctor (d1, female) asks about the patient's (p9, female) living habit for her diabetes control and starts with talking to the patient about her blood pressure reading at home. (The doctor is constantly typing and clicking at the computer throughout this excerpt, but this is not transcribed below except to indicate the activity during a silence.)

Excerpt 2:

- 01 d1 did you: usually check at home?
 02 p9 yes hmm the same
 03 d1 → =the same=
 04 p9 °=yes°
 05 d1 one twenty over eighty something=
 06 p9 =°yeah°=
 07 d1 =like that
 08 p9 °like that° (.) sometimes one hundred ten
 09 d1 → sometimes one hundred ten
 10 p9 °(ye- over)° eighty
 11 d1 → over eight (.) that's quite good □ /ha/* ((typing at the computer)) (1) so you
 12 remember to take the medicine every day?
 13 p9 yes [°(everyday in the)°] morning
 14 d1 [everyday]
 15 d1 → morning ((clicking at the computer)) (1) how about exercise?
 16 p9 yes
 17 d1 you do=
 18 p9 =walking
 19 d1 → walking exercise (.) every day?
 20 p9 every day walking
 21 d1 喔 /o/* (1) how about the diet?
 22 p9 er vegetables and fruits
 23 d1 → vegetables and fruits (.) le:ss er salty?
 24 p9 less salty=
 25 d1 =how [about fat]?
 26 p9 [and oily]
 27 d1 → less oily 喔 /o/* that's also good

* □ /ha/ and 喔 /o/ are Cantonese particles that are minimal responses (to signal understanding).

The doctor initiates this part of the consultation by asking whether the patient checked her blood pressure at home regularly (line 1). The patient expresses she did and that the reading was "the same" (line 2) as the reading

she just took at the clinic. The doctor then first other-repeats “*the same*” (line 3) to confirm the patient’s response, before supplementing “*one twenty over eighty something*” (line 5), “*like that*” (line 7) to affirm the reading. The patient then also first other-repeats “*like that*” (line 8), before supplementing “*sometimes one hundred ten*” (line 8). The doctor then once again repeats “*sometimes one hundred ten*” (line 9), before the patient adds “*over eighty*” (line 10), which doctor repeats (line 11).

A similar pattern of repeating and adding continues when the doctor asked if the patient took her medication every day (lines 11-12). The patient answers “*every day in the morning*” (line 13). The doctor repeats “*morning*” (line 15), then asks about the patient’s exercise habit (line 15). When the patient answers “*walking*” (line 18), the doctor repeats “*walking exercise*” (line 19) first, then asks “*every day?*” (line 19), to which the patient answers “*every day walking*” (line 20), repeating both the doctor and herself. Finally, repetition occurs rapidly when the doctor asks about the patient’s diet (line 21). The patient says “*vegetables and fruits*” (line 22), the doctor repeats “*vegetables and fruits*” (line 23). The doctor asks “*less salty?*” (line 23), the patient repeats “*less salty*” (line 24). The patient adds “*less oily*” (line 26), the doctor repeats “*less oily*” (line 27), closing this part for checking the patient’s lifestyle habits.

This excerpt showcases how the rhythm of “repeating, and adding, repeating, and adding” dominates this phase of the consultation, as if it is the structure that the participants implicitly follow to develop the conversation. With this rhythm and structure to begin a turn with an other-repetition—and not just by the doctor as in Excerpt 1, but also occasionally by the patient as in Excerpt 2—both doctors and patients are showing that what is previously said is intelligible and heard accurately (regardless of whether the response answers the question): the conversation progresses based on accurate hearing and understanding, which is indicated by the employment of other-repetition.

Repetition and rephrasing as mutual contribution to make meaning clearer

Whereas the previous section shows that repetition is produced (primarily by doctors) when intelligibility and/or understanding is achieved, this section illustrates that repetition and rephrasing is performed by both patients and doctors as a mutual contribution to make meaning clearer during meaning negotiation, the process to achieve understanding. The first case in point is Excerpt 3 where the doctor (d2, male) attempts to confirm how much medication the patient (p3, female) still possesses for her chronic disease.

Excerpt 3:

01 d2 ((looking at the computer)) do you still have enough medication?
 02 ((turns to p3 at ‘-cation’))
 03 p3 ((p3 pouts)) no: ((p3 slightly shakes her head))
 04 d2 no more today
 05 p3 ((p3 looking away; d2 still looking at p3)) er:
 06 d2 or:=
 07 p3 =I think only the three, the: ((turns to d2)) new medication I think
 08 ((starts scratching her neck and frowns)) around three pieces left (1)
 09 d2 → ((p3 and d2 looking at each other)) oh (.) oh left
 10 p3 ((nodding once)) yeah=
 11 d2 → =just (.) that mean three (.) three pills still remain
 12 p3 → three days for three days
 13 d2 → oh three days still remain (.) right?
 14 p3 ((nodding once)) yeah ((p3 turns to the computer))
 15 d2 so you’re still taking every ((turns to p3)) day
 16 p3 ((nodding once)) yeah
 17 d2 ((nodding once)) great ((turns to computer and starts to type))



Fig. 4. Line 8

Meaning negotiation in excerpt 3 begins with the doctor asking the patient if she still had enough medication (line 1). After receiving the patient's short verbal response ("no" in line 3), the doctor tries to clarify the patient's meaning by expanding her reply to "no more today" (line 4). The patient's reaction, however, possibly indicates uncertainty when she utters a lengthened "er" while looking away from the doctor (line 5), and then says "around three pieces left" (line 8) while scratching her neck and frowning (line 8; circled in Fig. 4). To affirm the patient's meaning amidst the signs of hesitancy, the doctor first other-repeats "left" (line 9) with an emphasis, which is confirmed both non-verbally and verbally by the patient with a nod and "yeah" (line 10), then other-rephrases the patient's response to "that mean three pills still remain" (line 11) to signal his understanding and confirm the information given by the patient. The patient then contributes to the clarity of meaning by further other-rephrasing "three pills" to "three days for three days" (line 12). To complete this process of meaning negotiation, the doctor contributes by saying "three days still remain" (line 13), repeating the patient's use of "three days" and his previous use of "remain," concluding the sense of shared understanding that is created (Watterson 2008). This understanding is endorsed by the patient again with both a nod and "yeah" (line 14).

Both the doctor and the patient in Excerpt 3 co-construct meaning by repeating and rephrasing each other's lexical choices that are salient to the meaning under negotiation. They both actively partake in the process through mutually contributing to the clarity of the meaning expressed (Mauranen 2012, 222), demonstrating that achieving understanding in ELF interactions is a "joint act" by interlocutors (Matsumoto 2018b, 236). Excerpt 4 is another exemplification where the patient (p5, female), who has regular follow-up appointments for her asthma, and the doctor (d2, male) collaborate to describe the patient's recent cough.

Excerpt 4:

- 01 d2 ((looks at p5 once, then turns to click at the computer)) so: cough two
 02 weeks (.) lately (.) right? okay ((starts typing))
 03 p5 °I think ((frowning)) maybe° ((d2 turns to p5)) too much air con
 04 d2 too much air ((d2 turns to computer)) con?
 05 p5 ((looking at d5)) yeah @@
 06 d2 @ ((looking at the computer)) is it improving? ((turns to p5) (1)
 07 p5 ((d2 and p5 looking at each other)) the room the room maybe too cold
 08 d2 mhm: ((d2 looks up and away)) (1) but not ((turns to the computer
 09 screen)) no: recurring cough I mean: no ((making circular movements
 10 → with both hands)) cough repeatedly ((turns to p5)) °right?°
 11 p5 ((shaking her head)) no no (.) ((d2 turns to computer to types while
 12 nodding)) just (.) it's not (.) ((d2 turns to p5)) eh ((making a circular
 13 → movement loosely with one hand)) continuous cough
 14 d2 → ((turns to the computer, nodding)) it's not continuous cough ((starts to
 15 type))
 16 p5 °no°

17 d2 °I see°



Fig. 5. Lines 9-10

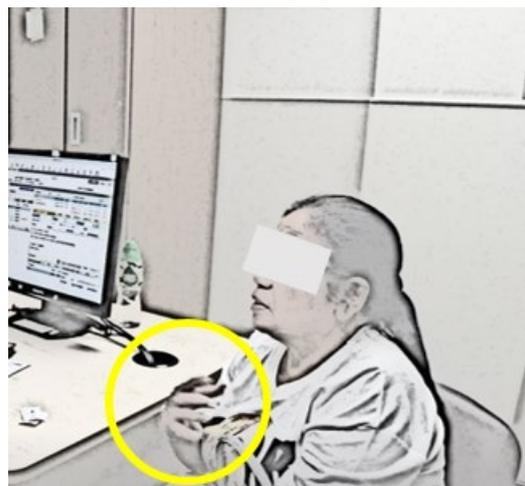


Fig. 6. Lines 12-13

The excerpt starts with the doctor asking about a cough (lines 1-2) that the patient mentioned earlier in the consultation, when she said it lasted two weeks. The doctor felt confused about the time course of the cough (as he said in his interview) and wanted to know clearly if the cough appeared only two weeks ago or throughout the past two to three months following her last appointment. The excerpt goes on with the patient sharing that the cough might be caused by “*too much air con[-ditioning]*” (line 3), which is indeed not the main concern of the doctor at the moment. The doctor asks if the cough was improving (line 6), but the patient does not respond accordingly (line 7). Then the doctor makes his focus more explicit by asking if there was “*no recurring cough*” (line 9), and immediately self-rephrases to “*no cough repeatedly right?*” (lines 9-10), which was accompanied by a gesture with which the doctor makes forward circular movements with his two hands (lines 9-10; circled in Fig. 5). The patient shows her understanding of the question and answers it first by shaking her head and saying “*no no*” (line 11), then supplements it with “*it’s not eh continuous cough*” (lines 12-13), other-rephrasing the doctor’s previous turn. Non-verbally, the patient also “repeats” the doctor’s gesture to one with which she made loose, forward circular movements with one hand (lines 12-13; circled in Fig. 6) to accompany “*continuous cough*.” Finally, the doctor affirms this information and his understanding by other-repeating the patient “*it’s not continuous cough*” (line 14). This process of meaning negotiation ends with the patient confirming one last time with a minimal response “*no*” (line 16), which is addressed by the doctor’s “*I see*” (line 17). These rapid exchanges of rephrasing and repetition demonstrate how the doctor and the patient collaborate to show their understanding and to make meaning clearer to the other in their interaction.

Other-repetition as facilitator to describe patients’ symptoms or conditions

Moving from the previous two sections where repetition is performed by mainly doctors and both doctors and patients, this section focuses on when repetition is employed mainly by patients. It shows that repeating the doctor’s verbal or non-verbal expressions seems to help patients describe their symptoms or conditions to the doctor. An example comes from Excerpt 5 where the doctor (d2, male) asks about the cough of a patient (p5, female) with asthma.

Excerpt 5

01 d2 ((typing at the computer)) any wheezing (.) ((turns to p5; imitates
 02 some high frequency sound)) hmm:=
 03 p5 ((p5 and d2 looking at each other; p5 frowning)) =sometimes
 04 d2 @
 05 p5 yeah@@
 06 d2 =yeah=
 07 p5 =when I’m sleeping (.) ((p5 looks slightly to the side; d2 continue to
 08 → look at p5)) sometimes I can hear (.) the wheezing

09 d2 wheezing (.) you can feel that
 10 p5 ((nodding)) yes ((turns to d2))
 11 d2 ((putting his hand next to his ear)) listen (.) you can hear that
 12 p5 → yeah I can hear that
 13 d2 ((turns to the computer, nodding)) okay (.) what was it like (.)
 14 ((imitates some high frequency sound)) /yi:/ ((turns to p5))
 15 p5 → ((opening her eyes more widely, nodding)) yeah yeah (.) it's like ((imitates
 16 → some high frequency sound)) hmm: like that
 17 d2 okay ((turns to types at the computer)) (1) but you feel okay other than
 18 the ((looks at p5)) wheezing ((turns back to the computer))
 19 p5 ((nodding)) yup yup (.) I'm okay
 20 d2 any difficulty in breathing: ((turns to p5))
 21 p5 ((shaking her head)) no ((d2 turns to type at the computer))
 22 d2 when you are sleeping (.) any difficulty in ((turns to p5)) breathing:
 23 p5 ah no (.) I'm okay ((d2 turns to the computer))
 24 d2 you feel fine ((types)) (.) ((shows gestures of running)) if [you're]
 25 p5 [I mean] ((d2
 26 turns to p5)) I spray the (.) the steroid before I go to sleep
 27 d2 ((d2 nodding)) yeah? you're on [steroid]?
 28 p5 → [() I'm] on steroid ((p5 and p2 nodding
 29 at each other)) (.) yeah
 30 d2 ((gestures spraying the steroid)) puff right?
 31 p5 → ((nodding once)) yeah puff

At the beginning, the doctor asks the patient if she could hear any “wheezing” while breathing, and produces a high frequency sound to imitate wheezing (lines 1-2). The patient replies that when she was sleeping, she could “hear the wheezing” (lines 7-8), other-repeating the doctor’s use of “wheezing.” The doctor then confirms this information by other-repeating and fronting “wheezing” to his turn “wheezing you can feel that” (line 9), which is confirmed by the patient with a nod and “yes” (line 10), before he further affirms this information by rephrasing himself to “listen you can hear that” (line 11). This time the patient provides a more explicit answer by saying “yeah I can hear that” (line 12), repeating the structure used by the doctor rather than giving only a brief response as her last turn (line 10).

Receiving the patient’s explicit reply, the doctor gives an acknowledgment with “okay” (line 13). Then he goes on to ask about the manner of wheezing with “what was it like” (line 13) and produces a high frequency sound to imitate wheezing (line 14). The patient responds to this question by repeating the structure of the doctor’s turn: she first says “it’s like” (line 15), then also produces a high frequency sound to imitate the wheezing that she felt (line 16). After the doctor acknowledges the patient’s response with “okay” (line 17), the conversation goes on with the doctor and the patient talking about how she was doing in general (lines 17-19) and if she experienced any difficulty in breathing (lines 20-24). The patient expresses that she was fine (lines 19, 21, 23) and that she would “spray the steroid” before going to bed (line 26). The doctor then gives a confirmation check (Kaur 2010, 200) “yeah? you’re on steroid?” (line 27), to which the patient confirms explicitly by other-repeating the doctor “I’m on steroid” (line 28), which is simultaneously confirmed non-verbally by both the doctor and the patient nodding to each other (lines 28-29), before the patient further supplements “yeah” (lines 29). But the confirmation process is not ending. The doctor continues to add “puff right?” while performing a gesture imitating spraying a steroid puff (line 30). The patient confirms non-verbally with a nod and verbally by other-repeating “yeah puff” (line 31).

Excerpt 6 shows that the lexical choice or expressions used by the doctor may have given the patient a “template” about how to describe her condition. Therefore, other-repeating the doctor’s turn (lines 8, 12, 15, 16, 28, 31) seems to have helped the patient “learn” a way to give a more explicit answer when responding to the doctor, since the patient, without the medical knowledge and vocabulary that the doctor possesses, may not know how (else) to describe her condition. Other-repeating the doctor seems to have helped ease this knowledge asymmetry (Mondada 2011a) as it provides the patient the expressions she may need to describe her conditions. This in turn helps enhance the doctor’s understanding of the patient and affirm the information that the doctor is gathering from the patient.

Besides the verbal aspect, repetition can take place non-verbally. For instance, the patient imitates the doctor’s production of a high frequency sound to describe her wheezing (lines 16), an instance where the non-verbal

element demonstrated by the doctor becomes a resource that “inspires” the patient how to express her condition. Also, in Excerpt 1, when the doctor asks whether the patient experienced chest pain at a particular spot or all over her chest (lines 4-6), the patient responds that it was all over the chest by other-repeating the doctor gesturally: the doctor opens his palm and moves it over his chest (circled in Fig. 1) to represent pain all over the chest; the patient produces a highly similar gesture (circled in Fig. 2). Therefore, the gestures provided by the doctor in this instance, similar to the expressions being verbally repeated in Excerpt 5 and 6 above, seem to be facilitating the patient to describe her condition: the patient can express her symptoms by repeating the appropriate gesture from the doctor.

Repetition of gestures as a signal for understanding and alignment to content

Other instances of repetition of gestures in Excerpt 1 and Excerpt 4 show that gestural repetition from a patient can also demonstrate that she understands the doctor and that she aligns with the content of the doctor’s turn. The first example occurs in Excerpt 4 where the doctor and the patient are in the process of establishing a shared understanding that the patient’s cough was not a recurrent one. Simultaneously when the doctor says “*no cough repeatedly*,” he makes some forward circular movements with his hands (line 9-10; circled in Fig. 5). To display that she endorses this understanding, besides saying “*it’s not eh continuous cough*” (line 12-13), the patient also imitates the doctor’s gesture by producing the same circular movements, albeit with only one hand (line 12-13; circled in Fig. 6). The patient’s gestural repetition of the doctor offers an extra indication that she understands the doctor and aligns with the content of the conversation—i.e. she is following the conversation—in addition to just her verbal repetition.

In Excerpt 1 when the doctor attempts for the third time to ask the patient when her chest pain occurs, he pats his chest once with his open palm concurrently as he says “*but for the pain*” (line 20; circled in Fig. 3) to emphasise the topic of his question. The patient, who does not reply to the doctor accordingly in his first two attempts, does catch the doctor’s question this time, and replicates the doctor’s gesture and utterance by also patting her chest once with her open palm and saying “*for the pain*” (line 21; circled in Fig. 3). Therefore, the gesture produced by the doctor may have helped him highlight his topic. As a response to this topic being made explicit, the patient’s duplication of the doctor’s gesture, in addition to the verbal repetition, helps exhibit that she follows and understands the content of the doctor’s turn.

These two examples show that gestural repetition is applied to indicate understanding and alignment just like verbal repetition. Similar to the observations made in classrooms where students produce gestural repetition (see also catchments (McNeill 2005) to show they understand and agree with their teachers (Smotrova and Lantolf 2013), gestures in our data are also a resource for attaining shared understanding (Matsumoto 2018a). More significantly, the example from Excerpt 1 highlights the importance of incorporating or even focusing on non-verbal resources when analysing an interaction, for without observing the gestures, the patient’s response would have been inappropriately classed as a non-understanding.

Discussion, conclusion, and future research

Our empirical study confirms previous research that medical encounters are one of the institutional settings characterised by “claims and displays of understanding” (Mondada 2011b, 545) and that repetition contributes much to meaning negotiation in MELF consultations. Our findings show that repetition (i) acts as confirmation of intelligibility and understanding; (ii) contributes to make meaning clearer; (iii) facilitates patients to describe their symptoms or conditions; and (iv) acts as a signal for understanding and alignment to content. While we have yet to analyse if and how doctors and patients demonstrate affiliation to each other or build rapport through repetition, there are many instances where they confirm intelligibility, understanding, and/or alignment to content via repetition. This concurs with Nozawa (2017) and Jin and Watson (2020) who argue that repetition plays a large role in affirming mutual understanding, and thus helps complete medical tasks such as accurate history taking in medical consultations. Additionally, unlike previous ELF research where participants other-repeat to exhibit alignment after a non-understanding is resolved (Watterson 2008), other-repetition in our data is often an initiative taken by participants, especially doctors, to indicate accurate hearing and alignment without an explicit non-understanding beforehand. This may suggest how displays of accurate hearing, which lay the foundation for mutual intelligibility and understanding via repetition, could be particularly prioritised in MELF more than other ELF contexts, and warrants further investigation.

Our data also show that rather than co-constructing the conversation with a combination of utterance completion and other-repetition (Mauranen 2016), doctors and patients mutually contribute to the conversation

through self- and other-repetition, which concurrently helps reduce potential ambiguity and reinforce the clarity and meaning of the conversation they are co-constructing. This suggests that the participants in this data set emphasise clear, shared understanding, and are willing to collaborate to achieve that goal, turning the interaction into a cooperative one despite the power asymmetry (Harvey and Koteyko 2013) brought by their social roles of doctors and patients. Beyond facilitating the completion of medical tasks, this cooperative practice might also enhance patient-centred care.

Although more research is needed, our data already indicate that another possible reason for using repetition could be that during information gathering, as doctors receive input from the patient, they also need to output their understanding into the computer, which adds to their cognitive load. This makes the role of repetition as “a strategy with which speakers’ working memory in comprehension and production is deliberately supported” (House 2010, 373) become particularly significant for these moments when doctors take notes on their computers. Indeed, Silverman, Kurtz and Draper recommend the use of repetition and rephrasing to facilitate patients’ response when gathering information in a medical consultation (2013, 71–83), where one of the objectives, in addition to ensuring mutual understanding, is to let patients know they are listened to and that what they say is valued (ibid, 61). However, participating doctors expressed in retrospective interviews that they could not recall being taught to offer other-repetition, nor were they aware that they were other-repeating much. This practical need for repetition when using another device (computer) may constitute a difference between MELF consultations and other ELF settings, again highlighting the potential for further developing research in MELF.

Further, the data in this paper focuses on the information-gathering stage. However, different stages of the consultation may yield different roles of repetition. The excerpts above show that repetition often indicates attainment of intelligibility and/or understanding, but other-repetition from a patient may not always display shared understanding, and possibly disguise inadequate understanding. In the information-gathering stage where the doctor has more need to understand the patient, other-repetition from the doctor seems to signal understanding. However, in the diagnosing stage, for instance, where the patient has more need to understand the doctor, the roles that other-repetition plays may be more diverse. We recommend that the use of repetition in different stages of a MELF consultation, and how patients denote (non-)understanding in a MELF context through repetition and other pragmatic strategies and non-verbal resources, should be further studied.

Finally, although the current chapter focuses more on verbal elements, non-verbal elements employed in the MELF interactions should not be overlooked. Unfortunately, whereas only gestures were considered in the current analysis, our data also suggest that inclusion of gazes and nods would benefit future MELF research. As has been identified in BELF interactions, interlocutors exhibit listenership by a combination of gaze and nods, with nods performing different functions including receipt of information and confirmation of understanding (Birlik and Kaur 2020). However, since the use of computer is central in medical consultations, such as for inputting history and checking medical records, doctors may not be able to always maintain eye contact with patients (e.g. Nielsen 2014). Without gaze, which is essential in demonstrating attentive listening (Goodwin 1981), nods (and other resources) may bear more significant roles in MELF consultations than merely a listener response (Bavelas, Coates, and Johnson 2002). Therefore, whereas broadly speaking more ELF research should be devoted to the use of non-verbal resources (e.g. Matsumoto 2019; Kaur 2018), future MELF research should continue to examine how interactants apply nods and other (non-)verbal resources to achieve various pragmatic functions. We hope that the different insights shared in this chapter will inspire more MELF studies, and more thinking on future interdisciplinary research that would contribute to both ELF and health communication, fulfilling the needs of different stakeholders using a lingua franca in medical and healthcare contexts.

Appendix – transcription conventions

[onset of an overlap
]	end of an overlap
=	latching – change of turn without gap
(.)	short pause
(1)	longer pause with number of seconds in bracket
:	lengthened speech
–	emphasised speech
°a°	speech softer than surrounding talk
?	rising intonation
s-	truncated speech
()	unintelligible speech

@ laughter
 (()) transcriber's description of non-verbal elements

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