Well, Now, Okey Dokey: English Discourse Markers in Spanish Language Medical Consultations

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Abstract

The purpose of this paper is to examine use of English discourse markers in otherwise Spanish language consultations. Data is derived from an audio-recorded corpus of Spanish language consultations that took place in a small community clinic in the United States as well as post-consultation interviews with patients and providers. Through quantification of the use of discourse makers in the corpus and discourse analysis of transcripts, we demonstrate that English-speaking dominant medical providers use English discourse markers more frequently and with a broader range of functions than do Spanish-speaking dominant medical providers and patients. We argue that such use of English discourse markers serves to exacerbate the power relationship between providers and patients even though the use of English discourse markers does not cause overt miscommunication in the ongoing interaction. Implications for providers who use a second language in their medical consultations are discussed.

Keywords

Introduction

The asymmetrical relationship between medical providers and patients in the medical consultation has been well-documented (Frankel, 1990; Maynard, 1991; Mishler, 1984; Peräkylä, 2002; Robinson, 2001; Silverman, 1987). The medical consultation is one of a number of institutional encounters that can be labeled gatekeeping encounters (Erickson & Shultz, 1983) as medical providers control access to information that patients need (Roberts & Sarangi, 2003). Therefore, medical consultations, like many types of bureaucratic interactions, carry with them an inherent social inequality between interactants that is taken for granted a priori and reproduced interactionally (Philips, 2004). This asymmetrical relationship between providers and patients affords the medical establishment social control when it comes to patients' diagnoses, treatment options, and interaction options within the medical consultation.

For some patients, ways that providers interact lead to better meaning making than it does for other patients. Certainly, language concordance between provider and patient has been argued to be fundamentally important to best practice in the medical consultation (Clarridge, Fischer, Quintana, & Wagner, 2008), more beneficial than cases of interpreter use (Davidson, 2000, 2001, 2002) or cases in which providers and patients have no access whatsoever to a shared language (Antia & Bertin, 2004). However, Roberts, Sarangi, and Moss (2002) have demonstrated that even when there is language concordance, treating patients who speak English (in the case of their study context, the UK) with limited

proficiency can result in linguistic and cultural misunderstandings. Furthermore, even in clinical settings that promote themselves as multilingual, one language may be privileged. Martinez (2008) demonstrates that supposedly language concordant medical facilities in the Texas borderlands privilege English over Spanish, which leads to worse health outcomes for Spanish-speaking patients.

The present paper examines a situation in a small community clinic in Southern California, United States, in which providers, not patients, use their second language, Spanish. Our data demonstrates that some providers who use second language Spanish code-switch, using English discourse markers during the consultation. We pose the following four research questions that guide our study of the use of English discourse markers in Spanish language medical consultations:

1. How does the frequency of the use of English discourse markers by Spanish-speaking dominant providers compare to that of English-dominant medical providers?

2. How does the frequency of the use of English discourse markers by Spanish speaking (bilingual and monolingual Spanish) patients compare to that of English-dominant medical providers?

3. For what functions are English discourse markers used by the two English dominant medical providers in the medical consultation?

4. In what ways does the use of English discourse markers by the two English dominant medical providers affect the interaction within the medical consultation?

Discourse Markers

Discourse markers provide what Gumperz (1982) terms contextualization cues as they signal verbally or non-verbally the currently enacted discourse frame, including how utterances relate to each other. Torres (2002) defines discourse markers as follows:

> Discourse markers - words like so, and, or y'know - may have both grammatical and discourse meanings, and they are multifunctional…most linguists would agree that discourse markers contribute to the coherence of the discourse by signaling or marking a relationship across utterances (p.65).

Any particular discourse marker can function differently in different contexts of use. Meanings of discourse markers can vary both by communicative context and by discourse context.

Discourse Markers and Communicative Context

Considering the growing body of research suggesting that particular uses of language are specific to the communicative context (e.g., Hall, Cheng, & Carlson, 2006), it is not surprising that this would be the case with discourse markers as well. DeFina (1997) provides a particularly compelling account of the context sensitivity of discourse markers. She claims that they "may assume specialized functions in certain types of discourse which may be partly or totally different from the ones described in existing studies of the same markers in conversational environments" (p. 338). We can see this in the use of *well* in television sportscasting (Greasley, 1994), the use of *and* to open particular types of questions in the medical consultation (Heritage and Sorjonen, 1994), the use of *well* and *but* in oral narrative (Norrick, 2001), the use of *well* in the courtroom (Innes, 2010), the use of *okay* in seminar talk (Rendle-Short, 1999), and the use of the Spanish discourse marker, *bien*, in the classroom (DeFina, 1997).

These studies have shown that discourse markers take on different meanings in different settings. For instance, Heritage and Sorjonen (1994) argue that and-prefacing before questions in medical consultations serves to show that nurses are 'doing bureaucracy' rather than 'establishing a helping relationship.' Heritage and Sorjonen provide the several examples of and-prefaced utterances from a conversation between a nurse and a patient. Following a segment in which the nurse and patient converse about the nature of the patient's pregnancy, the nurse asks, "A:nd uh: (1.5) how long were you in labor for the:n," (p. 14) which signals that the nurse is moving forward with the bureaucratic work of interviewing the patient. Therefore, and-prefacing takes on a specific meaning when used by nurses in the medical consultation. And-prefacing, then, is a discourse move that is associated in particular with the medical consultation speech event studied by Heritage and Sorjonen. This work demonstrates the possible context specificity of the meaning of discourse markers.

Discourse Markers and Discourse Context

While the particular meanings that discourse markers assume vary by communicative context, their meanings also vary in terms of how they appear in the discourse. Schiffrin (1987) has asserted that discourse markers can carry both pragmatic and semantic meaning and can be more pragmatically oriented or semantically oriented depending on the discourse context within which they are used.

Filipi and Wales (2003) demonstrate that *okay*, *right*, and *alright* can take on a variety of functions depending on the discourse context within which they are uttered. So, for instance, *alright* is alternatively used as a marker of interruption in the activity at hand, but in other discourse contexts, it might signal that the coming utterance initiates new information. In the first instance, a speaker might say "alright." with terminal intonation after a string of discourse on a particular topic. This marks an interruption in the activity at hand. In the second instance, a speaker might say "alright" followed by the initiation of a new topic. Filipi and Wales (2003, p. 450) use the following example: "[awright] NOW. (0.3) you head east and before you get to mill street." Use of discourse marker in one way or the other is entirely dependent on the discourse context within which it is uttered.

As a discourse marker, Filipi and Wales (2003) argue that *okay* is a pragmatic marker that occurs "at boundaries such as openings and closings, as well as phrase boundaries in the middle sections of various types of talk" (p. 431). Generally, *okay* marks transition from one segment of talk to another. *Alright* seems to be functionally similar to *okay*, though Turner (1999) argues that there is a difference in terms of scope in the use of *okay* and *alright*. According to Turner's argument, *alright* marks a major shift in topic, whereas *okay* marks subtle shifts in focus within the same topic. Filipi and Wales, on the other hand, argue that *okay* signals topic continuance, whereas *alright* signals a shift to a new topic. While *okay* and *alright* are quite similar as discourse markers, there seem to be subtle differences in their discourse functions.

The discourse marker, *well*, has been the subject of much research attention (Aijmer & Simon-Vandenberg, 2003; Blakemore, 2002; Cuenca, 2008; Garcia Vizcaino & Martinez-Cabeza, 2005; Innes, 2010; Greasley, 1994; Jucker, 1993; Lam, 2010; Norrick, 2001; Schiffrin., 1987; Schourup, 2001). Through this research, the meaning of the discourse marker *well* has been shown to be polysemous and elusive (Cuenca, 2008). As Norrick defines the function of *well* as a discourse marker, "the usual dialogic functions identified for *well* as a DM (discourse marker) are to preface utterances which reject, cancel or disagree with the content or tenor of the fore going discourse" (p. 851) as in "well I don't agree." Norrick (2001), however, furthers the definition of the function of *well* by

demonstrating that it also serves to mark the beginning or ending of an oral narrative or a return to an oral narrative after an interruption or digression as in "well getting back to my story."

The discourse marker *now* has been less researched. However, Fraser (2009) argues that it "signals immediacy of movement [Return/Continuation/New Topic]" (p. 897). It is what Fraser calls an "attention marker," signaling to the interactant that a shift is about to occur as in "now let's talk about your blood pressure."

Yeah is an affirmative response marker (Hlavac, 2006). It occurs quite frequently in discourse as demonstrated by Jucker and Smith (1998) even though other affirmative response markers, such as *yes*, *uh huh*, *that's right* and *yep*, are all alternative possibilities to perform the same function as in when an interlocutor says "yeah" to signal listenership.

Clearly, discourse markers take on meaning based on the discourse context in which they appear. Some discourse markers are more ambiguous than others, but the discourse context clarifies the function that the discourse marker takes on.

Bilingual Discourse Markers

The use of discourse markers in bilingual discourse complicates the matter further as speakers have two languages at their disposal. Torres (2002) argues that "in the case of Brentwood Puerto Rican Spanish, all speakers, regardless of language dominance, use English markers in their Spanish speech production, whereas Spanish-dominant speakers use English-language discourse markers in a restricted function" (p. 78). It is interesting that English crept in to the Spanish of this Spanish-speaking community in the United States. This use of English discourse markers in Puerto Rican Spanish in the United States probably reflects the fact that English is dominant in the United States. Hlavac (2006) found similar use of English discourse markers in Croatian language use among Croatian-English bilinguals in Australia. Such uses of code-switching are not neutral but index particular language identities and ideologies (Cutler, 2007, Gal, 1989, Low et al., 2009). Again, it seems possible that the use of these English discourse markers indexes a macro-societal context in which English is the dominant language (Hill, 1998). Moreover, Torres and Potowski (2008) determined that increased use of the English discourse marker *so* and decreased use of the Spanish discourse marker *entonces* is associated with decreased Spanish proficiency among the Spanish-English bilinguals they studied. Therefore, it is possible that heavier use of English discourse markers is associated with lower Spanish proficiency.

Data

Study Context

The research site for this study, the F Avenue Clinic, is associated with a religious community center in an urban area in California. There are four consultation rooms operable in the clinic as well as one room designated for educating community members. As indicated in its literature, the F Avenue Clinic is nurse-managed and aims for cultural competency, which entails maintaining a culturally diverse and multilingual staff. In addition to screening and diagnosing, providers also engage in educating patients. Thus, the providers must be able to communicate effectively with patients to meet these cultural competency and education goals, and are particularly motivated by their mission statement to engage in productive and effective communication with their patients and clients who are not highly comfortable users of English.

Clinical communication needs were addressed through the use of two bilingual nurse practitioners (Carrie and Laura), a bilingual medical doctor (Dr. Thomas), and one bilingual medical assistant (Maria). There were also two bilingual receptionists. Interactions in the clinic were between patients and Spanish-English bilingual providers.

This paper is drawn from a corpus of audio-recorded medical consultations that took place within the F Avenue Clinic as well as audio-recorded post-consultation interviews with both providers and patients. This corpus was collected over a period of nine months, from October 2009 to July 2010. The focus of this paper will be on the discourse markers of two English dominant bilingual providers, Dr. Thomas (DT) and Carrie (C), as well as two Spanish dominant bilingual providers, Laura (L) and Maria (M). It also includes five monolingual Spanish-speaking patients, Arturo (A), Dalia (D), Maria G. (MG), Ramon (R), and Samuel (S), Maribel (MB), Pamela (P), Rosana (RA) and two Spanish English bilingual patient, Lucia (L) and Carlos (C). The data includes a total of ten medical consultations with four different providers and ten different patients. We determined bilingual and monolingual status as well as language dominance of the providers and patients in post-consultation interviews. The patients and providers self reported their status as bilingual or monolingual and their dominant language.

Data Collection

Audio-recording equipment was set up in each consultation room in the clinic for these purposes. Consultations involved one-on-one interactions between adult participants and medical providers in most cases. The one exception was one consultation between a patient, Dalia and Dr. Thomas in which Dalia's Spanish-speaking husband was present. The researcher was also present in each medical consultation conducting participant observation and taking field notes.

All participants, medical providers and patients, participated in a post-consultation interview conducted by the researcher to assess how well they thought the consultation went, including how well the provider understood the patient and how well the patient understood the provider.

Transcription

The audio-recordings were transcribed using the *Express Scribe* computer program. The transcriptions allowed us to examine a written and linguistically coded corpus of both the interactions within the medical consultations and the post-consultation interviews.

Analysis

Specific communicative outcomes within particular medical consultations were determined by the identification of interactive processes. Audio-recording of individual medical encounters allowed qualitative analysis of interactions. Audio-recordings were also used to quantify the different means of communicating with individual patients within the medical facility.

Transcripts of audio-recordings allowed the fine-grained discourse analysis of consultations between monolingual Spanish-speaking patients and bilingual medical providers. Qualitative data informed the findings by demonstrating how conversational sequences were uptaken in the ongoing conversational interaction. We conceptualized meaning as created in the process of face-to-face interaction, concentrating on how we make meaning in our interactions as we go along (Garfinkel, 1967; Goodwin & Heritage, 1990). Analysis of this conversational uptake contributed to identification communicative outcomes.

The transcriptions constituted the corpus, from which discourse was coded, tagged and quantified. The transcripts were coded to identify the use of discourse markers. Quantitative analysis of the use of discourse markers allowed us to quantify the frequency of use of the different discourse markers that we found.

However, also critical to this evaluation was post-consultation interviews with both providers and patients. The post-consultation interviews with providers and patients allowed member checking (Rossman & Rallis, 1998) so that the research team understood how the participants themselves understood the function and organization of the medical consultation.

Findings

Provider Differences in Use of English Discourse Markers

In conducting quantitative analysis on the use of English discourse markers by English-speaking dominant and Spanish-speaking dominant providers, we obtained percentages for both total use of English words out of total words (English and Spanish) and total English discourse markers out of total discourse markers (English and Spanish) as indicated in Table 1. This quantitative analysis indicates a difference in the way the English-speaking dominant medical providers and the Spanish-speaking dominant medical providers conduct the medical consultation. Our data show that Dr. Thomas (DT) and Carrie (C), the English-speaking dominant providers, used English more frequently than did Laura (L) and Maria (M), the Spanish-speaking dominant providers, as shown in Table 1. Carrie and Dr. Thomas use English 8.5% and 9.6% respectively out of each of their total English and Spanish words spoken, while Laura and Maria use English .55% and .14% respectively out of each of their total words spoken (English and Spanish). This is important to note because though the focus of this paper is the English discourse markers, these English-speaking dominant medical providers use English for a wider range of functions than just discourse markers,

As shown in Table 1, Carrie uses English discourse markers 29%, Dr. Thomas, 31%, Laura, 0%, and Maria, .2% out of their total English and Spanish discourse markers. Generally, we can see that the consultations by both the English-speaking dominant providers show more use of English and English discourse markers than the Spanish-speaking dominant providers. Especially striking is the fact that the use of English discourse markers out of total discourse markers by these English-speaking dominant providers constitutes about a third of their total discourse marker usage, whereas the Spanish-speaking dominant providers use minimal English discourse markers. Laura uses no English discourse markers. Maria's use of English discourse markers includes three uses of the discourse marker *yeah*. Therefore, in response to research question 1, the English-speaking dominant providers a higher frequency of English discourse markers than Spanish-speaking dominant providers do. The English-speaking dominant providers also use a higher percentage of English than the Spanish-speaking dominant providers do, but this difference is especially pronounced when it comes to the use of English discourse markers.

Patient Use of English Discourse Markers

Quantitative analysis indicates that the monolingual Spanish-speaking patients use very little English and very few English discourse markers in their Spanish language medical consultations. However, English-Spanish bilingual patients use English and English discourse markers more frequently than do monolingual Spanish-speaking patients. As Table 2 demonstrates, the patients' use of English ranged from 6.25% to .2% as a percentage of total words. Their use of English discourse markers out of their total use of discourse markers (English and Spanish) ranged from 34% to 0%.

The eight monolingual patients, Dalia, Arturo, Ramon, Samuel, Maria G, Maribel, Rosana, and Pamela do not seem to adopt a pattern in which they use English and English discourse markers. However, Lucia and Carlos, who are bilingual and Spanish dominant, do seem to have a pattern of English use as indicated in Table 2. In fact, Lucia's pattern of English and English discourse marker use is quite similar to that of the English-speaking dominant medical providers. Carlos's use of English and English discourse markers is not as frequent as Lucia and the English-speaking medical providers but more frequent than the monolingual Spanish-speaking patients and Spanish-speaking dominant providers.

In our data, the only English discourse marker that monolingual patients use is *yeah*. Even the bilingual patients use a restricted range of English discourse markers. Lucia uses mostly *yeah* and four uses of *you know* (eight words). Carlos uses *yeah* four times and has two uses of *oh my gosh* (six words). Similar to Torres (2002) and Hlavac (2006), we see a restricted function of English discourse markers among the monolingual and bilingual patients.

What Tables 1 and 2 demonstrate is that the English-speaking dominant medical providers use English and particularly English discourse markers at a higher frequency than do Spanish-speaking dominant medical providers (Research Question 1) and at a higher frequency than do monolingual Spanish-speaking patients. However, the English-speaking dominant providers use English and English discourse markers at similar frequency to Lucia, the bilingual Spanish dominant patient, and at a less similar frequency than Carlos, another bilingual Spanish dominant patient. Perhaps Lucia's and Carlos's rate of English and English discourse marker use was affected by the provider with whom they interacted. Carlos's consultation was with Laura, who used little English and no English discourse markers, while Lucia's consultation was with Carrie, who used 8.5% English and 29% English discourse markers. In response to research question 2, English-speaking dominant medical providers use a higher percentage of English and English discourse markers than do Spanish-speaking monolingual patients. It is, however, important to note that the bilingual patients' pattern of discourse marker use is different than the monolingual patients as they use English discourse markers 34% and 12%, though as noted, they use a restricted range of English discourse markers. English-speaking dominant providers, therefore, use a wider range of English discourse markers than do the bilingual Spanish dominant patients and a much higher frequency of discourse markers than do the monolingual Spanish-speaking patients.

As we have indicated, the use of English discourse markers by Spanish-speaking dominant medical providers and patients is quite restricted in the context of our data, limited to *yeah*, *you know*, and *oh my gosh*. We will, therefore, focus on the English-speaking dominant medical providers, Carrie and Dr. Thomas's, use of English discourse markers throughout the remainder of the paper.

The majority of Carrie's English usage was comprised of discourse markers. This reflects the fact that her use of English was spread throughout the consultation as she used both Spanish and English discourse markers to frame her utterances. Dr. Thomas, on the other hand, used a smaller percentage of English discourse markers. Her use of English tended to be in large chunks when she was typing information into the computer or solving a problem with the information. Her use of English, then, often marked a detachment from interaction with the patient. However, like Carrie, Dr. Thomas did use English discourse markers throughout the consultation but not as extensively as Carrie did.

When Carrie and Dr. Thomas used discourse markers, their language of use was remarkably similar. As demonstrated in Table 3, we have categorized the language of their discourse markers as English, Spanish, or Language Neutral, which refers to discourse markers, such

as *okay*, that normally occur in both Spanish and English. Moreover, we have obtained percentages of use of each category out of total discourse markers for both Carrie and Dr. Thomas.

Both Carrie and Dr. Thomas used about one third English discourse markers, a little under one third Spanish discourse markers, and a little over one third of Language Neutral discourse markers.

Function of English Discourse Markers

Although Dr. Thomas and Carrie used English discourse markers at a similar frequency, they showed differences in their use of discourse markers. To demonstrate these differences, we have categorized the discourse markers into seven types (see Table 4). These include Response Markers, Negative Response Markers, Evaluative Response Markers, Attention Markers, Attention Markers of Disagreement, Topic Shifters, and Floor Shifters, which encompassed all of the English discourse markers in our data. These categories correspond with the function of each discourse marker.

We defined response markers as indicative of a response to previous discourse with the expectation of continuation of the old topic and previous speaker. We developed the category response marker based on Jucker and Smith's (1998) notion of affirmative response marker. Response markers act in a similar way to backchannel cues in our data since they seem to encourage a continuation of an interlocutor's previous turn. While negative response markers function very similarly to response markers, they indicate a negative response to previous discourse. Evaluative response markers also function in a similar way to response markers, but they act to evaluate the previous discourse, and rather than encouraging continuation of the previous discourse, they tend to shut it down. Evaluative response markers are used in much the same way that they are used to evaluate student responses in classroom discourse (e.g., Mehan, 1979). Attention markers (similar to Fraser, 2009) indicate that attention should be turned to the speaker's utterance, and attention markers of disagreement indicate that attention should be turned to the speaker's utterance, which will be a disagreement move. Topic shifters indicate movement from an old topic to a new topic. Finally, floor shifters indicate turning the floor over to a new speaker.

Note that some words, such as *right*, can be categorized differently depending on how they function in context[1]. Table 5 shows the quantification the use of particular English discourse markers by Carrie and Dr. Thomas out of total English discourse markers.

As Table 5 demonstrates, the function of Carrie and Dr. Thomas's discourse markers are somewhat different. While 39% of Dr. Thomas's English discourse markers are response

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[1]For instance, *right* can function as either response marker or evaluative response marker depending on its function in the discourse. In the following example, *right* functions as a response marker:

Samuel; pero cuando no hay nada hacemos..limpieza del [entro]

Samuel: but when there is nothing we clean the inside

Carrie; [right] [okay]

In the above example *right* is like a backchannel cue simply indicating a reponse to the interlocutors contribution. However, *right* functions as a evaluative response marker in the example below:

Carrie; okay… toma los dos juntos… [okay?]

okay… take the two together… [okay?]

Rosana; [en la] Hydrochlorozac=[in the]

Carrie; =Hydrochlorozac <L1> right <L2>

markers, 20% of Carrie's English discourse markers are response markers. Dr. Thomas (18%) also used more negative response markers than Carrie (5%). On the other hand, Carrie used evaluative response markers a little over a third (29%), while Dr. Thomas used them only 1%. Dr. Thomas and Carrie used English attention markers 16% and 8% respectively. Moreover, Dr. Thomas more frequently used English attention markers of disagreement (16%) than Carrie did (3%). Dr. Thomas and Carrie used English topic shifters 8% and 33% respectively, and neither provider used English floor shifters often. Carrie and Dr. Thomas did only 2% out of all of their English discourse markers. Carrie used English discourse markers more in Evaluative Response Marker and Topic Shifter categories, while Dr. Thomas used them more in Response Marker, Negative Response Marker, Attention Marker and Attention Marker of Disagreement categories. Carrie and Dr. Thomas's use of English discourse markers in Floor Shifter categories were quite similar. Therefore, with the exception of Floor Shifters, Carrie and Dr. Thomas used English discourse markers in their consultations for different functions (research question 3).

English Discourse Markers in Interaction

Qualitative analysis further explains the quantitative data. In particular, we will analyze discourse excerpts from Carrie and Dr. Thomas's consultations to examine how they use the seven categorized types of discourse markers in interaction and the affect of such uses on the interaction within the consultation.

Response Markers

The quantitative data indicated that Carrie used response markers 20% out of all of her English discourse markers, while Dr. Thomas used response markers 39% out of all of her English discourse markers. In Excerpt 1, we can see how these response markers function in interaction. Excerpt 1 involves Dr. Thomas and a patient, Arturo, who expresses confusion about his treatment since what he has read apparently contradicts Dr. Thomas's instructions.

In line 9 of Excerpt 1, Dr. Thomas uses the response marker, *yeah*. What is notable here is that *yeah* functions as a response marker even though it is in English, a language that Arturo does not speak. It indicates a response to Arturo followed by a next turn by Arturo on the same topic. In this case, Dr. Thomas's use the response marker *yeah* allows the patient and provider to achieve common ground in terms of who is holding the floor and who is listening. In this case, Arturo continues to hold the floor, treating *yeah* as a response to his previous turn but also as a sort of backchannel cue. Even though Arturo does not understand English, it is very possible that in context he understands the meaning of this English discourse marker.

In Excerpt 2, Carrie is involved in a consultation with a patient, Samuel. As they talk, Samuel mentions that he delivers pizza for a job. She uses the response marker *oh I see* in line 15. Carrie's use of the English response marker *oh I see* occurs after the patient switched to English in line 11, and operates very clearly as a response marker as it indicates a response to Samuel followed by Samuel taking a next turn on the same topic. In the case of Excerpt 2, the English response marker in line 15 may demonstrate alignment with the patient as the provider switches to English in response to the patient's switch in line 11. However, as our quantitative data indicates, such monolingual patient switches to English are not very common in our data.

In both Excerpts 1 and 2, the use of the English response markers in these otherwise Spanish interactions function in precisely the way we would expect a response marker to function. They indicate a response on the part of the providers that show listenership and encourage a continuation of the speakers previous turn (Jucker and Smith, 1998).

Negative Response Markers

Dr. Thomas used negative response markers more frequently (18%) than Carrie did (5%). We term particular discourse markers (e.g., *oh geez*, *oh boy*) negative response markers not because they negate the patient's account but because they demonstrate a response on the part of the provider that affiliates with the patient's account as a negative (unfortunate) one for the patient. In Except 3, Dr. Thomas interacts with Arturo, who is diabetic. In line 1, Arturo explains that his foot became swollen as Dr. Thomas physically examines the patient's feet and legs. She uses the English negative response marker *oh geez* in line 4.

The negative response marker in line 4 is followed by a 3 second pause, which corresponds with the fact that the interaction takes place in conjunction with Dr. Thomas's physical examination of Arturo's feet and legs. The use of the English negative response marker *oh geez* is typical of the function of negative response markers in our data more generally whether they are in Spanish or English. The negative response marker acts as a backchannel cue and is followed by Arturo's continuation of the previous discourse as he expresses that the swelling in his feet causes him concern. As demonstrated in Excerpt 3, these negative response markers act as backchannel cues but also show the provider's alignment with the patient's unfortunate situation.

Evaluative Response Markers

The quantitative data indicates that Carrie used what we have categorized evaluative response markers quite frequently (29%), while Dr. Thomas did not use them frequently (1%). The evaluative response markers are indicative of Carrie's consultative style. She tends to elicit patient responses, allow the patient to respond, and then evaluate that response. Excerpt 4 involves a consultation in which Carrie asks questions about the health of a patient, Lucia.

In Excerpt 4, Carrie asks Lucia a number of questions about her health. As she does this, it resembles quizzing her. She asks the questions, obtains a response from the patient, evaluates the response, and then moves on to the next question. We see this in line 4 when she says *good* and again in lines 6–7 when she says "goo:d (4.0) very good." This pattern of provider query, patient response, and provider evaluation is a typical one for Carrie, and explains the frequency (37%) of her use of evaluative response markers.

Carrie's use of evaluative response markers in Excerpt 4 follows a typical pattern in our data whether the evaluative response markers are in English or Spanish. This pattern is one in which the evaluative response markers are followed by a subsequent provider question.

Attention Marker

Dr. Thomas (16%) and Carrie (8%) used English attention markers with somewhat different frequencies. Attention markers function to draw attention to the speaker's following utterance. In Excerpt 5, Dr. Thomas uses the English attention marker *now* in line 1 to draw attention to her following utterance.

Dr. Thomas's attention marker in line 1 operates as we would expect an attention marker to operate (i.e., Fraser, 2009). Dr. Thomas uses the attention marker followed by her subsequent utterance, drawing attention to that utterance.

Attention Markers of Disagreement

Quantitative data indicates that Dr. Thomas engaged in attention markers of disagreement more frequently (16%) than did Carrie (3%). When Dr. Thomas used attention markers of disagreement, she was often engaged in disagreeing with the patient's previous discourse

and engaging in an explanation of her own viewpoint. In Excerpt 6, Dr. Thomas and Arturo discuss her need to obtain the results of his blood work before she can prescribe cholesterol medicine.

In Excerpt 6, Dr. Thomas explains that she needs Arturo's blood work to prescribe the correct medication. In lines 10–13, it becomes clear that Arturo had blood work done in August in Sacamento, seemingly indicating that those results were too old to be useful. Then in line 14, Dr. Thomas uses *well* as an attention marker of disagreement. Following *well*, she begins an utterance that expresses disagreement with Arturo's previous contribution as she asserts that the results are not that important because she can order another set of blood work. Therefore, her contribution in lines 14–19 conforms to what we would expect following an attention marker of disagreement.

Topic Shifters

Quantitative data indicates that Carrie used more topic shifters (33%) than Dr. Thomas (8%). Excerpt 7 involves interaction between Carrie and a patient, Samuel. In the interaction, Carrie is listening to Samuel's chest and abdomen with a stethoscope. Before the beginning of this except, she asks him to breathe in and out.

In lines 1–9, Carrie instructs Samuel to breathe in and out. Then in line 10, she uses, *okey dokey* as a topic shifter. In our data, *okey dokey*, much like *okay*, typically closes the old topic and transitions to the new. However, in line 11, Samuel continues to breathe in and out after Carrie has said *okey dokey*. It is not until line lines 12–13 that Samuel stops breathing in and out, and Carrie changes the topic. However, it is quite possible that Carrie had not yet removed the stethoscope form Samuel's chest when she said *okey dokey* in line 10, which could be why he continued breathing in and out.

Excerpts 1 through 7 provide examples of patterns of Carrie and Dr. Thomas's use of a variety of English discourse markers in otherwise Spanish language medical consultations. These English discourse markers seem to function very much as we would expect even though they are in a language that the monolingual Spanish-speaking patients report that they do not use. Therefore, it is important to note that they do not cause any overt derailment of the doctor-patient communication in these excerpts. However, their use does something more subtle. The prevalent use of the English discourse markers consistently indexes that these providers are primarily English speakers, which sets up a situation in which the providers and the Spanish-speaking patients come from different social contexts. Considering that the medical consultation is already an interaction type in which there is an asymmetrical power relationship between the provider and patient (Frankel, 1990; Maynard, 1991; Mishler, 1984; Peräkylä, 2002; Robinson, 2001; Silverman, 1987), the use of the English discourse markers adds another layer to this asymmetrical relationship. Not only may the provider and patient be distanced in terms of their institutional roles, but the English discourse markers also sets them apart in terms of their language style. Moreover, it is worth mentioning that the United States constitutes a macro-societal context in which English is ideologically dominant and Spanish is ideologically subordinate (e.g., Hill, 1998), and the providers' use of English discourse markers indexes their powerful role as English users in that macro-societal context.

In response to research question 4, in our data, the English-speaking dominant providers use English discourse markers of various types and functions in the Spanish language medical consultation interaction. In our data, their use does not seem to have an overt effect on the communication in the consultation, nor do they seem to take on specialized functions unique to this particular corpus. They do, however, index the fact that the English-speaking dominant providers and the monolingual patients come from different social contexts as the

use of the English discourse markers constitutes a pattern of use of English discourse markers on the part of the English-speaking providers that is different than that of the monolingual Spanish-speaking patients.

Discussion

1. How does the frequency of the use of English discourse markers by Spanish-speaking dominant providers compare to that of English-dominant medical providers?

    The data presented in this paper demonstrate that dominant English-speaking medical providers and dominant Spanish-speaking medical providers use discourse markers at different frequencies in their Spanish language medical consultations. This difference lies in the heavier use English discourse markers employed by the dominant English-speaking medical providers than the dominant Spanish-speaking medical providers.

    The way that these English-speaking dominant providers use English discourse markers in these otherwise Spanish language consultations is very much like the use of English discourse markers in English dominant bilingual communities as studied by Torres (2002) and Hlavac (2006). When these bilinguals interact in Spanish and Croatian in English dominant contexts, the bilinguals use English discourse markers. Something similar seems occur with the English-speaking dominant medical providers studied in the current paper.

2. How does the frequency of the use of English discourse markers by Spanish speaking (bilingual and monolingual Spanish) patients compare to that of English-dominant medical providers?

    The data presented in this paper demonstrate that there is a difference in the way that dominant English-speaking dominant medical providers and patients use English discourse markers in the medical consultation. The dominant English-speaking medical providers use the English discourse markers more frequently than the monolingual Spanish-speaking patients do. However, the one of the bilingual patients, Lucia, uses a similar pattern of English discourse markers to the English-speaking dominant medical providers. The bilingual patient, Carlos, uses English discourse markers less than the English-speaking dominant providers but still more than the monolingual patients and Spanish-speaking dominant providers.

    The English-speaking dominant providers' and the bilingual patients' pattern of English discourse marker use resembles the use of English discourse markers in other English dominant bilingual communities as studied by Torres (2002) and Hlavac (2006). However, the range of functions of the English-speaking dominant medical providers' discourse markers is greater than it is for Lucia and Carlos, the Spanish-dominant bilingual patients, echoing Torres (2002). Lucia uses only *yeah* and *you know*, while Carlos uses only *yeah* and *oh my gosh*. The English-speaking dominant providers use many different discourse markers as noted in Table 4. The use of English discourse markers, then, is different for the Spanish-dominant bilingual patients than it is for the English-speaking dominant providers in terms of the range of functions.

3. For what functions are English discourse markers used by the two English dominant medical providers in the medical consultation?

    We identified seven functions in which the English-speaking dominant medical providers use English discourse markers. However, the two providers differ in

terms of how frequently they use the discourse markers in these seven categories. For instance, Carrie's most used English discourse marker is the evaluative response marker, while Dr. Thomas's is the response marker, though Carrie also used response markers with some frequency. The difference in use of the English discourse markers by the two providers seems to be indicative of different interactional styles in the consultation. For instance, Carrie was generally teacher-like and evaluative (Excerpt 4), often resembling the Initiation-Response-Feedback pattern typical of classrooms (Mehan, 1979). Dr. Thomas, on the other hand, tended to listen to patient accounts without evaluating them explicitly, though she did use negative response markers with some frequency to show an affiliation with a patient's ailment (Excerpt 3).

The English discourse markers that we identified in these Spanish language medical consultations derive their meaning from the context of use (DeFina, 1997). It is interesting that they function in ways that are quite similar to the functions that previous research has assigned to them. They do not seem to take on a specialized function in the context of the medical consultations in the sense of DeFina (1997) besides the fact that they are English discourse markers in an otherwise Spanish medical consultation.

4. In what ways does the use of English discourse markers by the two English dominant medical providers affect the interaction within the medical consultation?

    The use of English discourse markers does not seem to have an overt effect on the interaction within the medical consultation besides their usual effect of contributing to the coherence of the discourse by signaling relationships between utterances (Torres, 2002). However, given that the monolingual Spanish-speaking patients are not English users, we have to wonder whether the English discourse markers contributed to discourse coherence for them. Our data does not show any overt miscommunication caused by the use of the English discourse markers. The post-consultation interview data that we do have with patients generally indicates that they understood their providers during the consultations, though some patients indicated that their English-speaking dominant providers were not fully proficient in Spanish. However, the overwhelming response to our question about whether there was anything the patients did not understand was "todo estuvo bien" (all was good). While there could be many reasons for that response, including not wanting to disparage the provider in the context of the clinic, there is a consistent response that indicates that patients understand their English-speaking dominant providers well.

    However, we argue that these little intrusions of English in the Spanish language medical consultations indexed the dominant role of English outside the clinic walls. The prevalence of these English discourse markers, therefore, may have had the effect of distancing the English-speaking dominant providers from their monolingual Spanish-speaking patients. Research on language and identity has demonstrated that languages are associated with particular affiliations (e.g., Gal, 1989), and that particular ways of using language index such affiliation (Cutler, 2007). Moreover, using a language that one's interlocutor does not use indexes disaffiliation with that interlocutor (Low et al., 2009). The switches to English may have been disaffiliative in these consultations, which would certainly lead to an exacerbation of an already asymmetrical relationship between provider and patient (Frankel, 1990; Maynard, 1991; Mishler, 1984; Peräkylä, 2002; Robinson, 2001; Silverman, 1987) in these Spanish language medical consultations.

Conclusions and Implications

The fact that English-speaking dominant providers use English discourse markers more frequently than Spanish-speaking dominant providers may be an indicator of different ways that these providers identify as bilinguals. While the English-speaking dominant providers index their identities as English users, the Spanish-speaking dominant providers do not. As in the case of Torres (2002) and Hlavac (2006), English creeps in to the Spanish of the English-speaking dominant providers in this English dominant context. It is interesting that this pattern also holds for Lucia, and to a lesser extent for Carlos, the bilingual patients. They also index their identities as English users through the use of English discourse markers. However, similar to what Torres (2002) found, these Spanish-speaking dominant bilinguals used a restricted range of discourse markers.

The Spanish-speaking dominant providers, on the other hand, did not index their identity as English users in the Spanish language medical consultations that we studied. When we informally asked Maria why she thought this may be the case, she said that she is Nicaraguan and does not really consider herself to be an English speaker. Perhaps the Spanish-speaking dominant providers, then, did not have the affiliation with the dominant English macro-societal context in the way that the English-speaking dominant providers did. It is important to ask the question whether such differences ultimately affect patient care and health outcomes. Though this issue requires further research, the use of English in general in a Spanish language medical consultation brings to mind Martinez's (2008) finding that privileging English over Spanish in the medical context leads to worse health outcomes for Spanish speakers.

This study clearly points to the need for further research regarding situations in which providers use their second language in medical consultations. Moreover, this study opens the door to further questions, such as whether the use of English discourse markers in this study represents a possible second language use strategy on the part of the providers. In light of Torres and Potowski's (2008) finding that heavier use of English discourse markers when using Spanish may be associated with lower levels of proficiency in Spanish, further research might investigate whether such use of discourse markers is associated with strategies to compensate for lower levels of Spanish proficiency. This would require provider perspectives on those micro-interactional moments when the shifts to English discourse markers occur. It would also be interesting to gain patient perspectives on the micro-interactional moments in which providers code-switch. Gaining such perspectives is possible, for instance, by playing back audio or video of the interaction and asking patients and providers to comment on moments when providers use English discourse markers. In this study, we did not have access to such data.

Although we encourage language concordance in the medical consultation in line with Clarridge, Fischer, Quintana, & Wagner (2008), we also see the need for providers to understand their own limitations as they perform these complex professional interactions in a second language, including the effects of subtle and possibly unintentional shifts to the first language and how such shifts might affect the interaction.

Acknowledgments

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Appendix

Transcription Conventions

1. Turn Sequence	Left to right and top to bottom order marks turn sequence
2. Overlap	[ ]
3. Hold (short closure/pause)	..
4. Pause, untimed	…
5. Timed Pause	(1.0)
6. Truncated word	wor-
7. Laugh	@

8. Laugh voice	@word
9. Inhale	(H)
10. Exhaled release	(Hx)
11. Utterance final question	?
12. Question, utterance continues	?,
13. Falling intonation	.
14. Emphatic	<u>word</u>
15. Switch to first language	<L1>
16. Switch to second language	<L2>
17. Unintelligible string	((xxx))
18. Uncertain word	#word
19. Linked utterances	= =

Adapted from Du Bois (2005)

Table 1

Frequency of English and English Discourse Marker Use by Providers

	Part.	Total Words (Eng. And Span.)	Total English Words	% English Words/ Total Words (Eng and Span.)	Total Discourse Markers (Eng. and Span.)	Total Eng. Discourse Markers	% Eng. Discourse Markers/ Total Discourse Markers
Eng.-Sp Dom. Prov.	Carrie	3455	332	8.5%	603	172	29%
	Dr. Thomas	6793	558	9.6%	456	142	31%
Span.-Sp.	Laura	3827	21	.55%	272	0	0%
Dom. Prov.	Maria	2768	4	.14%	155	3	.2%

Table 2

Frequency of English and English Discourse Marker Use by Patients

	Part.	Total Words (Eng. and Span.)	Tot. English Words	% English Words/ Total Words	Tot. Discourse Markers (Eng. and Span.)	Tot. English Discourse Markers	% English Discourse Markers/Total Discourse Markers
Bilingual Patients	Lucia	560	35	6.25%	93	32	34%
	Carlos	811	25	3.1%	85	10	12%
Monoling Patients	Dalia	1021	7	.68%	69	2	.3%
	Arturo	1456	4	.27%	71	0	0%
	Ramon	400	2	.5%	64	1	.2%
	Samuel	414	1	.24%	36	0	0%
	Maria G.	835	2	.24%	71	1	.1%
	Rosana	629	2	.32%	43	2	.5%
	Pamela	545	2	.37%	97	0	0%
	Maribel	976	2	.2%	61	0	0%

Table 3

Language of Use of Discourse Markers

Participant	C	DT
Total Discourse Markers (Eng. and Span.)	603	456
Total English Discourse Markers	172	142
% English Discourse Markers	29%	31%
Total Spanish Discourse Markers	171	130
% Spanish Discourse Markers	28%	29%
Total Language Neutral Discourse Markers	260	184
% Language Neutral Discourse Markers	43%	40%

Table 4

Categories of Discourse Markers

Category	Discourse Markers	Explanation
Response Markers	Yeah, yes, right, oh yeah, oh yeah?, oh sure enough	Indicative of a response to previous discourse with expectation of continuation of the old topic and previous speaker
Negative Response Markers	oh geez, oh boy, shoot, uh oh, imagine that	Response Markers that indicate a negative response to previous discourse
Evaluative Response Marker	oh good, good, very good right, wow, that's wonderful, I see, you're right, perfect, excellent, it's okay, very interesting, that's alright	Response marker that acts to evaluate the previous discourse
Attention Markers	Then, now, let's see, so	Indicate that attention should be turned to the speaker's utterance
Attention Markers of Disagreement	well, but, I mean, course, actually, or, but	Indicate that attention should be turned to the speaker's utterance, which will be a disagreement move
Topic Shifters	Kay, mkay, nkay (we coded these as English because of their phonological characteristics), alright, okey dokey, basically	Indicate movement from an old topic to a new topic
Floor Shifters	Right?, kay?	Indicate turning the floor over to a new speaker

Table 5

Percentage of Use of Categories of English Discourse Markers

	C Raw Number	C %	DT Raw Number	DT %
Response Markers	34/172	20%	55/142	39%
Negative Response Markers	9/172	5%	26/142	18%
Evaluative Response Marker	50/172	29%	1/142	1%
Attention Markers	14/172	8%	23/142	16%
Attention Markers Disagreement	6/172	3%	23/142	16%
Topic Shifters	56/172	33%	11/142	8%
Floor Shifters	3/172	2%	3/142	2%

Table 6

Excerpt 1

1	Arturo; lo que yo estaba haciendo	**1**	Arturo; what I was doing reading
2	leyendo de la medicina..porque	**2**	about medicine..because here it
3	aquí me dice no está de acuerdo	**3**	tells me is not in agreement
4	con usted ((Dr. Thomas is	**4**	with you ((Dr. Thomas is hitting
5	hitting keyboard obscuring the	**5**	keyboard obscuring the
6	sound))…aquí me	**6**	sound))…here it tells me
7	dice..come medicamente con	**7**	..to take medicine with
8	comida=	**8**	a meal=
9	Dr. Thomas; =yeah=	**9**	Dr. Thomas; =yeah=
10	Arturo; =y usted me dice que media	**10**	Arturo; =and you tell me that half
11	hora antes de la comida	**11**	hour before a meal
12	Dr. Thomas; no no esto no esto es	**12**	Dr. Thomas; no no this this is
13	con comida..esto es media hora	**13**	not with food..this is
14	antes (5.0) media hora	**14**	half hour before
15	antes de las comidas	**15**	(5.0) half hour before a meal
16	Arturo; no mas esa	**16**	Arturo; no more that
17	Dr. Thomas; no mas esto	**17**	Dr. Thomas; no more this
18	Arturo; [oh]	**18**	Arturo; [oh]
19	Dr. Thmas; [esto] esta es antes	**19**	Dr. Thomas; [this] this is before this
20	esta es con	**20**	is with
21	Arturo; m:	**21**	Arturo; m:

Table 7

Excerpt 2.

1	Carrie; u:m:..pero en esta mano está	**1**	Carrie; u:m:..but in this hand it's
2	bien?	**2**	fine?
3	Samuel; esta sí=	**3**	Samuel; this yes=
4	Carrie; =okay y no hay dolor=	**4**	Carrie; =okay and there's no pain=
5	Samuel; =mhm=	**5**	Samuel; =mhm=
6	Carrie; =verdad? y un—cual..mano	**6**	Carrie; =right? and a- which..hand
7	usa para escribir?	**7**	do you use to write?
8	Samuel; esta=	**8**	Samuel; this=
9	Carrie; =okay…alright…qué clase	**9**	Carrie; =okay…alright…what type
10	de ta—trabajo es?	**10**	of wo-work is it?
11	Samuel; hago::…yo soy <L2>	**11**	Samuel; I do::…I am <L2>
12	driver <L1>del [((xxx))]	**12**	driver <L1> of [((xxx))]
13	Carrie; [oh]	**13**	C; [oh]
14	Samuel; pizza=	**14**	Samuel; pizza=
15	Carrie; =oh I see	**15**	Carrie; =oh I see
16	Samuel; <L1>pero cuando no	**16**	Samuel; <L1>but when there is
17	hay nada hacemos..limpieza del	**17**	nothing we do..cleaning of the
18	[dentro]	**18**	inside
19	Carrie; <L2>[right okay]	**19**	Carrie; <L2> [right] [okay]

Table 8

Excerpt 3

1	Arturo; y sí me ponga hinchado el		**1**	Arturo; and yes the foot gets
2	pie		**2**	swollen
3	(4.0)		**3**	(4.0)
4	Dr. Thomas; ah: oh geez		**4**	Dr. Thomas; ah: oh geez
5	(3.0)		**5**	(3.0)
6	Arturo; y tengo miedo que		**6**	Arturo; and I'm afraid that
7	(1.6)		**7**	(1.6)
8	Dr. Thomas; y tiene razón..cuando		**8**	Dr. Thomas; and you have
9	empezó?		**9**	reason..when did it start?
10	Arturo; me la descubrí el sábado		**10**	Arturo; I discovered it on Saturday
11	(1.0)		**11**	(1.0)
12	Dr. Thomas; le duele cuando		**12**	Dr. Thomas; does it hurt to touch
13	toca?		**13**	it?
14	Arturo; no no tengo sensibilidad en		**14**	Arturo; no no I don't have feeling in the foot
15	el pie			

Table 9

Excerpt 4.

1	Carrie; suéltelo por favor..usted		**1**	Carrie; =release it please..you
2	le duele?..no?		**2**	hurt? no?
3	Lucia; no		**3**	Lucia; no
4	Carrie; <L2>good…<L1>esto?		**4**	Carrie; <L2>good… <L1>this?
5	Lucia; no		**5**	Lucia; no
6	Carrie; <L2>goo:d (4.0)		**6**	Carrie; <L2>goo:d (4.0) very
7	very good…<L1>okay y nada		**7**	good…<L1>okay and nothing
8	más solamente las rodillas		**8**	more only the knees nothing
9	no le duele acá: ni aha=		**9**	hurts here nor there=
10	Lucia; =en veces=		**10**	Lucia; =at times
11	Carrie; =<L2.>yeah… <L1>las		**11**	Carrie; <L2>yeah… <L1>the
12	muñecas [mhm]		**12**	wrists [mhm]
13	Lucia; [mhm]		**13**	Lucia; [mhm]
14	Carrie; <TSK> okay		**14**	Carrie; <TSK> okay

Table 10

Excerpt 5

1	Dr. Thomas; now <L2> es cierto		**1**	1. Dr. Thomas; now <L2> it's certain
2	sus ultimo uhm exámenes era más		**2**	that you last tests were more than a
3	que un año o casi no?		**3**	year or so no?
4	Arturo; no siete meses tengo=		**4**	Arturo; no seven months I have=
5	Dr. Thomas; =siete meses		**5**	Dr. Thomas; =seven months

Table 11

Excerpt 6.

1	Dr. Thomas; ((Hx)) la problema	**1**	Dr. Thomas; ((Hx)) the problem
2	es..esto esto medicina esta por	**2**	is..this this medicine is for a class of
3	un clase de: colesterol alto un	**3**	high cholesterol one one is the
4	un es la triglicerides	**4**	triglycerides they aren't for the
5	no están por la otra	**5**	other bad cholesterols..and I don't
6	colesterol mal..yo no sé que	**6**	know what your profile is..of your
7	como esta su prefile..de: de su	**7**	cholesterol..who
8	colesterol..quién lo hizo lo	**8**	did it the last
9	ultimo..donde	**9**	time..where
10	Arturo; m: en Sacramento	**10**	Arturo; m: in Sacramento
11	DT; en Sacramento	**11**	DT; in Sacramento
12	A; pero ya xxx tiene desde	**12**	A; but already xxx has since August
13	agosto..siete meses	**13**	..seven months
14	Dr. Thomas; well esta no	**14**	Dr. Thomas; well this is not
15	importa por la menos no se	**15**	important at the least it doesn't help
16	ayuda um..venga por aquí para	**16**	um..come here or a little because I
17	un poquita porque	**17**	know that I am
18	yo se que: voy a examinar a	**18**	going to examine you more
19	usted mas pero:…((Hx)) (9.0)	**19**	but…((Hx)) (9.0)
20	A; recoge las resultados..de	**20**	A; you gather the results..of
21	Colesterol	**21**	Cholesterol

Table 12

Excerpt 7.

1	Samuel; (H)		**1**	Samuel; (H)
2	Carrie; y sácalo.		**2**	Carrie; and let it out
3	Samuel; (Hx)		**3**	Samuel; (Hx)
4	Carrie; otra		**4**	Carrie; another
5	Samuel; (H)		**5**	Samuel; (H)
6	Carrie; y sácalo.		**6**	Carrie; and let it out
7	Samuel; (Hx) (H) (Hx)		**7**	Samuel; (Hx) (H) (Hx)
8	Carrie; una vez. one more.		**8**	Carrie; one time. one more
9	Samuel; (H) (Hx)		**9**	Samuel; (H) (Hx)
10	Carrie; <L2>okey dokey.		**10**	Carrie; <L2>okey dokey
11	Samuel; (H) (Hx)		**11**	Samuel; (H) (Hx)
12	Carrie; good…okey dokey…		**12**	Carrie; good…okey dokey…<L1>
13	<L1>voy a planear sus		**13**	I'm going to prepare your
14	recetas=		**14**	prescriptions=
15	Samuel; =[okay]		**15**	Samuel; =[okay]