

INTERACTION AND CONVERSATIONAL CONSTRICTIONS IN THE RELATIONSHIPS BETWEEN SUPPLIERS OF SERVICES AND IMMIGRANT USERS¹

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Abstract

This article deals with aspects of interaction between doctors and immigrant users whose native language is not Spanish (immigrant non-native speakers of Spanish: INNSS) in healthcare centers in Spain. The methodological focus is based on institutional conversation analysis following Drew and Heritage's studies (Drew & Heritage 1992; Heritage 1997; Drew and Sarjonen 1997), and ethnographic research (Cicourel 1992). It is my intention to examine the characteristics and peculiarities -if any- of doctor-patient interaction when the participants are immigrants and non-native speakers of Spanish who are not fluent in the language of interaction, in this case Spanish. The study is based on quantitative and qualitative data which come from surveys and recordings carried out in healthcare centers in northern Madrid, Spain, during 2000 - 2001.

Keywords: Doctor-patient interaction, Professional asymmetry, Institutional conversation analysis, Ethnography, Immigration.

1. Introduction

According to Heritage (1997: 164), participants in institutional encounters use a series of linguistic and interactional resources specific to the situation and in accordance with the participants' linguistic and cultural competence. Many of these resources are also used in daily conversation and they are not exclusive of institutional encounters, but they are used in a specific way. The main objective of this study is the analysis of the characteristics and peculiarities of the interaction between doctors and patients who are immigrants and non-native speakers of Spanish (INNSS). The main elements taken into account are the participants' knowledge and use of the language, as well as the domain of the institutional setting. The methodology used combine previous studies carried out in different institutional contexts (see Atkinson and Drew 1979; Maynard 1984), and from different

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perspectives (Drew and Heritage 1992; Fisher and Todd 1993; Maynard 1992; Mishler 1994; Conley and O'Barr 1990; Coupland et al. 1991; West 1984; Atkinson 1999). I also incorporate the ethnomethodological research based on the idea that the members of a society are competent experts of the identities, institutions and practices in daily interactions (Cicourel 1992, 1995). This paper follows current qualitative studies starting in the 90's. It is based on the local constitution of social realities with special emphasis on a detailed description of how the participants understand reality and socialize. The data come from recorded interviews between doctors and INNSS patients in healthcare centers in the northern area of Madrid, Spain, during 2000 - 2001.

2. Analysis and comparison of the standard doctor-patient interview structure to the specific Doctor- INNSS patient interview

According to Heritage (1997: 164), the characteristics of the institutional interaction are:

1. the participants possess some specific roles,
2. a series of constrictions characteristic of the institutional context are imposed, and
3. inference marks and particular procedures associated to each institution exist.

And the basic elements in institutional interaction are:

1. assignment of the participants' roles
2. general structure
3. sequential organization
4. lexical choice
5. asymmetrical relationships

These are also the steps I will follow for the analysis of the data obtained in the recorded conversations.

In the case of doctor-INNSS interaction, as far as I know, there are few studies dealing with the interaction between suppliers of services and immigrant users. One of the reasons is the difficulty in obtaining permission to record or to witness such encounters. The need to keep the information private for both the suppliers (they are already the government's agencies, private institutions, or non-governmental organisations (NGOs)) as well as the users (sometimes illegal immigrants) contributes to this lack of data and studies. For this study, it was necessary to elaborate detailed reports for the NGOs and institutions carefully explaining the purpose and use of the data that I wanted; to receive hundreds of rejections from government representatives, doctors, immigrants, and NGO volunteers; to win the trust of some doctors who had previously collaborated in the collection of information through surveys, but who didn't like the idea of recording their encounters with immigrants; to obtain written permits in different languages: Arabic, English, French, Polish, Romanian, Russian, Georgian, etc. so that the users knew our purpose firsthand and could sign for the recording authorization, strictly guaranteeing their anonymity. These difficulties took a long time and a lot of effort, but finally I got five

recordings. The analysis which follows is based on them. Nevertheless more research needs to be done.

Before beginning this comparative analysis and for a better understanding of the institutional context where the experience takes place, some ethnographic data about the participants, that is, family doctors (GP) and INNSS, may be useful.

As for the doctors, Spain has a universal health system. The family practitioners working in healthcare centers are assigned a certain number of patients, being the seniority in the center the norm usually applied; therefore, the doctors that are incorporated later are the ones that have open patient lists and those that attend more immigrants.

As for the users, medical assistance is guaranteed by law for any pregnant woman and child under 14 even if they do not hold legal status or are in the process. This means that some of the patients have just come to Spain, and it is the first time they visit a healthcare center while others have been in Spain for some time and have visited a doctor before. These patients obviously have different levels of Spanish and knowledge of the institutional mechanisms for interaction.

In my corpus, the doctors are used to attend immigrants, and these know some Spanish. The analysis of the basic elements in institutional interaction applied to the data from the recorded interviews provides the information explained in the sections that follow.

2.1. Assignment of the participants' roles

Specific roles assigned to the participants in doctor- patient encounters are similar to other encounters where a professional-client relationship exists. In this relationship, there are sections, for example, where one participant usually asks questions while the other one answers. The imbalance that takes place between both parts constitutes a characteristic feature of the institutional context and not an exception. According to Heritage (1997: 165) if this system is altered, variation in the users' participation, changes in the interaction order and in the kind of contribution as well as in the expectations created can be produced. For example, in those sections where the doctor is supposed to ask - e.g. evaluation - in doctor-INNSS encounters, it is sometimes the patient who asks the doctor and it is sometimes the doctor who provides information instead of the patient.

According to the data from our study as we will see next, when the users are INNSS, they don't always dominate the interaction system and the restrictions imposed by the context as mentioned above. As a consequence some changes in the roles assigned are produced. These changes also alter the rate of participation, the interaction order, and the contribution types. Some of these changes are seen in Paragraphs 1 and 2 where the INNSS is the one who asks questions and seems to take a more active role³. Thus, in Paragraph 1 of my corpus, the patient is the one who asks more questions and questions not always related with illness (1 (2, 4)) while the doctor provides general information (which is not necessarily related) and he is also the one who talks more (1 (5)):

³ At this point I must say that other studies show that better informed patients take a more active role in doctor-patient communication as well (cf. Wodak, R. 1966: Disorders of discourse. London: Longman, pp. 40ff.), whereas explanations are more frequent with inexperienced patients. Put these differences could be explained otherwise as well.

Paragraph 1 [D = doctor, P = patient] (D wants to know when P has to go to another hospital for a specific checking)

- 1 D: Y aquí pondrían 1003... ¿Cuándo tienes que ir a la consulta?
 - 2 P: ¿Cuál día?
 - 3 D: Sí
 - 4 P: Yo primero hablar con jefe... Cuando descanso un día.... Es que tu escribir un día... ¿puedo así?
 - 5 D: Es que... yo te puedo citar para verte yo... um.. Yo puedo decir cuando vienes tú aquí.. pero no cuando vas tú al hospital. Eso tiene que ser hospital quien dice cuando vas ¿vale?
 - 6 P: Sí, sí.
-
- 1 D: And here it would say 1003... When is the next appointment?
 - 2 P: Which day?
 - 3 D: Yes
 - 4 P: Me first to speak with boss... When I rest one day.... when you write one day... can I do like that?
 - 5 D: The thing is that... I can make an appointment to see you ... um.. I can say when you come here.. but not when you go to the hospital. It is hospital that says when you go . OK?
 - 6 P: Yes, yes.

In paragraph 2 we see that the user fails to answer questions because he lacks some knowledge about the reality, the doctor being the one who has to provide it. On the other hand, this information is not necessary medical information as we can see in the following example (2 (3, 5, 7)) and later on.

Paragraph 2

- 1 D: ¿Tienes la tarjeta del hospital? [Silence]
 - 2 P: ¿Cuál.. cuál? ¿del jefe? No, no ...sólo papel. No... no sólo papel que me ha dado señora... ahora....
 - 3 D: ¿El papel que te dio la señora (...) aquí arriba? [P shows D some paper
 - 4 D: has a look at them] No. Éste sí.
 - 5 P: No. Tarjeta médico, no
 - 6 D: No tarjeta. Pero cuando fuiste al hospital....
 - 7 P: Sí, sí, sí...
 - 8 D: ¿eso tú lo tienes?
 - 9 P: Sí, casa
 - 10 D: En casa
 - 11 P: Uno tiene arriba hospital....
-
- 1 M: Do you have the health card?
 - 2 P: Which one, which one? Of the boss? No, no... only paper. No... no only paper that give me the lady now....
 - 3 D: The paper that the lady gave you (...) up here? No. This one yes.
 - 4 P: No, no health card

- 5 D: No card. But when you went to the hospital....
6 P: Yes, yes, yes...
7 D: You have that?
8 P: Yes, home
9 D: At home
10 P: hospital has one)

Changes of roles of this kind are quite common in the analysed corpus when compared with doctor-native speakers patients conversations.

2.2. General structure of the interaction

In the specific institutional context that we are dealing with, the general structure of the doctor-patient interaction is usually that of an interview organized along the following activities (See Borrel i Carrio 1999):

- Initial greetings
- Enunciation of problems
- Evaluation and discussion of the patient's state
- Discussion and prescription of the treatment and/or of check-ups
- Farewells

Two other common characteristics are:

- Casual inserts
- Bureaucratic negotiation

With regard to the casual inserts, also called "conversation of circumstances," these are made up by comments on topics or aspects of daily life that are not related to the medical consultation. Frankel (1990) considers that a casual insert is a strategy to distract the patient's attention while the doctor performs a technical action during the physical exam. Díaz (1999: 35), on the other hand, insists that, apart from having a distracting function, the content of this sequence is neither incidental nor irrelevant for the participants but performs some social function.

In the case of bureaucratic negotiation, Diaz (1999: 40) comments, and I agree with him, that in the Spanish health system the patients are the main axis of the bureaucratic handling of their problems: They have to go from one office to another to get prescriptions and check ups, and they must also learn the appropriate procedure for each service. The effectiveness of their effort will depend on their capacity to carry out these bureaucratic tasks. In other words, this means that the patient has to develop abilities to make appointments and to obtain the appropriate services in an efficient way.

When the doctor helps the patients solve these difficulties, sequences of bureaucratic negotiation takes place which might include comments on how to fill out documents, explanations on how to get a check up, instructions for how to request an appointment with a specialist, consultations on the appropriate handling of the patient's

relationship with other services, explanations about the importance of keeping a copy of the reports, directions on how to make a new appointment, some advice on which are the relevant documents to take to each office (or service), or explanations on how to obtain prescriptions and how to take medication.

In my corpus, the activities or sections assigned to the standard medical consultation are basically the same ones as in the standard conversation (Drew and Heritage 1992), but differences arise in the relevance given and time dedicated to each section, specifically in the case of casual inserts and bureaucratic negotiations which are more frequently used and rather longer. For example, we find a bureaucratic insert in Paragraph 3, where D explains in 3, 7, and 9 the way the Spanish health system works, he also repeats P's words, writes the name of the prescription and shows it to him:

Paragraph 3:

- 1 D: Otro problema ¿cuál era? El problema de la señora
 - 2 P: Cuando yo trabajar, yo puedo darle un papel a ella... para farmacia.
 - 3 D: Ya. Cuando vengas aquí te haremos un papel como éste el próximo día..... no hay ningún problema.... Esto ella lo puede comprar en la farmacia ¿eh? No hay problema..
 - 4 P: Sí, yo puedo comprar,...yo antes ... comprar, pero no puedo comprar...
 - 5 D: Sí, lo puedes comprar con esto.
 - 6 P: Sí, pero sino... vale más dinero
 - 7 D: Sí, claro, más dinero, pero es que en España los medicamentos...
 - 8 P: Sí, esto... como cortar así.
 - 9 D: Sí, cuando corto así [He tears a prescription from the block] parte lo pagas tú y parte lo paga el estado.... Entonces.. es más barato.
-
- 1 D: Another problem what was it? The problem with the lady
 - 2 P: When me to work, I can give her a paper ... for pharmacy.
 - 3 D: Yes. When you come here we will give you a paper like this next day..... there is no problem.... She can buy this in the pharmacy ok? there is no problem...
 - 4 P: Yes, I can buy,... me before... to buy, but I cannot buy...
 - 5 D: Yes, you can buy it with this.
 - 6 P: Yes, but without ... it costs more money
 - 7 D: Yes, I know, more money, but in Spain medicine...
 - 8 P: Yes, this... as cutting this way..
 - 9 D: Yes, when I cut this way [He tears a prescription from the block] you pay for part of it and the state pays for the other part... Then... it is cheaper.

Doctors can also initiate casual inserts as in Paragraphs 4 and 5:

Paragraph 4:

- 1 D: Tu madre, ¿vive?
- 2 P: Sí, es mayor también, vive, está bien. Y no quiere, no quiere venir. *Le ha hecho la fuerza para que viniere aquí*, y mira. Y allí se hace mucho trabajo por mí, porque yo mando dinero, yo mando todo, porque yo tenga dos

- castas*. Si viniera aquí, para mí mejor. Todo lo que.... Yo tampoco *quiriera* ir ahí. Y ellos no quieren venir aquí, ya, cosa está así.
- 3 D: Y ¿tienes hermanos en Marruecos?
- 4 P: Sí, sí. Tengo dos, uno es profesor y otro ser..., trabajar aquí. Está bien, tengo la vivienda bien ahí todo bien
- 5 D: Mmm
- 1 D: Is your mother still alive?
- 2 P: Yes, she is old too, she's alive, she is OK. And she doesn't want, she doesn't want come. I force her to come here, and look. And there, she makes much work for me, because I send money, I send everything, because I have two houses. If she came here, for me better. Everything.... I no want go there either. And they not want come here, OK, it like that
- 3 D: And do you have brothers or sisters in Morocco?
- 4 P: Yes, yes. I have two, one is teacher and other be, work here. It's ok, my home is OK there, everything OK..
- 5 D: Mmm)

Thus, in Paragraph 4 (1, 3) D asks direct questions that apparently are not related to the medical interview, although these interruptions may be sometimes in- between institutional and casual conversation.

The same happens in Paragraph 5 (1), where D ask where the patient comes from and he even adds some personal comments (5 (5, 6)):

Paragraph 5

- 1 D: ¿De qué parte de Marruecos, eres tú?. ¿De...?
- 2 P: Eljadira
- 3 D: Eljadira, cerca de Casablanca
- 4 P: Cerca de Casablanca. Sí, casi noventa y cinco de Casablanca
- 5 D: Pues a lo mejor tenga que ir yo a Casablanca
- 6 P: Ah, sí
- 7 D: El mes que viene. En abril
- 8 P: Ah, en abril. Sí, marzo también es un buen tiempo, ahí. Marzo y abril. Parte de abril, sí.
- 1 D: What part of Morocco are you from? From...?
- 2 P: Eljadira
- 3 D: Eljadira, near Casablanca
- 4 P: Near Casablanca. Yes, almost ninety five from Casablanca
- 5 D: Perhaps I have to go to Casablanca.
- 6 P: Ah, yes?
- 7 D: Next month. In April
- 8 P: Ah, in April. Yes, March is also a good time, there. March and April. Part of April, yes.)

In my corpus, in the treatment section, strategies such as repetition, doctor's notes, or drawings on a piece of paper generally accompany the doctor's explanations with the purpose of guaranteeing the correct understanding as in Paragraph 6 (1, 3, 5, y 7):

Paragraph 6

- 1 D: Se puede tomar todos los días pastilla gorda... hay que ir bajando. ¿eh? Entonces, la semana que viene .. esta semana, a partir de mañana... la gorda... las pastillas son así [[he draws on a piece of paper] Esto lo quitas y cortas un trozo ¿entiendes bien?
 - 2 P: Sí, sí
 - 3 D: Y lo guardas... Pasado, el sábado, cortas otro trozo y lo guardas
 - 4 P: Sí, sí, todo día uno solo, y lo guardo... noche no
 - 5 D: Noche no tomar, solo por la mañana ¿vale? Mira esto [showing a drawing]. El domingo, este trozo y este trozo que has guardado te lo tomas ¿eh? Así todos los días... Vamos a bajar poco a poco.
-
- 1 D: You can take one big pill every day ... you have to take less... OK? Then, next week ...this week, starting tomorrow... the big pill... the pills look like this [he draws on a piece of paper] You throw this away, and you cut a piece off. Do you understand?
 - 2 P: Yes, yes
 - 3 D: And you keep it... Next day, on Saturday, you cut another piece off, and you keep it.
 - 4 P: Yes, yes, all day one only, and I keep it... night , no.
 - 5 D: Night no take, only in the morning. OK? Look at this [showing a drawing]. On Sunday, this piece and this piece that you have kept, take it, OK? This way every day... we will lower the dose little by little.)

Thus, in paragraph 6 (1), D explains P how he has to reduce the intake of pills unwrapping and cutting one pill and putting away half of it for next day. In order to make the explanation easier, D draws, and in 6 (3) he continues explaining step by step the process for the next few days. In 6 (5), D rephrases P's words and explains the intake for the third day (Sunday), and the following days.

The same strategies are used in Paragraph 7, when the doctor repeats the name of the medicine, and also the treatment:

Paragraph 7

- 1 D: Nialastan
- 2 P: -----
- 3 D: Nialastan, que era una por la mañana y otra por la noche
- 4 P: Sí
- 5 D: Va a tomar por la noche, solamente
- 6 P: Vale
- 7 D: Solamente por la noche
- 8 D: Vale

And after a brief interruption he continues:

- 9 D: Bueno, y la pomada. La pomada que le voy a recetar, eehh, que le voy a mandar, la tiene que comprar, es muy barata
10 P: Si, vale---
11 D: Pero es que no entra con el seguro, eh, pero es muy barata
12 P: Vale, ya.---
13 D: Se va a dar por la mañana
14 P: Vale
15 D: Y por la noche. Por la mañana y por la noche, así [rubbing his leg] un masaje por la pierna, ¿eh?
16 P: Vale
17 D: Vale.
- 1 D: Nialastan
2 P: -----
3 D: Nialastan that was one in the morning and another at night.
4 P: Yes
5 D: You will take it at night, only.
6 P: OK
7 D: Only at night
8 D: OK

(After a brief interruption)

- 9 D: OK, and the ointment. The ointment that I am going to prescribe you, that want you to use, you have to buy it, it is very cheap
10 P: Yes, OK
11 D: It isn't included in the health insurance, OK? But it is very cheap
12 P: OK, yes--
13 D: Use it in the morning
14 P: OK
15 D: And at night. In the morning and at night, like this [rubbing his leg] massaging on your leg, OK?
16 P: OK
17 D: OK)

Thus, in paragraph 7 (9), D repeats information by using synonyms (*I'm going to prescribe, I want you to use, you have to buy ...*), and he also adds some extra information that can be considered a casual insert in 8 (11) (*It isn't included in the health insurance*), perhaps anticipating the P's question about the price. Thus D repeats the information (*it is very cheap*).

Casual inserts are also frequently produced by INNSS as we see in Paragraph 8 (1, 3, 4, 5, 7):

Paragraph 8 [P talks about her father in Morocco with D]

- 1 P: Cuando el ha venido en aquí, yo le he arreglado todo. La ha dejado los papeles para comisaría. Para... una residencia de cinco años, entra, sale de todo. Pero, como es tan nervioso está muy mal, no aguanta mucho aquí, y al verano, se dijo tenga que ir, tenga que ir. Bueno.
- 2 M : Dos, hacemos dos de....
- 3 P: Hace un favor si es posible sí. Que como ha venido aquí, no hay familias, no hay amigos. Todo el día está solito en la casa, como dice está un poquito
- 4 D: Y no habla español
- 5 P: No habla español, ni nada. Y sabes una cosa, de nuestra conquista, todo el día con la mi mujer. Y a mi mujer no, no dice nada con él. *Na* más que hola, y buenos días y *na* más. Respeto de los abuelos *era* así. Hola y buenos días. Nada. Nada
- 6 D: No, no
- 7 P: Ni sienta con ellos, ni ver la televisión con ellos, ni nada, de nada. *Na* más que dan de comida y *na* más
- 8 D: Ahh
- 1 P: When he came to here, I fixed for him everything. He left the papers for police. For ... permit for five years, he enters, he leaves, everything. But, as he is so nervous he is very bad, he can't be much here, and in summer, he said I have to go, I have to go. OK
- 2 D: Two, we make two of....
- 3 P: You do me a favor if possible yes. As he has come here he not have families, friends. The whole day he is alone in the house, as he says a little bit ...
- 4 D: And he doesn't speak Spanish
- 5 P: He doesn't speak Spanish, nothing. And you know something, of our conquest, the whole day with the my wife. And to my wife not, she doesn't say anything with him. Nothing more than hello, and good morning and nothing else. Respect for the grandparents was like this. Hello and good morning. Nothing. Nothing
- 6 D: No, no
- 7 P: She no sits down with them, no watch television with them, nothing at all. Nothing more than give food and nothing more.
- 8 D: Ahh)

The same happens in Paragraph 9, where the patient talks about her sister and the doctor follows the conversation:

Paragraph 9 (D has asked P for some personal details, and D is filling out a form)

- 1 P: Eh, tengo mi hermana aquí. Yo he traído una vez mi hermana aquí. Ha venido una vez aquí
- 2 D: ¿Sí? ¿tu hermana?
- 3 P: Sí, sí, ha venido un día aquí
- 4 D: ¿Cómo se llama?
- 5 P: Se llama Shamira-----.Se llama Shamira

- 6 D: Shamira
 7 P: Sí
 8 D: No, no me acuerdo
 9 P: Sí, ha venido... vino.. Ella trabaja aquí-----. Le ha encontrado un trabajo bien. E trabaja muy bien
 10 D: Bueno.¿Cuántos hijos tiene tu hermana?
 11 P: No, no, no está casada
 12 D: Ah, no está casada
 13 P: Sí, sí, no, no
 14 D: Ah, entonces no sé quién es
 15 P: Ha venido, casi, casi un mes aquí. Un día ha venido aquí
 16 D: Mmm. No sé quién es. Ahora mismo, no
 17 P: Sí, sí, porque ha venido una vez
 18 D: Sí
 19 P: Ha venido una vez, na más. *Que ha ido*
 20 D: A lo mejor no estaba yo, el día que vino
 21 P: Ah, bueno
- 1 P: Eh, I have a sister here. I´ve brought my sister once here. She has come once here
 2 D: Yes? Your sister?
 3 P: Yes, yes, She has come here once
 4 D: What´s her name?
 5 P: Her name is Shamira...Her name is Shamira
 6 D: Shamira
 7 P: Yes
 8 D: No, I don´t remember
 9 P: Yes. She´s come... She came.. She works here She is found a job well. Eh, she works very well
 10 D: Well, how many children does your sister have?
 11 P: No, no. She´s not married
 12 D: Ah, she´s not married
 13 P: Yes, yes, no, no
 14 D: Ah, then I don´t know who she is
 15 P: She has come almost, almost a month here. A day she has come here
 16 D: Mm, I don´t know who she is. Not now, no
 17 P: Yes, yes, because she has come once
 18 D: Yes
 19 P: She´s come just once, only a time. That she´s come
 20 D: Perhaps I was not here the day she came
 21 P: Ah, well).

In my corpus, farewells also frequently include emotive moving elements and expressions of gratitude that we see in Paragraphs 10 and 11.

Paragraph 10

- 1 D: Pues nada más. Hasta la semana que viene que te contaré como bajar la dosis y quiero que me cuentes si con menos pastillas dolor o no dolor.
 2 P: Gracias
 3 D: Venga, hasta luego
 4 P: Gracias.
- 1 D: [...] Well, that's all. I'll see you next week and tell you how to lower the dose and I want you to tell me if with fewer pills pain or no pain.
 2 P: Thank you
 3 D: See you later
 4 P: Thank you)

And the same happens in paragraph 11:

Paragraph 11

- 1 P: Vale, muchísimas gracias
 2 D: De nada
 3 P: Y perdona por tanta molestia
 4 D: De nada.
- 1 P: OK, thank you very much
 2 D: You're welcome
 4 P: And sorry bothering you so much
 5 D: You're welcome)

These utterances, as we know, are not specific of these encounters, however the use of expressions that are not common in standard D-P encounters (e. g. 11 (3) and repetition (10 (2, 4) produce more emphatic utterances.

2.3. Sequential organization

As I anticipated previously, sections are associated to specific sequences that include a series of routine activities for the participants. Heritage (1997: 167) also points out: "Each section is *jointly* oriented to - indeed *co-constructed* - by both participants as involving a task to be achieved." And he adds:

The purpose of describing these sections is to identify task-orientations which the participants routinely co-construct in routine ways. Overall structural organization, in short, is not a framework - fixed once and for all - to fit data into. Rather it is something that we're looking for and looking at only to the extent that the parties orient to it in organizing their talk.

This means that, depending on the service provided by the institution or the moment of the interaction, specific linguistic forms are also expected. Thus, in the medical context, in the evaluation section, the interaction, as in many institutional contexts, is characterized by the question-answer sequences in which the question is a routine formula used by the supplier of services while the answer is provided by the patient. In this sense, the doctor

usually tries to get information and this function is generally performed with questions that can vary in form: Direct, indirect, playing with the intonation, or giving alternatives. However, in the treatment section, the doctor usually tells the patient what to do, and this function is generally performed with the imperative ('Take' / 'Tómate'...), the immediate future ('you're going to take' / 'te vas a tomar...'), or the present ('you take' / 'te tomas'). When the doctor speaks of bureaucratic negotiations he/she usually gives advice, and the use of conditional sentences or other linguistic structures associated with this function are common ('If I were you' / 'si yo fuera tú'; 'you should' / 'deberías') or performative verbs like "to recommend" ('recomendar') "to advise" ('aconsejar'). These are resources that are not exclusive of institutional settings as I mentioned before but they prevail in certain contexts and they acquire a specific meaning (See Ventola (1987)).

Depending on the section, the asymmetric distribution of time is another characteristic in institutional contexts. Thus, in the evaluation section, the professional generally uses shorter sentences to ask for information while the patient uses longer sentences in answering the questions, consequently taking more time. However, in the treatment section, it is the professional who produces longer sentences and also needs more time.

In my corpus, the patterns mentioned are frequently changed by both doctors and patients. In the case of the doctors, he/she sometimes gives information that would be unnecessary with Spanish patients, he/she also usually repeats information, and uses other uncommon extralinguistic resources: Drawings, gestures, charts, or leaflets as we have seen in previous examples. In other words, the professional tries to accommodate his/her language to that of the user to make it more comprehensible and, in turn, the INNSS develops other communication strategies. Some of these accommodation processes observed in the case of the provider of services are:

- Short sentences
- Simplified language
- More careful pronunciation
- Formulation of alternative questions (or... or)
- Formulation of yes/no (direct) questions
- Use of generic vocabulary and tendency to avoid technical terms
- Use of ungrammatical sentences with the omission of articles, prepositions, auxiliary verbs, or use of infinitives instead of personal forms
- Higher tolerance of abrupt changes of topic (e.g. when producing a casual insert)
- Frequent reformulation
- Need to take/recapture the initiative
- Difficulty in predicting the continuity of the conversation

In some of the above examples these strategies are made evident as also happens in Paragraph 12 and 13:

Paragraph 12

- 1 D: ¿Qué trabajas?
- 2 P: Hoy descanso
- 3 D: Hoy descanso... ¿qué trabajas todos los días?

- 4 P: No, 2 ó 3 horas... 7 por la mañana 3 horas
 5 D: ¿Vas a las 7 y estás tres horas....?
 6 P: Yo ... por la mañana desde las 7 hasta las 3.
 7 D: Vas a las 7 hasta las tres... O sea trabajas de 7 a 3.
 8 P: Sí, sí
 9 D: O sea 7 a.m. a 3 p.m. [he writes this on a piece of paper and shows it to him] ¿vale?
 10 P: Sí, sí
 11 D: ¿todos los días? ¿menos 1 ó 2 libres a la semana?
 12 P: 1 a la semana fiesta. Hoy descanso.
- 1 D: What do you work?
 2 P: Today rest
 3 D: Today rest... what do you work every day?
 4 P: No, 2 or 3 hours... 7 in the morning three hours
 5 D: You go at 7 o'clock and you are three hours....?
 6 P: Me... in the morning from 7 o'clock to 3 o'clock.
 7 D: You go from 7 o'clock to three o'clock... That is to say you work from 7 to 3.
 8 P: Yes, yes
 9 D: That is to say 7 a. m. to 3 p. m. [he writes this on a piece of paper and shows it to him] OK?
 10 P: Yes, yes
 11 D: Every day? Except 1 or 2 days off a week?
 12 P: 1 a week free. Today rest.)

Thus, we can see that in Paragraph 12, D uses simplified, colloquial language, even ungrammatical sentences (12 (1)), and he reformulates the INNSS words (12 (3,7,9)). At the same time he uses direct questions that require simple answers (12 (5,11)).

In Paragraph 13, the doctor asks the same question using three different forms and again reformulates the INNSS answer (13 (3, 5)):

Paragraph 13

- 1 D: ¿Trabajas? ¿estás trabajando? ¿trabajas ahora o no?
 2 P: Sí....trabajando....tenga cuidar de una vieja.....sí
 3 D: Cuidas de una anciana
 4 P: Sí, aquí por la avenida de Barcelona.... no te he dicho a calle...
 5 D: En la avenida de Barcelona....estas trabajando en una casa cuidando a una anciana
 6 P: Sí
 7 D: Solamente eso, cuidando a una anciana....
 8 P: Sí, sí
 9 D: ... ¿no haces otras tareas en la casa? ¿otros trabajos domésticos? ¿cuidas a la anciana?
 10 P: No... yo no lo sé no...ya... [She shows the health card and points] yo estoy aquí, yo trabajo. Está muy enfermo ... está muy enfermo... [She points

at the card] y va a ir al hospital, necesita operación ¿operación? Y yo voy a estar en el hospital...

- 1 D: Do you work? Are you working? Are you working now or not?
- 2 P: Yes.... working.... I have take care of an old lady..... yes
- 3 D: You take care of an old lady
- 4 P: Yes, here on Barcelona Avenue I have not told you to street...
- 5 D: On Barcelona Avenue.... You' re working in a house taking care of an old woman
- 6 P: Yes
- 7 D: Only that, taking care of an old woman....
- 8 P: Yes, yes
- 9 D: ... Don't you do other things in the house, other household tasks? Just taking care of the old woman?
- 10 P: No... I don't not know ... already.. (She shows the medical card and points) I am here, I work. She's very sick ... she is very sick... (she points at the card) and she will go to hospital, she needs surgery surgery? And I will be in the hospital...)

In the case of the INNSS patients, the patterns are also frequently changed. For example, in the evaluation phase, the INNSS patient introduces questions, as in paragraph 14 (2), he/she provides short answers, sometimes monosyllabic utterances, or sometimes he/she does not even answer if the doctor does not insist as in Paragraph 12 (1, 3) above.

Paragraph 14 (after helping to fill out some papers and explaining carefully what to do)

- 1 D: Ya está. Solamente poner esto, no necesita nada más.
- 2 P: Bueno, el que decir ahí, no sé aquí que se....
- 3 D: ¿No?, pues el nombre, los apellidos, la fecha de nacimiento y el diagnóstico. Pero el diagnóstico es nada.
- 1 D: Only put this, you don't need anything else
- 2 P: OK. What say that? I don't know what
- 3 D: No? OK, it 's your name, your last name, your date of birth and the diagnosis. But the diagnosis is nothing)

Or the patient sometimes doesn't understand the doctor correctly, and he/she responds partially or with monosyllabic words to the questions without providing the additional information required whereas a native speaker would do it, as it happens in paragraph 15 (8, 10), where we also observed repetition:

Paragraph 15

- 1 D: Es, *Eshuaf*
- 2 P: *Eshuaf*
- 3 D: Elmustafá
- 4 P: Elmustafá

- 5 D: Ay, no como nombre.
 6 P: Sí sí
 7 D: Elmustafá ¿La fecha de nacimiento?
 8 P: Sí
 9 D: La de usted
 10 P: Sí. La fecha de nacimiento
 11 D: ¿No se la sabe?
 12 P: Sí, *se* la sabe, sí
 13 D: No se la sabe

- 1 D: He is, Eshuaf
 2 P: Eshuaf
 3 D: Elmustafá
 4 P: Elmustafá
 5 D: Oh, not like a name.
 6 P: Yes, yes
 7 D: Elmustafá . Date of birth?
 8 P: Yes
 9 D: Yours
 10 P: Yes. Date of birth
 11 D: You don't know it ?
 12 P: Yes, I know it
 13 D: You don't know it.)

Some other communication strategies used by the INNSS patients include and seen in previous examples are: CHECK

- Ungrammatical utterances 9 (9, 19)), (13 (2))
- Incorrect election of generic lexical terms as I will explain in more detail later see later (13 (2))
- Abundance of repetition 9 (3, 5, 9), (15 (4))
- Frequent use of monosyllabic words (13 (6, 8)), (15 (6,8)),
- Frequent explanations 12 (4)
- Supplying more information than required (13 (10)).

And we also find:

- Code switching
- Abruptly changing the topic
- Changes in the level of the register
- Misuse or scarce use of confirmation elements such as 'OK' 'aha' uhhh' 'vale' 'ya' to maintain contact ('Back-channel')

The previous examples show these strategies as well as Paragraph 16:

Paragraph 16

- 1 P: el pie... ahora una *tablet*... mañana... solo uno y un día puedo caminar y

- pasado poco me duele.
- 2 D: Ya
- 3 P: Y después mucho más... no tomar *tablet*... y luego me duele mucho..
- 4 D: A ver si he entendido bien. Tú por la mañana te tomas la pastilla. Una sola... y no te duele... Por la tarde comienza a dolerte ya..
- 5 P: No, no, por la noche poco, poco dolor... y por la mañana poco me duele... y un día no tomar, un día no tomar y después no caminar... como antes.
- 6 D: O sea, que el día que no tomas pastilla....
- 7 P: Un día o dos...
- 8 D: Está bien... Enséñame las pastillas que estás tomando... las pastillas...
- 9 P: ¿Dakortin?
- 10 D: Dakortin... ¿30 ó 50?
- 11 P: 30
- 12 D: ¿Y qué tomas? ¿una entera o media?
- 13 P: Una
- 14 D: ¿una?
- 15 P: Sí
- 16 D: O sea [writing on a piece of paper] que tú tomas todos los días de Dakortin 30 una pastilla grande
- 17 P: Sí, sí
- 18 D: Todos los días una
- 19 P: Sí, una por la mañana, y una por la noche cuando ... 9 y 10... me duele poco... porque yo voy a trabajar y no puedo hacer trabajo porque ahora quiero trabajo...
- 1 P: My foot... now one tablet... tomorrow... only one and one day I can walk and next day hurts me little.
- 2 D: OK
- 3 P: And later much more... not take tablet... and then it hurts me a lot..
- 4 D: Let's see if I have understood you. You in the morning take the pill. Only one... and your foot doesn't hurt ... In the afternoon starts hurting...
- 5 P: No, no, at night little, little pain... and in the morning hurts me little... and one day not take, one day not take and later not walk... like before
- 6 D: That is to say, the day that you don't take pill....
- 7 P: One day or two...
- 8 D: OK... Show me the pills that you are taking... the pills...
- 9 P: Dakortin?
- 10 D: Dakortin... 30 or 50?
- 11 P: 30
- 12 D: And what do you take? A whole one or half?
- 13 P: One
- 14 D: One?
- 15 P: Yes
- 16 D: That is to say [writing on a piece of paper] that you take a big pill of Darkotin 30 every day
- 17 P Yes, yes

- 18 D: Every day one
 19 P: Yes, one in the morning, and one at night when ... 9 and 10... it hurts me little... because I am going to work and I cannot make work because now I want work...)

We find invented words (16 (1)), ungrammatical utterances (16 (5)), repetition (16 (5, 8), detailed explanations (16 (16), or use of monosyllabic words (16 (11, 13, 15, 17). Repetition is obvious in the next example too:

Paragraph 17 [while D is writing on a piece of paper]

- 1 D: Próximo día... traes la tarjeta de sanidad... como ésta ¿vale?
 2 P: Próximo día traer la tarjeta del hospital [lee lo escrito]
 3 D: Tú tienes que traer aquí la tarjeta del hospital... la que es como ésta..
- 1 D: Next day... you bring health card... like this. OK?
 2 P: Next day bring hospital card (she reads that written)
 3 D: You have to bring the card here... the one like this...)

In the following paragraph, the INNSS uses an apparently unconnected and repetitive language that shows the lack of L1 proficiency. In fact, most of the INNSS have learned or are learning Spanish as adults without receiving any instruction, except basic courses for beginners. These characteristics influence the type of interaction that takes place as can be seen in the following example:

Paragraph 18 [P is speaking about her father while the doctor writes a report]

- 1 P: Y yo quiere que he hecho la, que la poquitín de fuerza para arreglar los suyos papeles para que se va y venir tranquilo. Pero no lo sé. A ver que dice lo demás..... consolado. Cómo es señor mayor, no le vas a dejar que venir, buff. Eh, que yo *hice* mucho, que yo tenga todo para que viniera mi padre aquí y todo mi hermanos. Hay que esperar, hay que esperar. Con *duana* y con todo.
- 1 P: And I want that I have made the that little of effort to fix his papers so that he leaves and come calm. But I don't know. Let see what they sayconsolated. As he is an old man, you won't leave him that to come, buff. Yes, I made a lot that I have everything so that my father came here and all my brothers and sisters. Oh he must wait, we must wait. With the customs and with everything.

In the case of insert of questions on the part of immigrant users, this fact contrasts with doctors' tendency to monopolize the right to ask questions in Western cultures as Fisher (1983) and West (1984) point out. Thus, when INNSS patients are the ones asking questions, these are marked by the irregularity that characterizes the non- favorite shifts; then, the doctor may answer the question or change the subject or start another sequence. In the analyzed corpus, however, INNSS's questions are usually answered by the doctors.

This fact also contradicts the patient's disposition to not participate in clinical

conversations since this passive participation and the patient's answers characterize the asymmetric clinical relationship (Fisher and Todd 1993; Díaz 1999). Furthermore, in Western cultures, asking the doctor direct questions may be considered redundant or a sign of bad manners. In my corpus, however, the INNSS patient frequently formulates questions, but they are people who come from other cultures where the distribution of doctors' and patients' roles, the contribution to the construction of knowledge, and the decision making procedure are not necessarily the same ones. Thus, the controversial category of the 'cultural environment' together with the linguistic one can affect the way patients are categorized. This is a topic that will be analyzed in a future paper.

2.4. Lexical choice

The kind of lexical choice made by the participants in the institutional setting is indicative of the understanding and handling of the situation. This choice of words shows the type of institutional tasks to be performed, the speakers' relationship with the institution as well as the speakers' command of the language (codes, styles, general or specific terms) and their awareness of the other. Drew (Drew et al. 1997: 99) calls these resources "'descriptive adequacy' of lexical choice with respect to the type of institutional context concerned", and includes:

- Use of terms restricted to the institutional context
- Variation in the use of technical or colloquial vocabulary
- Explanation of terms
- Preference for descriptive words
- Variation in the choice of "I" or "we" on the part of the professional to refer to the institution
- Tendency to use institutional euphemisms (e.g. diverse forms to refer to 'pain')
- (Heritage and Sorjonen 1994)
- Use of consent formulas or elements of confirmation (back-channel), including body movements such as head movements or raising of brows

The use of these resources constitutes a way of controlling the information that the doctor wants the patient to know and also a way of influencing their relationship. Thus, when dealing with lexical choice, the use of appropriate vocabulary contributes to make communication more effective. However, in the case of INNSS, when they are not fluent in Spanish, this task is extremely difficult. Then, the tendency is to use generic terms, repetition, inconsistent use of register levels, borrowings, or invention of new words or code switching as 'tablet'. The rate of use of these resources is usually related, on the one hand, to asymmetry of knowledge between the patient and the doctor and, on the other hand, to problems derived from incomplete knowledge of Spanish by INNSS. As a result we find expressions and words like: "Papastilla", a non-existing word for "pastilla" ('pill'), or "paspirina" for "aspirina" ('aspirin'), or "análisis de oreja y de ojos" ('ear and eye check-ups') instead of "reconocimiento de vista y oído" ('hearing and eyesight check-up'), or "la empadronamiento" ('the census') instead of "el empadronamiento" (using a wrong determiner and changing the gender from masculine ('el') to feminine ('la')). The same

happens with the use of “la conocimiento” (‘knowledge’) instead of “el conocimiento”. Or expressions that are a direct translation from their L1 as when a patient from Morocco says “cuando la abrimos la televisión” (‘when we open the television’) instead of “cuando ponemos la tele” (‘when we turn the TV on’), or very colloquial expressions as in “yo tenga de cuidar una vieja”, using really colloquial Spanish to refer to an elderly woman, instead of “tengo que cuidar de una anciana” (‘I have to take care of an elderly woman’) or in the following dialogue when the patient mentions “the Moor”, a term that has negative connotations in Spanish when referring to people from Morocco. Some of the above comments are seen in the following example:

Paragraph 19

- 1 D: No toma ningún medicamento ahora, bueno
- 2 P: No, no, ya la ha quitado hace mucho. Sí, hace mucho, ya la ha dejado, porque antes que tienes un poquito de asma pero ya -----porque con seis meses de tratamiento es, ... está bien con medicamento de todo. Cuando yo estoy viviendo en Madrid. Pero hace dos años no tenga ni una programa y estoy bien de salud, no...
- 3 D: Mmm
- 4 P: Y yo la hecho una prueba de estas, de de orina, de todo. De la oreja, de los ojos
- 5 D: Mmm
- 6 P: De todo. De todo. Y, el soy moro se pide esta cosas así
- 7 D: ¿Para qué es el seguro?
- 8 P: Una seguro de vida
- 9 D: Un seguro de vida

- 1 D: You are not taking any medication now, good
- 2 P: No, no, I have already stopped it long ago. Yes, long ago, I have stopped it, because before I had some asthma but -----because with six months of treatment... it is... it is well with medication of everything. When I am living in Madrid. But I have not had for two years a program and I am good of health, no...
- 3 D: Mmm
- 4 P: And me I have made a test of these, of of urine, of everything. Of the ear, the eyes...
- 5 D: Mmm
- 6 P: Of everything. Of everything. And, as a Moor.. it is requested this way this things
- 7 D: What is the insurance for?
- 8 P: Life insurance
- 9 D: Life insurance)

We see the use of synonyms (19 (2)) (‘la ha quitado /la ha dejado’), use of apparently unconnected speech (19 (2)), repetition (19 (6)), inconsistent use of register level (19 (6)).

The doctor also tries to accommodate his speech to the patients’ command of

Spanish. Thus in paragraph 20 he avoids technical terms and uses descriptive words, synonyms, repetition and direct forms, and even ungrammatical sentences. For example:

Paragraph 20

1 D: Venir a consulta el día que tengas libre ¿eh? Y mientras tanto tomas 2 o sea esto... 2 trozos para todo el día. Solo esto por la mañana... ¿vale?

1 D: Come to my office the day that you have free, OK? And meanwhile you take 2, that is to say, this... 2 pieces for the whole day. Only this in the morning... OK?)

That is, the doctor tries to neutralize or to diminish the communicative distance by accommodating the grammar and vocabulary use to INNSS's knowledge of the language.

2.5. *Asymmetric interactions*

Heritage (1997: 175) points to four types of asymmetries that are common in these encounters. They are:

1. participation asymmetry,
2. asymmetry of knowledge regarding the interaction system in the institution,
3. asymmetry of knowledge and epistemological avoidance,
4. asymmetry in the right of access to knowledge.

In the case of the asymmetry of participation, as Heritage (1997: 175) points out, the existence of this asymmetry means "implicit contrast with the standard of 'equal participation' between speakers in ordinary conversation," that is to say, the participants assume that equality doesn't exist in the participation.

Such asymmetries are also given in daily speech but, in that case, the interventions are not associated to specific roles, social norms or institutional tasks as in the case of doctor-patient interaction. In this case a direct relationship exists between the tasks and the institutional roles, the participants' rights and obligations. For example, in the question-answer structure, as I mentioned before, the professional is generally the one who asks the questions, which also implies a selection of terms and of other strategies directed at getting the appropriate answer or required information.

In the case of the asymmetry of knowledge, Heritage (1997: 175) defines it as the "'Knowhow' about the interaction and the institution in which it is embedded." The asymmetry arises (and often some tension) from the different perception of the situation: For the supplier of services - the professional or the doctor - the case is routine while for the user or patient the case is unique.

Furthermore, in the case of the professional, the institutions usually follow procedures or "procedure calendars" and they have material that facilitates their work: Forms, protocol norms, or performance guides that their representatives know and use. The user, on the other hand, lacks the routine and the knowledge, and he/she usually assumes a more passive role.

In the case of the asymmetry of knowledge and epistemological avoidance, it basically means that, in professional/user encounters, the professional possesses a superiority of knowledge and of information with regard to the user that may even produce breakdowns in communication as Heritage indicates (1997: 178):

Lack of medical knowledge may provoke that the user does not know or understand the purposes lying behind particular questions, and they may not grasp the line of inquiry which the doctor is pursuing in questions on what seem to be unconnected topics.

Fisher's (1983) and Silverman's (1987) studies on the so-called "hidden calendar of doctors' questioning" confirm such a statement. To this superiority of knowledge what is called 'epistemological caution' is usually associated. This caution is frequent in many institutions and it can be described as the professional's intention of avoiding being involved in making closed decisions and sometimes signing agreements, protocols, etc. This caution is more common in some institutions than in others, for example, in trials and in medical diagnoses.

Finally, in the case of the right of access to knowledge, the asymmetry in knowledge also arises when the user possesses limited resources to communicate, and the professional tries to achieve that balance either by using specific strategies or by performing different roles as, for example, the doctor acting like a father in a consultation with a child, or by lowering the linguistic level of his/her intervention, or by using a simpler language and even incorrect grammar. All these resources have been seen in previous examples and may contribute to fill the breach between the provider and the receiver of institutional services.

To understand these asymmetries in doctor-patient relationships it is useful to take into account Mishler's (1984) distinction between the "voice of medicine" and the "voice of the life world." According to him, the evaluations of doctors seem to reproduce the voice of medicine, while patients speak from the voice of the life world. In the case of Doctor-INNSS patients, these typical asymmetries in medical consultations are made more evident. They may even create tension because, as Heritage (1997: 177) points out, routine organizational contingencies are taken for granted by one party but remain unknown to the other, being the source of many other kinds of difficulties and confusion.

In my corpus, the INNSS patient usually lacks the knowledge of how to act out the role that corresponds to him/her in this type of encounter as well as the expected way of interacting. He/she also possesses a faulty knowledge of the communication language and his/her needs usually go beyond the strictly medical topic. As a consequence some changes in the roles and the institutional routine take place as, for example, the introduction of a new or non-related topic, avoidance of answering a specific question, or a failure in guiding the answer towards the attainment of the professional's goal.

Data from my corpus reveal that the doctor tries to overcome that communicative breach by accommodating his/her language to that of the user while the user usually repeats and adds information to guarantee the mutual understanding as we can see in the following example:

Paragraph 21 [At the end of the consultation the doctor talks to the patient's son and gives him some candy]:

1 D: ¿Quieres otro?

2 P: ¿Has visto? ¡qué médico!
 3 D: Para luego
 4 P: ¡Qué médico! ¡qué bueno!
 5 D: ¿Quieres otro?
 6 Child: No
 7 D: Sólo uno. Los guardamos para el próximo día que vengas
 8 Child: Sí
 9 D: Vale
 10 P: Pues bueno gracias
 11 Child: Gracias
 12 D: De nada
 13 Child: De nada
 14 D: ¿Cómo se dice gracias, en árabe? *Xucram*
 15 P: *Xucram*
 16 D: *Xucram*. Adiós
 17 P: Hasta luego. Gracias.

1 D: Do you want another one?
 2 P: You see that? What a doctor!
 3 D: For later
 4 P: What a nice doctor!
 5 D: Do you want another one?
 6 Child: No
 7 D: Only one. I'll keep them for the next day that you come
 8 Child: Yes
 9 D: Ok
 10 P: Thank you
 11 Child: Thank you
 12 D: You're welcome
 13 Child: You're welcome
 14 D: How do you say 'thank you' in Arabic? 'Xucram'
 15 P: Xucram
 16 D: Xucram. Good-bye
 17 P: See you later. Thank you).

Even here, as Maynard (1989) points out, although the patient's autodescription and the doctor's diagnosis refer to the same domain of shared reality, in principle they are treated as different forms of knowledge, one of which (that of the doctor) enjoys privileges over the other (that of the user). This doesn't mean that we are speaking of independent cultures, the doctor's and the patient's, but rather that there are two different ways of interacting (see Coupland et al. 1994).

In other words, Doctor-INNSS patient encounters are organized in such a way as to elicit descriptions and evaluations that work in a different way according to who produces them, or more exactly, according to the latter's position. This fact, together with the cultural differences that may accompany the participants means that the asymmetries can be accentuated and the effort needed to break the communication breach is bigger. In

my corpus, the doctors were used to seeing immigrant patients; however, this is not always the case, as comments on mass media, specialized medical press and conversations with immigrants and members of NGOs reveal. More research needs to be done.

3. Consequences of institutional structure variation in doctor-INNSS patient interaction.

Institutional dialogues follow a plan that the participants usually respect, and these usually direct the interaction with the purpose of responding to patterns and expectations. If the participants' profile or some of the structural elements change, then, some alterations can be expected. This is what happens in doctors' and INNSS patients' conversations at healthcare centers. In these interactions, activities that are not typically associated with the institutional context can be found. The following are some of these changes as revealed by the analysis performed in previous pages.

In the case of the doctors' intervention the data show:

- Exchange of roles
- Petition of information not strictly medical (e.g. whether patients have a health card or how many relatives he/she has in the city)
- Higher percentage of bureaucratic negotiation and of casual inserts
- Frequent explanation
- Higher percentage of interruptions
- Use of paraphrase and reformulations
- Frequent repetition
- Higher percentage in the use of certain speech acts: Directives, commissives.

In the case of the INNSS patients' intervention the data reveals that they also modify their role and type of relationship with regard to the institution. This is done through the use of strategies such as:

- Requiring non-medical information
- Using a higher percentage of specific speech acts like requests and questions
- Mixing different levels of the language
- Using politeness systems in unexpected ways
- Initiating conversational topics
- Giving more information than requested
- Repeating the same information several times
- Asking for confirmation
- Preference for brief answers and direct questions

The study reveals that these changes are mostly brought about for institutional and communicative reasons. In the case of doctors, this is shown in their tendency to monopolize the handling of the consultation (see Hak 1994); in the case of patients, this is manifested in a lack of mastery of both the structure of the institutional dialogue, and the language system and its use. The result is a series of changes and adaptations on the part

of the participants.

With respect to the doctors, the limited time available to complete their function leads him/her to direct the conversation towards that end. So, they try to accommodate their language to that of the INNSS; and to develop certain abilities that are not used in standard medical consultations with L1 patients, and that doctors often do not possess.

As for the patients, they may not be familiar with the dynamics of the medical interview. In achieving this objective they try to provide the doctor with the requested information - sometimes excessive, sometimes limited, either because they act according to their cultural patterns or because they lack the confidence in the language of interaction.

In conclusion, I can say that I consider the investigation carried out for this paper insufficient but relevant in spite of the difficulties in obtaining data. This kind of research allows for direct and quantifiable information on institutional contexts and immigrants in a changing society.

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